

REPORT OF THE
HIV HEALTH PROMOTION
STRATEGY REVIEW
GROUP

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CHAPTER 1

Introduction

1.1 It is now a decade and more since the UK Government put in place a range of far-reaching public health measures in responding to the most serious disease threat this country had faced for many years. Thanks to those actions HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) has not progressed to the pandemic level once feared. Nevertheless, new infections still occur in significant numbers in Scotland and there is no clear sign that they are on a downward track. Every case of HIV infection is a personal disaster.

1.2 Scottish Office Ministers set up a group to review HIV health promotion strategy in the conviction that effective prevention is achievable. The remit was – “to review the effectiveness of current HIV/AIDS health promotion activities by statutory and voluntary bodies in terms of preventing further spread of the virus; and to consider whether there should be any change in the emphasis and future direction of such activities, or how they are funded”. The main conclusion of this report is that health boards and other agencies need now to revisit their current approaches to prevention in an effort to progress from the current “steady state” to a clear downward track in the numbers of new infections recorded annually (although we recognise that if an increase in the numbers of individuals being tested for HIV is achieved, that may well, paradoxically, result in an increase in new infections, at least in the short-term). An effective vaccine against HIV may be many years away and there is a real risk that current low numbers of cases could begin to climb once more, if complacency sets in.

1.3 The Review Group approached its task by considering the risks of transmission in gay men, the adult heterosexual population, young people and injecting drug users. It took account of the ground-breaking report of the Ministerial Task Force in 1992 (“Prevention the Key”) and the policy statement “An Evolving Strategy” of 1995, which heralded a greater emphasis on targetting those groups which epidemiology confirmed were vulnerable and recognised that some of these targetted prevention efforts might best be undertaken by community-based groups among these vulnerable populations.

1.4 The membership of the Review Group was drawn from health boards and voluntary sector interests, also education, social work, health education, epidemiology and HIV-positive people.

1.5 Broadly speaking, the Review Group’s recommendations represent gradual evolution from the conclusions of the earlier reports. That these reports got it right is reflected in the fact that HIV/AIDS is a problem under control in Scotland compared with most of the world. The advent of the new combination drug therapies (highly active antiretroviral therapies), delivering at least relative well-being to many HIV patients has been a significant development that, in the view of the Review Group, helps to justify some degree of change in the approach to prevention, particularly in the hitherto controversial area of testing. There is therefore a firm recommendation that health boards and other agencies should adopt a policy of more positive encouragement to testing, particularly among gay men.

1.6 The Review Group considers its conclusions are consonant with the thrust of the White Paper on Public Health “Towards a Healthier Scotland”, in particular, with the

recognition of the importance of maintaining vigilance against HIV and promoting sexual health positively. During the period when this report was being written the Report of the Working Group on Sex Education in Scottish Schools was published: again, the Review Group is pleased to note the high degree of congruence of the conclusions in Chapter 5 and those of that report.

1.7 Chapter 2 provides a brief overview of the epidemiology of HIV in Scotland; Chapters 3, 4, 5 and 6 deal respectively with each of the main transmission groups affected currently or potentially affected by HIV i.e. gay men, the adult heterosexual population, young people and injecting drug users; Chapter 5 concentrates mainly on HIV in the context of sex education in schools, reflecting the Review Group's conviction that this is a key area where progress may be made; Chapter 7 covers other transmission routes; Chapter 8 refers to the transmission of hepatitis C; Chapter 9 identifies a number of issues for decision by the Scottish Executive; and Chapter 10 draws together all the recommendations made in the report.

1.8 I am grateful to the Review Group members for their enthusiastic contributions to the deliberations.

Nicola Munro
Chair

CHAPTER 2

The current epidemiology of HIV in Scotland

2.1 The data referred to in this overview were provided by the Scottish Centre for Infection and Environmental Health.

2.2 It is now 15 years since the first case of AIDS was diagnosed in Scotland and 14 years since it became apparent that epidemic spread of HIV had occurred among injecting drug users in the East of Scotland. Since then 1031 cases of AIDS and 3027 HIV infections had been reported to the Scottish Centre for Infection and Environmental Health by December 1999. Of this total, at December 1999, 1150 had died and 1877 were thought still alive. 1234 had undergone immunological monitoring, and thus were in clinical care, in 1998 and/or 1999.

2.3 The total number of new infections in 1999 was 157, the lowest figure recorded since 1994. The average number of new infections between 1988 and 1999 was 160 – the lowest figure being 134 and the highest 182, which illustrates both that the epidemic in Scotland has for some time been relatively under control and that there is as yet no clear indication that new infections are on a downward track.

Transmission groups

(i) Homosexual/bisexual males

2.4 It was encouraging that in 1999, 57 new infections were reported among homosexual/bisexual men, compared to an annual average of 77 between 1995 and 1998. It is notable that 12 (21%) of these cases were probably acquired outside Scotland. Such imported infections were as high as 33% in 1998 and 32% in 1997. The majority of cases continue to come from Lothian and Greater Glasgow Health Board areas. It is also notable that 5 cases were aged under 25 at the time of diagnosis. The prevalence of HIV among gay men tested in Scotland is currently around 4%, the highest of any transmission group.

(ii) Heterosexual men and women

2.5 In 1999, 59 infections were reported amongst heterosexual men and women (who were not injecting drug users) – this is the highest annual figure ever recorded and compares with an annual average of 54 reports during 1995-1998. Of this total, 5 were known to have had a sexual partner who had injected drugs; the corresponding figures for 1997 and 1998 were 11 and 9 respectively. The figure of 5 cases reported in 1999 is the lowest annual total recorded for this high risk group since the mid-1980s.

2.6 32 of the cases in 1999 were probably acquired abroad (22 in Africa); the corresponding figures for 1997 and 1998 were 19 and 27 respectively. The figure of 32 in 1999 is the highest annual total ever recorded for imported infections among heterosexuals. In 6 of the 53 cases no high-risk partners were declared and infection was probably acquired in the UK. The remaining cases are still under investigation.

2.7 Despite the relatively large number of new infections reported among heterosexuals in 1999, the evidence is that the incidence of indigenous heterosexual transmission of HIV in

Scotland is low. The small number of reports of heterosexual infections where an injecting sexual partner was involved confirms that measures to reduce the incidence and prevalence of HIV among injectors has helped to control the transmission of infection from injecting drug users into the wider heterosexual population.

2.8 Data from the unlinked anonymous HIV testing surveys confirm that the incidence of HIV among heterosexuals is low, and if anything, in decline. The prevalence of HIV among non-injecting heterosexual males attending genito-urinary medicine clinics throughout Scotland in 1998 was 0.16%, the lowest annual prevalence recorded since testing began in 1991. The corresponding figure for women was 0.28%; however, if persons with a non-UK nationality or geographical exposure are excluded, the prevalence decreases to 0.20%. The prevalence of HIV among mothers giving birth in 1998 was 0.02%, the lowest annual rate since testing began in 1990.

Injecting Drug Users (IDUs)

2.9 18 new infections were recorded among IDUs in 1999 – the lowest on record and comparing with 25 and 39 in 1998 and 1997, respectively. 3 of the 12 cases diagnosed in 1999 were aged under 25 years. The prevalence of HIV as regards IDUs having a named HIV test in Scotland also decreased to its lowest level of 0.9% in 1998, compared with between 2% and 3.7% during 1989 to 1993 and a constant prevalence of 1.5% during 1994 to 1997. In 1998 there was little geographical variation in prevalence.

2.10 It is generally considered that interventions such as vigorous health promotion, needle and syringe exchange and methadone maintenance programmes have together been effective in making HIV transmission among IDUs in Scotland now a relatively rare occurrence. Nevertheless, increasing numbers of cases of other bloodborne viruses e.g. hepatitis B or C signify that many IDUs are continuing to share injecting equipment. This implies an increasing potential for a resurgence of HIV among IDUs in Scotland.

CHAPTER 3

Preventing transmission among gay men

3.1 The prevention of HIV amongst gay men in Scotland represents a major challenge. Although there is reason to believe there is less risk-taking (that is, through engaging in unprotected anal intercourse) among gay men in Scotland than fifteen years ago, to a great extent the conditions for transmission still exist. There is a good deal of “repeat testing” by many gay men, which suggests that significant numbers are engaging in unprotected anal intercourse. Recent research among gay men in bars and clubs in Glasgow and Edinburgh confirmed that around 30% had unprotected anal sex with at least one partner in the previous year and around 10% with more than one partner. Those gay men most at risk of HIV may represent, however, a distinct group capable of being targeted effectively with prevention efforts.

3.2 It is widely believed that safer sex has been incorporated into the culture and language of the gay community. Gay men have been at the forefront of HIV work and especially prevention throughout the course of this epidemic. Nevertheless, there is a growing concern that the gravity of HIV infection and the need to tackle it are not high enough in the range of priorities for many individuals, partners and communities. There is a need for collective action to build on and sustain what is working well for gay men.

Barriers to HIV prevention

3.3 Given the pioneering work in HIV prevention credited to gay men and the ready co-operation of many in the gay community, there is a strong base for HIV prevention work with gay men. There are examples of effective work in urban areas such as Glasgow and Edinburgh and in rural areas such as Highland, where the approach is that the gay community itself adopts a lead role, supported by the local statutory agencies. Nevertheless, effective prevention work is made more difficult where gay men themselves are in denial, or if health boards fail to recognise the problem.

3.4 In a population which faces stigmatisation and discrimination in various contexts, doing what the individual knows and believes to be best for him and others can become more difficult than it otherwise need be. When compared with the level of detail available on the spread of HIV through sex between men and women, there are gaps in information regarding gay men and where and how the epidemic is being maintained. Research results from outwith Scotland might not translate to the Scottish context. The work done by the Medical Research Council’s Sexual Health and Reproductive Department in Glasgow is an example of good quality research.

3.5 The annual AIDS (Control) Act reports by Scottish health boards provide evidence of patchiness in the provision of prevention efforts aimed at gay men. (See also “Services for Gay & Bisexual Men in Scotland”. Kilpatrick, R, SCVO 1996 and the recent National AIDS Trust publication “Are Health Authorities Failing Gay Men?” (NAT 1999)). One success of the HIV prevention work with injecting drug users in the 1980s in Scotland, and particularly in Lothian, was to improve generic health provision for this group and strengthen links between specialist hospital-based provision and community health services. But health facilities are not always adequate or appropriate to the needs of gay men accessing them.

Given the link between health and social care generally and effective HIV prevention, this lack in some areas needs to be addressed.

3.6 One of the risks of promoting a stronger interest and participation on the part of generic provision for gay and homosexually active men is of the “professionalisation” of HIV, and the exclusion of gay men themselves from decision-making processes. It is gay men themselves who will make a difference in individual behavioural choices and community action to prevent the spread of HIV and their capacity to decide and act for themselves should be reinforced not undermined. There is accumulating evidence that HIV prevention work with gay men is most effective when it follows a community development model, engaging gay men and mobilising them in the fight against HIV.

Integrated approach

3.7 Given that combinations of interventions are likely to be more effective than any single approach, prevention activity with gay men must be integrated, recognising that sexual behaviour is one part of the individual’s life and is associated with a range of other needs and experiences. For example, the issue of safer sex for gay men will often be raised in the context of self-esteem and personal safety. It also necessitates close collaboration between agencies e.g. one agency may be funded to work specifically with homosexually active men in cruising areas, but will need to collaborate with agencies which can be a first point of contact for issues related to sexual identity (e.g. gay and lesbian switchboards), and with the police, given the legal and safety dimensions of work in public sex environments.

Peer education

3.8 Many gay men will have limited direct contact with prevention agencies. The behaviour to be targeted is unsafe sex and it is the prevention of HIV through the empowerment of men which must be the ultimate objective. Peer education models have been promoted in a variety of settings and for a variety of topics and have proved particularly effective in the field of HIV prevention among gay men in various countries.

- **We therefore recommend that programmes of peer education be developed for work with gay men; and that the Health Education Board for Scotland, perhaps in co-operation with Healthy Gay Scotland, approaches the gay press to explore the potential for getting effective information and prevention messages across.**

Volunteering

3.9 One vital step towards participation of gay men in the fight against HIV and in promoting peer education programmes is to use volunteers. This approach provides opportunities for people to give help to the gay community’s response to HIV and utilises the wide range of experiences and skills available.

- **It is recommended that health boards actively recruit, train, support and utilise volunteers for HIV prevention and encourage voluntary bodies they may fund to do so.**

Settings

3.10 Gay men socialise in a variety of settings where much direct work needs to be done. There are often barriers or hindrances to such work, given the nature of the areas themselves, including consideration of legality, safety and privacy. Where these settings are commercial, e.g. bars, clubs and saunas, owners', managers' and workers' co-operation is vital. Local licensing authorities also play a role in ensuring health and safety for the clients of the establishments. In other areas, such as public sex environments, legal and community sensitivities need to be recognised and partnerships developed to enable work to be most effective. In this respect, the appointment of police liaison officers has been effective in ensuring a joint approach which respects the realities and risks of cruising areas as well as the responsibilities of law enforcement.

- **We recommend that police forces should consider appointing liaison officers to co-operate with leaders of the gay community towards achieving protection for gay men in public sex environments; sufficient protection should also be the aim for heterosexual people in such settings.**

3.11 There are various other settings in which men meet, make contact, or negotiate sex. Each has its complexity for agency work and must be conducted with flexibility and imagination, as well as caution. One such setting is in prisons, where men not gay-identified may become homosexually active with associated risks. The Group appreciated the opportunity to learn from Dr Alan Mitchell, Medical Adviser to the Scottish Prison Service, of the Service's existing pro-active approach to HIV prevention. It was noted that information on HIV/AIDS was given to new prisoners as part of induction, with the emphasis being, understandably, on the risk associated with needle and syringe sharing. Currently, the Scottish Prison Service (SPS) makes condoms available to prisoners, but is to review its current policy whereby condoms are made available to prisoners only on liberation and for periods of home leave.

- **We recommend that the Scottish Prison Service considers whether it can do more to reduce the potential for HIV transmission in prison.**

3.12 Other areas where direct intervention may be difficult include the Internet, which is often used for the purposes of direct sexual contact as well as for accessing explicitly sexual material. Web-sites which promote safer sex or the integration of safer sex with these other sites might be a way of raising awareness with a difficult-to-reach population.

Levels of intervention

3.13 The various contexts and settings for safer sex work with gay men make it essential that gay men have the opportunity to think about, talk and be made aware of HIV issues in different ways. The gay community itself is not homogenous and men live, work and socialise in a range of ways and must therefore be engaged in ways which reflect the reality of their different lifestyles, as well as their specific needs. Hence, scene-based work, which reaches the maximum numbers of men, needs to be backed up with opportunities away from the pressures and limitations of such work by group-work, and couples and individual support and, where necessary, counselling. This range of approaches is resource-intensive and requires careful management where volunteers are being employed. There is increasing evidence, however, of the effectiveness of a range of interventions at these various levels,

especially given the difficulties which some men have in adjusting or sustaining safer sex for a variety of complex reasons. It should not be forgotten either that HIV positive men, particularly those who are responding well to combination therapies, also have health promotion needs which need to be addressed by services.

Condom distribution

3.14 In order to encourage safety when men choose to have anal sex, condoms need to be promoted and their availability with water-based lubricant ensured. There are difficulties in accessing condoms suitable for anal sex, due to factors such as commercial disincentives due to a limited market, ignorance of which condoms are suitable, embarrassment in buying such extra-strong condoms, and remoteness from retail outlets. It is also important to note that although sex is on the minds of many men who visit the settings referred to above, preparation for safer sex may not be. Free distribution of condoms and lubricant in commercial gay venues in urban areas is an effective method of ensuring that the means of making anal sex safer are readily available. Other options, such as community pharmacies, mail order and internet outlets need to be explored and piloted in rural areas.

- **We recommend that health boards should examine the availability of condoms suitable for gay men in their areas and, if necessary, seek to make them available or promote their availability with retail outlets.**

Risk from oral sex

3.15 It was noted that the Department of Health in England had issued the report of an expert group set up by the UK Chief Medical Officers' Expert Advisory Group on AIDS in June 2000, which pointed to a certain level of risk of HIV transmission associated with oral sex practices. Health promotion for gay men should take account of the conclusions.

Earlier diagnosis

3.16 Recent information indicates that in Scotland 49% of gay men infected with HIV are unaware of their HIV status and some of these have rectal or urethral gonorrhoea. This raises concerns regarding risk to the health of the individuals themselves as well as the risk of transmission to others. The later the HIV diagnosis, the more likely it is that the infection has progressed to a serious stage, and the less effective combination therapies are likely to be. The specific reasons why some gay men in Scotland who have put themselves at significant risk of HIV infection do not test for HIV need to be explored. Genito-urinary medicine (GUM) services are key locations for HIV testing, diagnosis and treatment of other sexually transmitted diseases and for conveying preventive information. Facilities for testing need to be improved and promoted.

- **We recommend that health boards step up their efforts to encourage gay men to undergo HIV testing; ensuring there is access to gay-friendly GUM services open at suitable times; and in the larger boards consider setting up clinics offering a sexual health service specifically for gay men.**

3.17 If the aim is the prevention of HIV transmission, the greater the proportion of people whose infection has been diagnosed and are therefore in touch with services, the greater the opportunity for effective intervention. The success of combination therapies means the

balance has swung much more in favour of HIV testing. Testing may now be encouraged more rigorously, because those found to be HIV positive are likely to benefit from the new drugs, both prolonging their lives and increasing its quality. Effective treatment will also almost certainly reduce the infectivity of the individual.

- **We therefore recommend that health boards ensure that comprehensive services, including appropriate counselling that communicates HIV prevention messages, and follow-up services, are available, including access to anti-retroviral therapy when clinically appropriate.**

3.18 Alongside the promotion of improved HIV testing facilities, confidentiality issues need to be recognised and the implications of HIV testing thoroughly explored in counselling by trained workers. Community-based agencies should be used wherever possible.

- **We therefore recommend that health boards review current practice in test-related counselling towards maximising, with due sensitivity to the individual, the potential for identifying sexual partners who may have been at risk of infection.**

Gay and lesbian switchboards

3.19 Prior to the first identified cases of HIV, gay and lesbian switchboards had been established to provide confidential information and support to people about issues of sexuality. These switchboards are staffed almost entirely on a voluntary basis and have incorporated safer sex and HIV issues into their work. They continue to play a key role in work with the gay community, but often receive very limited support or resources from local government or health boards. Switchboards play a different but complementary role to the National AIDS Helpline in its remit to provide advice and information to callers from across the UK on concerns related to HIV and AIDS.

- **We therefore recommend that health boards and local authorities consider providing appropriate support to such switchboards in their areas to communicate HIV prevention messages.**

Homosexually active men

3.20 Some homosexually active men do not identify openly as gay or bisexual and are therefore difficult to reach. But they may be at risk of contracting HIV. They include:-

Male sex workers

3.20.1 The needs of male sex workers should be recognised in any national strategy. It is essential that agencies work together closely to promote safer sex among male sex workers. The context in which male sex workers operate requires the integration of safer sex and HIV work with other needs, such as homelessness, drug and alcohol problems, mental and physical health, and safety. The workers and their clients are not a static group and are often stigmatised and marginalised by society, including the gay community. Work with this group requires the shared expertise of a variety of agencies. In order to reach the greatest number and different types of male sex workers, peer-education based approaches are required, together with advocacy and low threshold, “one-stop” facilities.

Ethnic minorities

3.20.2 Different cultural backgrounds require different approaches. The lack of acknowledged homosexual identities in some ethnic minority communities makes work with such communities and individuals within them more complex. There is limited information available on homosexuality, sexual risk-taking or HIV in such communities. Agencies may recruit volunteers and workers from minority communities with due regard for equal opportunity requirements, but should also consider the scope for joint work with agencies and ethnic community interests.

Alcohol and drugs

3.21 The association between alcohol and drug use and sexual risk-taking is complex. It may be related more to the context of use, excuse factors, or increased susceptibility to infection than to disinhibition or lack of control. The link between increased sexual risk-taking and alcohol or drug-related problems may reflect mental health or depression, being young and inexperienced, or peer-pressure. Young people who are gay, lesbian or bisexual face similar pressure to those who are heterosexual, and it may be argued that the different underlying considerations may make substance use more prevalent and problematic. HIV prevention agencies should work with people with alcohol or drug-related problems in the context of a holistic approach. Where problems of substance use are paramount for the individual, referral to or work with specialist agencies may be more appropriate however.

Organisational

3.22 The Strathclyde HIV and AIDS Network and Gay Men's Task Group work in the West of Scotland, and the Gay Men's Task Group and Lothian HIV Coalition in the East are examples of successful co-operative and collaborative promotion of the needs of people living with HIV and joint initiatives. In less populous areas work with gay and bisexual men is more limited, although such areas may be in fairly close proximity to meeting places used by gay men, usually in the cities, and cross-boundary working can be effective. Putting such arrangements in place will usually require some funding by health boards and local authorities, and should include groups such as switchboards (see 3.19 above).

- **We recommend that health boards and local authorities should promote and support community-based bodies towards the achievement of effective cross-boundary working.**

Capacity-building

3.23 One of the difficulties of initiating or sustaining work with gay men is the limited capacity of the gay community to organise itself and thereby identify and respond to HIV-related needs. Such capacity-building can also help the gay and lesbian community to respond to a range of health and social needs, as well as to advocate effectively on its own behalf.

- **We therefore recommend that, in areas with significant levels of HIV infection, health boards should consider the scope for stimulating the formation of a gay men's HIV prevention agency as a potential vehicle for spreading HIV prevention messages.**

CHAPTER 4

Preventing transmission among the adult heterosexual population

4.1 Paragraph 2.5 noted that 1999 marked the highest recorded number of new infections among heterosexuals. Broadly-speaking, HIV infection and AIDS have not become as acute a problem across the whole population as was once feared. In particular, the heterosexual spread of HIV infection in Scotland has been less than predicted at one time. There is nevertheless a continuing risk and the challenge is to overcome any complacency among the population generally, and to take due account of the prevalence of infection and risk-taking behaviour. Prevention strategies must continue to address the issue of heterosexual transmissions, as evidenced by the gradual increases in numbers of infections noted in Chapter 2, albeit that numbers are low relative to size of population. Continuing vigilance is clearly justified. Sexually transmitted infection rates and the fact that Scotland has one of the highest rates of teenage pregnancy in Western Europe¹ provide firm evidence of a continuing high incidence of unprotected sex. The challenge remains how to address HIV and sexual health effectively through health promotion, while recognising the sensitivity and complexity of sexual relationships.

4.2 The non-statutory sectors, health boards, local authorities, schools and the Health Education Board for Scotland (HEBS) have already undertaken significant and valuable health promotion work in addressing HIV. It is also important to recognise the success of work among injecting drug users which has also had real impact in reducing infection rates within the whole population. The aim should be to build upon the valuable existing services such as those provided for injecting drug users and sex workers, as well as in sensitively-managed contact-tracing. Prevention approaches that seek to influence risk-taking behaviour should continue to be developed. The Review Group considers that, rather than continuing to focus primarily on HIV, the most effective way of communicating with young people in particular is through a more general approach to sexual health education and that there should be a particular emphasis on reaching young people (which is taken up in Chapter 5).

4.3 The White Paper on Public Health “Towards a Healthier Scotland” recognises that there are many linked causes of ill health including poverty, bad housing, and problems in our education and environment. Inequalities can have a knock-on effect on sexual health; as the White Paper confirms, “Good sexual health is a positive dimension of a healthy lifestyle and is also important for the wider community”. Although Government has a strong role to play, it is considered that the commitment of public, private, voluntary and community bodies, as well as individuals, also contributes importantly to promotion of good sexual health. Sexual health education activity is motivated by concern for public health and the desire to positively promote well-being.

Sexual relationships and HIV

4.4 The incidence of sexually transmitted infections such as genital herpes, chlamydia and genital warts and the increasing incidence of gonorrhoea provide clear evidence of continuing unsafe sex practices. While alertness to HIV must clearly be maintained, the Group considers that the time is right to develop a more general health promotion strategy in sexual health. We recognise that health boards serving areas of low HIV incidence have often effectively

¹ Towards a Healthier Scotland, The Stationery Office, February 1999

been adopting this approach in recent years. This approach will have the benefit of addressing public attitudes towards other preventable diseases, as well as unwanted pregnancies and abortions.

- **We recommend the development of a broad-based health promotion strategy for sexual health, within which due attention is paid to such specific issues as HIV/AIDS prevention, prevention of other sexually transmitted infections and the prevention of unwanted pregnancies.**

Health education

4.5 Health education is never presented in a vacuum and it is a fact there is an enormous emphasis on sex in the media; the attitudes to sex projected in the media may well influence behaviours. To be effective, sexual health education should seek to develop informed attitudes and decision-making based upon knowledge, understanding, skills and dispositions. Educational activities should be consistent with good practice in health promotion methodology and, in particular, should be designed to meet the specific needs of the target audience.

4.6 Various aspects of sexual health affect people at different points in their lives. For example, to focus upon such issues as unwanted teenage pregnancies and chlamydia will be of more relevance to young people than stressing the risks of having sex with sex workers. In assisting people in making choices, health education activities and associated materials should reflect these needs, without being prescriptive. What is required is a consistent approach throughout, which recognises the positive aspects of sexual health within relationships. Such information should be devised for all to understand. A sexual health strategy must reflect the very personal nature of the subject while recognising sexual health as a public health concern. In encouraging people to make individual healthy choices, there are elements of both personal and community responsibility and protection involved.

4.7 Some believe that sex education encourages sexual experimentation. Experience in Holland would not support this view. The Dutch have for many years provided a systematic and thorough sex education programme for their young people. This approach encourages openness and honesty about sexual health and is supported by easily accessible contraceptive services. In spite of having a lower age of consent than in the UK, sexual activity is on average initiated at a later age.

- **We therefore recommend the development of a range of initiatives and materials towards promoting good sexual health for individuals as they reach different life stages.**

4.8 Reference has already been made to the difficulty inherent in maintaining awareness of the risk of HIV infection among the heterosexual population, when that risk is known to be very low. This presents a particular challenge to health promotion agencies. It will not be helpful to exaggerate the level of risk facing heterosexual adults who neither inject drugs, have a HIV-positive partner or engage in casual sex. Nevertheless, the number of new infections recorded in 1999 among heterosexuals was the highest ever and the long-term trend is upwards. We identify those at greater risk as being **those who travel abroad**, particularly to Africa and other areas where HIV is widespread, since the most recent data

confirm that infections are frequently acquired abroad, and **uninfected partners** of HIV positive people.

4.9 In recent years around half of new HIV infections among heterosexuals have been acquired while abroad: indeed, more than half in 1999. These cases may arise from casual sexual relationships on holiday or business travellers having sex with sex workers, or as a result of return visits to home countries by foreign nationals resident in Scotland. It is also claimed there is growing interest in “sex tourism” for both heterosexuals and homosexuals. And, of course, there has been a steady increase over the years in the amount of international travel undertaken. It is of concern that the Scottish public may not be sufficiently aware that, while the risk of contracting HIV in Scotland is relatively low, the risk is much higher in other countries, particularly in Africa and Asia.

- **We recommend that the Health Education Board for Scotland and the Scottish Centre for Infection and Environmental Health (in recognition of its role in providing advice to doctors on the health risks of foreign travel) should review current arrangements for advice on HIV to travellers.**

4.10 From dealing with initial diagnosis and subsequent changes in lifestyles to long-term treatment, couples of whom one is HIV positive often require support and care, and the role and needs of the uninfected partner are important. Although treatment is effective, combination therapies can have unpleasant, and on occasions serious, side-effects. Compliance with the complicated treatment regimes require motivation and self-discipline and support given to people on treatment should also be extended to partners towards ensuring they maintain safe sex practices.

- **We recommend that health professionals be encouraged to recognise the key role of partners and the need to support them in avoiding infection.**

4.11 The Group were grateful for comments received from the Haemophilia Society making the valid observation that those who care for HIV sufferers are also in need of support, but it was felt to be straying outwith the Group’s remit to make any recommendations in this area.

Condom availability

4.12 Access to and availability of condoms for the sexually active adult population is a significant part of a sexual health strategy, particularly in the context of public health and the prevention of sexually transmitted infections and unwanted pregnancies. However, it is important to recognise that not everyone is comfortable about encouraging their use.

- **We recommend that health boards review the various existing condom availability schemes already in operation against the criteria of ready accessibility and instruction in appropriate use.**

Oral sex

4.13 The reference at para 3.15 may also be relevant to heterosexuals.

CHAPTER 5

Preventing transmission among young people

5.1 This chapter focuses on the approach to young people, with a particular emphasis on the opportunity to influence them positively during the school years. The comments and recommendations made here bear on all young people irrespective of sexual orientation.

5.2 The Review Group welcomes the recognition in the White Paper “Targeting Excellence” that “the provision of effective health education in Scottish schools is vital”. The White Paper also confirms that pupils should be equipped with knowledge and skills to make sound moral choices and adopt a healthy lifestyle. For sex education to be effective, a context of loving relationships should be advocated, which encourages individuals to value one another for what they are and to look after their own bodies. Teaching involving negotiation skills requires to be specific to the subject area being taught, in order to be fully effective. Since parents have an important role to play in endorsing what is learned in school, a partnership between schools and communities should be encouraged. The existing curriculum framework for sex education is endorsed, but the Review Group believes that further effort is needed to ensure the security of the infrastructure and its effective co-ordination. Health education and sex education must be given due emphasis within the overall programme of personal, social and health education delivered by schools and supported by local education authorities.

- **We therefore recommend that further advice and active encouragement be provided to education authorities by the Scottish Executive Education Department on how to deliver the curriculum objectives.**

5.3 Developments in training such as the Scottish Virtual Teachers’ Centre, which will allow teachers to access a wealth of teaching material through the Internet and to exchange ideas and share best practice, are welcomed. Nonetheless, some concerns exist about the extent to which existing training initiatives adequately address the needs of the teaching profession. The Review Group would like to see all teacher education institutes put in place the nationally-agreed framework for pre-service training supplemented by suitable health professionals. This would aid a culture shift, whereby teachers would feel able to teach children to an equivalent standard in subjects outwith their specialist field such as health education. There may be credible alternative arrangements, for example using school nurses where these exist, to help co-ordinate and support health promotion in schools.

5.4 The report of the Excluded Young People Action Team, established under the auspices of the Scottish Social Inclusion Action Team, placed a strong emphasis on the development for young people of ‘personal resources’, for example self-esteem, self-confidence, aspiration and practical life-skills. Because of the benefits such support can provide, particularly to the most vulnerable, the report recommended that greater prominence be given to the development of these ‘personal resources’. For the same reasons, the position of personal and social education co-ordinator which exists within some schools is to be commended. The Review Group would wish to see local education authorities encouraging and supporting the appointment of such co-ordinators across Scotland, although in making this recommendation, it is noted that there is at present an ongoing review of teachers’ conditions of service. Co-ordination and support for health promotion in schools is also required at education authority level.

5.5 Elements of a sex education programme can usefully be delivered by an independent person. Outside agencies can have an important role to play within a programme, but it must also be stressed that their involvement should be planned carefully and provide clear added value, and that responsibility for sex education, and health education more generally, still rests with the school. In assisting headteachers in making decisions as to who is best equipped to come into their schools, information about suitable service providers would be helpful. Education authority officers and health board health promotion departments are well placed to advise and support health-promoting school initiatives.

5.6 Often time allocation can be an issue in giving health education sufficient priority. The Review Group understands that the Scottish Executive Education Department is to consider this issue and welcomes the fact.

We therefore recommend that:

- **in order to ensure that this issue has a secure place within our schools, further central advice be issued to local authorities**
- **the training of teachers in this area of work be reviewed**
- **the position of personal and social education co-ordinator in schools be encouraged and its status reviewed**
- **headteachers are provided with up-to-date information by education authorities about organisations providing sexual health education services and the quality standards that should apply.**

Young people's needs

5.7 Sexual experience within the teenage population varies very widely. Sexual activity is associated with a number of factors including age, stage of personal development, educational achievement and aspirations and socio-economic background. By the age of 20 however, most young people will have become sexually experienced. It should also be recognised that the majority of younger teenagers will not be sexually active, although many will be involved at various stages in developing relationships. Therefore, all young people require specific information to assist them in making healthy choices. This need is acknowledged internationally and there is "growing recognition that owing to a variety of biological and social factors, adolescents are vulnerable to a range of health problems, including those that result from: too early, unwanted and unprotected sexual activity; the use of tobacco, alcohol and other psychoactive substances; accidentally and intentionally inflicted injuries; and mental problems such as depression".²

5.8 In giving support to young people and making sure they have access to services, there is a gap outwith the school setting. It can also be harder to reach young people who are frequently absent from school and it is vital there is an avenue available to reach this

² Weekly Epidemiological Record, No 8, 26 February 1999

vulnerable group, who are more likely to get involved in risky behaviour³. In promoting good health, evidence suggests that additional support in the form of teenage-dedicated services may be advantageous⁴. Young people's centres already exist in Scotland and this is an evolving concept. We believe these projects should be developed as a resource for young people (mainly secondary school pupils) and provide a secure and welcoming environment, with opening times relevant to their needs. Various models for different community needs would evolve from a central framework and would look at broad issues such as building self esteem; relationships; family issues; alcohol issues; eating disorders; problems at school and sexual health. We noted that the Executive is developing the "Walk the Talk" project with Fast Forward and Community Learning towards providing young person-friendly services.

5.9 This concept of young people's centres sits well with the concept of Healthy Living Centres, which are intended to improve the health and well-being of people generally, and there should be active encouragement for GPs and health promotion services to make some input. Such initiatives could involve specific advice as well as more general health promotion messages, with provision of access to particular services directly or through referral. These options would be developed and considered in a partnership between the community and local service providers. It is for consideration whether such centres could be developed within the concept of community schools.

- **We therefore recommend that pilot young people's centres be established at local level by health boards and local authorities, which might be linked to existing local facilities or Healthy Living Centres as these are developed.**

Aspirations of young people

5.10 In the process of growing up, it is vital that young people are supported and encouraged to have high aspirations and to assume appropriate degrees of personal responsibility. The evidence indicates that those with low academic or low educational aspirations are most likely to get involved in risky behaviour.⁵ Many factors are positively influential, particularly experience of a social environment where success and opportunity are expected. Since children tend to be moulded by the view of the world of those around them, it is important that such an outlook permeates to the community, teachers and pupils, bearing in mind the strong influence of the peer group. The Review Group therefore welcomes the Executive's emphasis on creating a positive ethos within schools and encouraging high expectations and achievement⁶.

- **We therefore recommend stimulating high aspirations among all young people in the conviction that this will encourage positive and responsible attitudes to sexual health.**

³ Sexual Health of Scottish 15 year olds: Preliminary Findings from the 1998 Health Behaviour in School-Aged Children Survey (HBSC) : Briefing Paper to the HEBS Board, January 1999, prepared by Dr Candace Currie, RUHBC, Medical School University of Edinburgh

⁴ "An Overview of Effectiveness of Interventions and Programmes Aimed at Reducing Unintended Conceptions in Young People" Health Education Authority, 1998, J Meyrick and C Swann and "The Implications of Research into Young People's Sex, Sexuality and Relationships" Health Education Authority, 1998, P Aggleton, C Oliver and K Rivers

⁵ As ³ above.

⁶ Targeting Excellence, The Stationery Office, January 1999

Role of parents

5.11 Parents, understandably, have many questions regarding the issues they face in bringing up their children. Support can come from other parents and various professionals. Parents may at times need reassurance in setting boundaries for their children and talking to other parents often helps to legitimise their understanding and also provides mutual support. Providing a home background which involves approval and reassurance also helps to raise the aspirations of young people. In recognising that parents have a vital role to play in the education of their children and endorsing what is learnt at school, parents should be actively encouraged to provide mutual support. The Executive has indicated its support for Family Centres and these could provide an opportunity for such support along with the provision of factual information. Such centres could help parents to discuss sex and sexuality with their children in a setting that encourages openness. Since there is an association between the adoption of safe sex attitudes and parents who talk to their children about sexual matters⁷, it is vital that good inter-personal skills are nurtured in this way.

5.12 Other opportunities for support for parents might be presented through Healthy Living Centres and New Community Schools, as mentioned in the White Paper “Towards a Healthier Scotland”. In determining how these projects will operate, a basic framework might be proposed, for example, having opening hours convenient to working parents, the provision of a pre-school interface and the involvement of the voluntary sector.

- **We therefore recommend that the Executive considers the scope for integration of parenting support needs in the area of sex education of their children in Family Centres, Healthy Living Centres and Community Schools, and continue to build upon existing primary school parent room initiatives, and secondary school and community parent programmes.**

Condom availability

5.13 While not endorsing the indiscriminate distribution of free condoms, we believe it must be acknowledged that health professionals have a role in providing access to contraception. Although sex education is likely to deal with sexual health issues within the context of stable and loving relationships, it has to be recognised that sexual behaviour takes many forms. It is important therefore that information and access to condoms are encouraged in order to facilitate safer sexual health practices. Decisions as to whether the teaching of condom usage should be incorporated within the school setting should be made on a local basis and involve negotiation between parents and schools. The youth and community/informal education setting should be encouraged to play a role in education on condom usage.

- **We recommend that safer sexual practices including condom use be promoted by health professionals and by schools in an appropriate context within a health education framework. For those who choose to be sexually active, health professionals should provide clear access to advice, services and condoms.**

⁷ Sexual Health of Scottish 15 year olds: Preliminary Findings from the 1998 Health Behaviour in School-Aged Children Survey (HBSC) : Briefing Paper to the HEBS Board, January 1999, prepared by Dr Candace Currie, RUHBC, Medical School University of Edinburgh

Further and higher education students

5.14 The current National (UK) Survey of Sexual Attitudes and Lifestyles should indicate how widely practised unsafe sex is among the heterosexual population. The recent incident in Doncaster of HIV transmission among heterosexuals frequenting night clubs highlights how readily HIV can spread through unprotected sexual intercourse. It also flags up the role of alcohol and substance misuse in reducing inhibitions and thus affecting behaviour. Colleges and universities provide an appropriate setting for HIV prevention activity among young adults more likely to be engaged in regular sexual activity.

- **We recommend that health boards liaise with students' unions, colleges and universities towards achieving effective prevention.**

5.15 This chapter has outlined a strategy not only to deal with the present, but also to invest in our future. Paying special attention to young people now and equipping them with social skills that will be valuable throughout life will have long-term positive consequences in promoting health. The challenge to schools, local authorities, health boards and the voluntary sector is to carry this through and, to youngsters who gain these important life skills, to sustain what is learned throughout their lives.

5.16 But, while schools have a role to play, it is essential to recognise there is no panacea and, although it is reasonable to expect the Executive to establish a framework of sex education, the impact of individual choices cannot be overstated. This strategy aims to provide foundations to which all can subscribe, with a view to society in general benefiting from altogether healthier lifestyles for our young people.

CHAPTER 6

Preventing transmission among injecting drug users

6.1 From evidence assembled in Scotland in relation to HIV and injecting drug use it can be shown that a good deal has been achieved to prevent a major epidemic. This is borne out by the continuing falls in numbers of new infections described at paragraph 2.9. Nevertheless, vigilance is still required towards continuing the reduction of HIV transmission among injecting drug users (IDUs), and to assist in the reduction of transmission of hepatitis. However, it has to be recognised that the power of addiction, inadequate local services to IDUs and a lack of understanding and information with regard to injecting drug use will continue to hinder transmission reduction.

6.2 As stated in the Scottish Executive's national drugs strategy ("Tackling Drugs in Scotland: Action in Partnership") the overall aim should be to reduce the incidence of injecting, sharing and polydrug misuse among drug misusers.

6.3 We also noted that the Advisory Council on the Misuse of Drugs has recently reported on tackling drug deaths and consider our report will help to address their recommendations.

6.4 The epidemic spread of HIV among IDUs in Edinburgh and Dundee became apparent in 1985, following the development and introduction of a test which could detect HIV antibodies. On the basis of data from various sources, including the retrospective HIV antibody testing of sera collected in the early 1980s, it is clear that the epidemic spread of HIV among IDUs in Edinburgh and Dundee occurred during the period 1983-86. While some IDUs from Glasgow became infected during 1985-89, epidemic spread did not occur, despite the city having the highest prevalence of injecting drug use in Scotland and one of the highest prevalences in Western Europe. In recent years, HIV transmission among IDUs throughout Scotland has remained under control. Not only have the numbers of diagnoses declined – despite the numbers of IDUs having a named HIV test remaining steady over the years – the great majority of the cases identified in recent years were older IDUs who likely acquired their infection some years before. Nevertheless, HIV transmission among IDUs in Scotland has not been eradicated.

The role of interventions in the prevention of HIV among IDUs

6.5 Why did the frequency of HIV transmission among IDUs in Scotland decrease in the mid to late 1980s and remain at a low level throughout the 1990s? Due to the impracticalities of conducting randomised controlled trials on interventions such as needle and syringe exchange or methadone substitution therapy, it has been impossible to prove experimentally that these initiatives were responsible for preventing the spread of HIV among Scotland's IDUs. Indeed, HIV transmission among Edinburgh and Dundee injectors started to decline prior to the implementation of needle and syringe exchange schemes in these cities and, in Glasgow, the epidemic spread of HIV among its population of injectors never occurred. However, following the identification of the problem (especially in the East of Scotland) in 1985, IDUs reduced their frequency of needle and syringe sharing in response to the message of the dangers, conveyed to them – both directly and through the media – by a multitude of health care professionals including drugs workers, nurses, public health physicians and other doctors.

6.6 Needle and syringe exchange and methadone maintenance interventions, which were introduced in the late 1980s and were further developed during the early to mid-1990s, led to further reductions in needle and syringe sharing. Not only did the frequency of needle and syringe sharing decrease, but the type of sharing also altered. In the early to mid-1980s it was not uncommon for one needle and syringe to be used indiscriminately by large numbers of injectors in “shooting gallery” settings. It was the discontinuation of this particular culture which prevented the further epidemic spread of HIV among IDUs.

6.7 Needle and syringe sharing activity is monitored annually through the Information and Statistics Division’s Scottish Drug Misuse Database surveillance scheme. Anonymous data are collected from drug users presenting to general practitioners and specialist drug services throughout Scotland with a new drug problem. Of 2,569 injectors who were registered in 1997/98, 28% indicated they had shared a needle and syringe in the previous month. Although this surveillance does not differentiate injecting with a used needle or syringe from passing on injecting equipment, this level of “sharing” is worryingly high.

6.8 Throughout the last decade, health boards and local authorities have worked hard to develop needle and syringe exchanges and methadone services for injecting drug users. Inequalities in service provision, however, still remain. Needle and syringe distribution rates, for example, appear to vary widely among health board areas; in some health boards, injectors received, on average, 10-30 needles and syringes during 1998/99 while in others the average annual numbers exceeded 100. In Greater Glasgow, a health board with a developed network of needle and syringe exchanges over 700,000 sets of equipment were distributed to injectors between April 1998 and March 1999. Each of this board's current injectors, estimated to be about 8000, would have received, on average, less than 100 sets during the 12 month period. Injectors, however, typically inject drugs about 1000 times per year. Even taking into account that some injectors obtained sterile needles and syringes from unofficial sources, and that the numbers of these are not recorded, there is a large discrepancy between the numbers of needles and syringes required by injectors and the numbers distributed to them. There is good evidence that injectors who live nearer to and receive more needles and syringes from official exchange schemes inject with used needles and syringes more frequently than those who live further away and receive less needles and syringes from such facilities.

6.9 Methadone maintenance therapy is now more available than ever before. Some health boards' methadone services are better than others. A study supported by the Chief Scientist’s Office of the Scottish Executive, to evaluate the impact of methadone maintenance therapy on a cohort of Glasgow injectors, revealed large reductions in injecting (and thus sharing), crime and morbidity over a one-year period of evaluation; further investigations are required to evaluate the longer term impact of methadone therapy.

6.10 A high proportion of injectors in Scotland continue to share needles and syringes and other injecting paraphernalia - behaviours which continue to result in sporadic HIV infection and high rates of hepatitis C and hepatitis B transmission among this population. There is good evidence that needle and syringe exchange and methadone maintenance interventions lead to a reduction in such sharing.

- **We therefore recommend that:**

safe injecting behaviour ie: zero sharing, of all types of injecting equipment be advocated by all health professionals in contact with IDUs and drug users who are considered likely to become injectors;

health boards and local authorities review the provision of harm reduction services, in particular needle and syringe exchange and methadone maintenance, in their areas and ensure that all injectors have reasonable access to such services, having regard to times of opening and the location of services relative to where IDUs reside.

6.11 Research carried out in 1994 and 1998 indicated there were between 15,000 and 20,000 IDUs in Scotland. Data collected through the Scottish Drug Misuse Database and from other sources suggest that the numbers of young people who started their injecting careers in recent years remained steady or increased. The most effective way to prevent potential injectors from becoming infected with HIV or other bloodborne viruses is to deter them from injecting in the first place. It would appear, however, that the success of current interventions to prevent the initiation of injecting has been extremely limited. While it is important that school children have a sound understanding of the dangers of drug use and injecting, it is unclear what interventions will lead to a reduction in drug use and, in particular, drug injecting initiation. Accordingly, research is required urgently.

- **We recommend that interventions to reduce drug use and injecting initiation are designed and evaluated using, where possible, randomised control trial methods.**

Care and treatment of IDUs in Scotland

6.12 It was extremely encouraging to note that almost 80% of IDUs with severe HIV disease, as indicated by a low CD4 count, were receiving combination therapy. It is quite possible that for most of the IDUs who were eligible for therapy, but were not receiving it, there were contraindications which justified no treatment. However, being prescribed therapy does not always equate to complete or even partial adherence to the regimen.

Health promotion issues

6.13 The emergence of the AIDS epidemic during the 1980s stimulated interest in the phenomenon of injecting drug use, because re-used needles and syringes are vehicles for transferring HIV from one person to another. In developing the means of preventing further spread of HIV infection among IDUs, there are several areas where greater understanding is needed and where further research might prove helpful:

- defining the specific sub-cultural values that underlie the use of needles and syringes for administration of psychotropic drugs;
- identifying the mechanisms of initiation into injecting drug use, and the changes in route of administration over time;
- examining the drug-taking practices of heroin users; and
- examining the gender differences in patterns of drug-taking behaviour.

Specific sub-cultural values among those using psychotropic drugs by injection

6.14 Experiences of a research cohort (Page, Smith 1999) indicate that the onset of drug use by injection takes place in social contexts where slightly more experienced peers instruct new users in the administration and appreciation of unfamiliar drugs. Very few interviewees reported sub-cutaneous or intra-muscular injection. Most first experiences were probably intravenous. Reasons for preferring injected drugs to alternative means of ingestion include the longer-lasting effects or intensity of the 'high'. Injection also means that hardly any of the expensive drug is wasted, while smoking or snorting involves some wastage.

The mechanisms of initiation into injecting drug use and change in the routes of administration over time

6.15 Because more recent recruits to injecting drug use are likely to be young adolescents, it is important to disentangle the effects on injecting risk behaviour and HIV incidence of how young they were and when they started injecting (Ameijden et al 1992,1994). Data suggest that more innovative preventative efforts are needed, and should be targeted at both recent onset IDUs and young injectors. Insight into the psychological characteristics of new injectors, the history of drug use, and utilisation of methadone programmes prior to the onset of injection, may help to develop strategies to prevent drugs users from starting to inject. HIV and hepatitis C (HCV) prevention can be improved through behaviour skills training and developing specific interventions that target peer group environments, rituals, partner relations and life-style drug users. It is essential to know why drug users try to maintain intravenous drug use - how the issues are perceived "from their side".

- **We recommend that peer educators who have injected in the past should continue to be recruited to work with putative injectors and young or new injectors.**

The gender difference in patterns of drug-taking behaviour

6.16 Quillet et al (1998) report that in the course of a 4 year study, a quarter of sex partners who had not injected at the start of the study began injecting drugs. This underlines the importance of drug injection between those with close relationships. Of considerable surprise is the finding that sex partners with no history of illicit drug use beyond marijuana, were most likely to become injectors.

6.17 Gossop et al (1994) report that women are more likely to have a sexual partner who is a drug user, and to be living with another user, than men. Thus, close social attachment to other drug users was seen as presenting high risk factors for women with regard to prognosis and treatment.

6.18 There has been some reference earlier to information already available, but there are specific areas where further research, in relation to the particular circumstances of IDUs in Scotland is desirable.

- **We recommend more research is conducted into:
the precise mechanism for transmission of infections amongst IDUs;**

why injecting continues to have so strong a pull compared with the other ways of taking drugs and what might be done to change this behaviour;

the social/sociological factors impacting so negatively on IDUs that continue to make the risks of injecting worth taking;

the variety of injection practices eg back-loading and front-loading, taking place in particular areas; employing current injectors to assist the research at appropriate sites; and

why there is such variation in the provision of clean needle and syringes to IDUs among different health board areas across the country.

National health promotion activity

6.19 This is undertaken by the Health Education Board for Scotland whose activities and approach reflect both their arena-based strategy overall and their role as a national agency. Work focuses on communicating primarily with those among the population, principally young people, who are experimenting with drugs or using them on an occasional basis. Other work aims to support staff who have a health education role within particular settings and/or in relation to drug misuse, amongst other topics. This may involve providing support materials, supporting demonstration projects and publishing research information. Addressing the information needs of those involved in intravenous drug use has not been attempted. This is primarily because such needs are probably best met by local services, which are more likely to be sensitive to local patterns of and changes in drug misuse.

SUMMARY OF CURRENT SERVICE PROVISION

Health boards

6.20 Drug Development Officers were asked to respond to a simple questionnaire in consultation with their health board to provide a snapshot of current service provision in Scotland. The results are summarised at Annex A. The following recommendations arise from consideration of the overall picture provided.

- **A variety of interventions, including drug-reduction treatment, substitute prescribing and detoxification, should be made available to reduce an individual's dependence on heroin.**
- **Health boards and social work departments should ensure that therapeutic and rehabilitation services commissioned by them address key factors in relation to drug users' initiation into and persistence in injecting.**
- **Drug users should be encouraged regularly to accept referral to therapeutic counselling.**
- **Since thirty per cent of injectors, as reported to the Scottish Drug Misuse Database, have shared a needle and syringe in the previous month, health boards should**

review the effectiveness of needle and syringe exchange schemes in helping prevent IDUs sharing needles and syringes and other equipment.

- **In particular, health boards should re-assess the return rate being achieved for used needles and syringes.**
- **Therapeutic and rehabilitation services should encourage IDUs and their partners to adopt safer sex practices and reduced risk practices in relation to drug use.**
- **More pro-active service delivery for women drug users should be a priority for service commissioners.**

Local authority social work departments

6.21 An audit of services for injecting drug users provided or purchased by local authority social work departments was carried out on behalf of the Review Group. A questionnaire on departments' service activities was circulated to all local authorities. The results are presented in Annex B.

6.22 Health promotion is an integral part of services provided by local authorities which are specifically targeted at both drug misusers and people with HIV and HIV-related illness. For the majority of local authorities, services are offered within a harm-reduction approach. These services include the provision of health promotion material, counselling, and clean needles and syringes as part of overall needle exchange schemes.

We recommend that:

- **Social work departments should engage with local health promotion departments and other relevant agencies to develop appropriate health promotion/sexual health initiatives for young people looked after by the local authority.**
- **Social work departments should ensure that staff have access to substance misuse training programmes and up-to-date information on drug use behaviour and trends in their area.**
- **Social work departments should liaise with local health promotion departments and the Health Education Board for Scotland to ensure that up-to-date materials and resources are made available to service users and staff.**
- **Social work departments should collaborate with health boards to develop programmes targeted at socially excluded young people engaging in high-risk drug-taking activities in order to prevent initiation into injecting drug use.**
- **Increased efforts should be made by social work departments, social care agencies and health boards to develop joint-working protocols and joint care plans for drug users on substitute prescribing programmes to ensure adherence to treatment and prevent relapse or a return to injecting drug use.**

Prisons

6.23 In 1993, at least 13 IDUs became infected with an identical strain of HIV inside HM Prison Glenochil during the first six months of that year as a consequence of sharing used needles and syringes. This was the first proven outbreak of HIV infection in a prison anywhere in the world and the findings demonstrated that, given favourable circumstances, HIV could still spread rapidly among injecting populations.

6.24 In March 1993, the Scottish Prison Service (SPS) published its Guidance on the Management of HIV/AIDS Prisoners, which is about to be reviewed given the recent advances in treatment. Also, in 1993 SPS introduced a policy of making sterilising tablets readily available to all prisoners for use, among other things, in cleaning injecting equipment and paraphernalia. The recently-published SPS Substitute and Detoxification Prescribing Guidelines encourage the appropriate continuation of methadone prescribing in prisons when such has been commenced in the community and there is no evidence of current illicit drug misuse. In 1999, a pro-active hepatitis B immunisation programme was established across all Scottish prisons, whereby all those admitted to custody are encouraged to become immunised. The uptake rate among the prisoner population across establishments is around 70%.

CHAPTER 7

Preventing transmission by other routes

Antenatal testing

7.1 The group considered whether routine testing of pregnant women for HIV/AIDS should be extended in Scotland. At present, it is offered in Tayside, Lothian and Fife. This means that routine testing will be available in parts of Scotland where most cases of HIV among pregnant women have been detected but not in other areas where occasional cases have occurred.

7.1.2 If routine testing had been in place throughout Scotland between 1995 and 1998, and had been taken up in every case, the Scottish Centre for Infection and Environmental Health estimate that 5.7 cases of infant HIV could have been prevented, that is 1.4 a year. The benefits would have been more pronounced in urban areas.

7.1.3 There is a careful balance to be struck. On the one hand, because screening is already in place in several high risk areas, extending it to other parts of Scotland might bring little additional benefit for the costs involved. On the other hand, universal screening would be a very direct measure in the sense that every positive result could allow the application of proven prevention measures. Universal screening in both high and low prevalence areas is also recommended by the Expert Advisory Group on AIDS and the National Screening Committee for the following reasons:

the alternative to universal screening in low prevalence areas is selective screening and this has been shown to be ineffective in identifying HIV infected pregnant women. There is now clear evidence that interventions can significantly reduce the risk of HIV being passed from mother to baby. All interventions require the knowledge of HIV status in pregnant women. Continuation of selective screening for HIV is therefore considered ethically unacceptable and it could also give rise to legal action

taking an overall HIV prevalence of 0.02% for the UK, under most scenarios considered in the analysis, it is cost-effective to screen universally

- **Against this background, the Group recommends that antenatal screening for HIV be offered routinely to all pregnant women. The offer should take the form of indicating to pregnant women that HIV testing is being done routinely, but that they can decline to be tested, if they wish. This has proved a more effective approach than simply offering a test. It is essential that every woman is given clear information about the HIV test – and the other antenatal tests that will be done – so that she can give her informed consent to allowing the tests to be done. She also needs to be given the opportunity to discuss any related issues with a suitably trained member of staff.**

Sex industry

7.2 It can be argued there has been solid success in the prevention of transmission by sex workers, as evidence confirms there has not been a single case of HIV transmission through non-injecting drug-using prostitutes in Scotland. Most sex industry workers do protect

themselves, and, in so doing, their clients. As the sex industry becomes increasingly global, with some workers coming to this country from areas with higher HIV prevalence, it is possible that a new route for infection in the heterosexual population will appear. In view of anecdotal evidence suggesting there are pressures on female sex workers not to use condoms, the emphasis on prevention needs to be sustained. The complexities of this group's health and social care needs are acknowledged in that street workers often engage in prostitution in order to sustain drug misuse habits.

- **We recommend continuation of the successful work done by health boards, local authorities and the voluntary sector in regard to the sex industry, including peer-education work and training for those who work with prostitutes. The provision of condoms in outreach work should also be encouraged.**

CHAPTER 8

Preventing hepatitis C infection among injecting drug users

8.1 The Review Group was not asked specifically to consider the problem of hepatitis C (HCV) infection among IDUs, but felt justified in doing so because of its close connection with HIV and the high level of interest in this topic among health professionals and drug workers.

8.2 While HCV prevalence among injectors has declined during the era of harm reduction interventions such as needle and syringe exchange, it is of concern that recent surveillance in 1995/96 has shown infection in 16-19 years olds in Glasgow and Edinburgh. These individuals would have commenced their injecting during the era of needle and syringe exchange. There is also a growing number of anecdotal reports which indicate that HCV is being acquired by injectors who have never shared needles and syringes, but frequently share other injecting paraphernalia such as filters. This suggests further consideration needs to be given to the current response to the problem of sharing equipment and the likelihood of transmission and we note that the review by the Scottish Needs Assessment Programme (SNAP) published recently concluded that it is plausible that sharing paraphernalia is a cause of transmission. There are legal restrictions on the issue of paraphernalia other than needles and syringes, but this does not rule out other forms of effective preventive action. While needle and syringe exchanges may have helped to reduce HCV transmission among IDUs in Scotland, it has failed to control its spread among this population.

8.3 Two main reasons have been suggested for HCV being so much more prevalent among injectors in Scotland than HIV – (i) that a much larger reservoir of HCV than HIV had been established among Scotland's IDUs by the time safer injecting practices were being promoted in the mid-1980s following the discovery of HIV and, (ii) transmission studies have shown that HCV is fifteen times more easily transmitted than HIV through the percutaneous route. These observations confirm that continuing HCV transmission among injectors in Scotland presents a major public health challenge. Even if current interventions have reduced the chances of an IDU acquiring HCV in any single year of injecting, many injectors will ultimately become infected; with 60% of IDUs being chronic carriers of HCV, and a typical 12 year injecting career involving in excess of 10,000 injecting events, the probability of an IDU being exposed to HCV is extremely high.

8.4 It is possible that the nature of existing arrangements for access to clean needles and syringes and the absence of a clear message about the dangers of sharing other paraphernalia have been factors in the failure to control the spread of HCV. Clearly, a greater understanding as to why and how IDUs are becoming infected with HCV in the era of needle and syringe exchange is required to inform the development of new interventions which will further reduce the chances of IDUs becoming infected.

8.5 The Review Group concluded it is no longer appropriate to focus effort and resources on one bloodborne virus (HIV) however important. Hepatitis has become more prevalent and more easily transmitted, hence a similarly major public health issue, and we consider that a wider view should be taken of bloodborne viruses in regard to health promotion and the development of "messages". This will require a more sophisticated set of messages and approach to the identification of target populations to be successful.

We therefore recommend:

(i) that the uses of earmarked HIV Prevention funding provided to health boards be extended to cover prevention of transmission of other bloodborne viruses, particularly hepatitis C, and mainly, but not exclusively, among IDUs.

(ii) that the Scottish Executive reviews the existing guidance governing the issue of needles and syringes to IDUs in the light of the apparent transmissibility of hepatitis C through other injecting paraphernalia.

CHAPTER 9

Issues for The Scottish Executive

Targets

9.1 We considered whether there is scope for setting targets for reducing transmission, recognising that targets may often help in providing a clear focus and objective. However, if our recommendation to seek to encourage more gay men to come forward for HIV testing is acted on, there is likely to be an increase in the numbers of new infections reported, at least in the short term.

- **We therefore recommend that a medium-term broad target be adopted of continuing reductions in numbers of new infections in each of the main transmission groups.**

AIDS Control Act

9.2 The Group has not considered in any depth the question of the continuing usefulness or otherwise of the reports submitted annually by health boards to the Scottish Executive. Given that the Scottish Executive Health Department is now directly responsible for monitoring the use made of HIV prevention allocations to boards, it would seem sensible for the Executive to revisit the rationale for these reports and

- **We recommend accordingly.**

Funding

9.3 For many years HIV Prevention funding has been “earmarked” ie allocated to health boards from the centre on the basis that it could not be used for other purposes without specific permission. That was also true of funding for HIV/AIDS Treatment and Care until recent years, when it was concluded that funding should be merged into health boards’ general allocations. The case for retaining earmarking of Prevention funding has centred on the argument that the life-threatening nature of the disease requires a degree of central control to ensure that the national prevention effort is not slackened. Those opposed to earmarking argue that no other serious disease problem is managed in this way and that it has not in practice been effective in ensuring that health boards’ use of such funds has always been strictly relevant to HIV prevention. There is also a recommendation (para 8.5) that health boards should be allowed at least to widen the use of the funding to cover prevention of transmission of other bloodborne viruses.

- **We recommend that in the light of this report’s conclusions and recommendations that the existing earmarking arrangements should continue for the next 2 years ie to March 2002, and then be reviewed.**

Level of funding

9.4 The current level of funding across Scotland is £6.119 million. From 1 April 1999 allocations have been based on a formula devised to introduce greater equity, taking into

account HIV incidence and prevalence and population. The total amount has not increased for some years.

We recommend:

- **health boards review the current use of HIV prevention funds to ensure it reflects the epidemiology of HIV in their areas.**
- **that the Executive considers increasing the present level of funding in view of its real-terms reduction in recent years and in order to provide additional resources to facilitate implementation of this report's recommendations.**

CHAPTER 10

RECOMMENDATIONS

Transmission among Gay Men

- **Programmes of peer education be developed for work with gay men; and that the Health Education Board for Scotland, perhaps in co-operation with Healthy Gay Scotland, approaches the gay press to explore the potential for getting effective information and prevention messages across. (para 3.8)**
- **Health boards actively recruit, train, support and utilise volunteers for HIV prevention and encourage voluntary bodies they may fund to do so. (para 3.9)**
- **Police forces should consider appointing liaison officers to co-operate with leaders of the gay community towards achieving protection for gay men in public sex environments; sufficient protection should also be the aim for heterosexual people in such settings. (para 3.10)**
- **The Scottish Prison Service considers whether it can do more to reduce the potential for HIV transmission in prison. (para 3.11)**
- **Health boards should examine the availability of condoms suitable for gay men in their areas and, if necessary, seek to make them available or promote their availability with retail outlets. (para 3.14)**
- **Health boards step up their efforts to encourage gay men to undergo HIV testing; ensuring there is access to gay-friendly GUM services open at suitable times; and in the larger boards consider setting up clinics offering a sexual health service specifically for gay men. (para 3.16)**
- **Health boards ensure that comprehensive services, including appropriate counselling that communicates HIV prevention messages, and follow-up services, are available, including access to anti-retroviral therapy when clinically appropriate. (para 3.17)**
- **Health boards review current practice in test-related counselling towards maximising, with due sensitivity to the individual, the potential for identifying sexual partners who may have been at risk of infection. (para 3.18)**
- **Health boards and local authorities consider providing appropriate support to such switchboards in their areas to communicate HIV prevention messages. (para 3.19)**
- **Health boards and local authorities should promote, and support community-based bodies towards the achievement of effective cross-boundary working. (para 3.22)**
- **In areas with significant levels of HIV infection, health boards should consider the scope for stimulating the formation of a gay men's HIV prevention agency as a potential vehicle for spreading HIV prevention messages. (para 3.23)**

Adult Heterosexual Population

- **The development of a broad-based health promotion strategy for sexual health, within which due attention is paid to such specific issues as HIV/AIDS prevention, prevention of other sexually transmitted infections and the prevention of unwanted pregnancies. (para 4.4)**
- **The development of a range of initiatives and materials towards promoting good sexual health for individuals as they reach different life stages. (para 4.7)**
- **The Health Education Board for Scotland and the Scottish Centre for Infection and Environmental Health (in recognition of its role in providing advice to doctors on the health risks of foreign travel) should review current arrangements for advice on HIV to travellers. (para 4.9)**
- **Health professionals be encouraged to recognise the key role of partners and the need to support them in avoiding infection. (para 4.10)**
- **Health boards review the various existing condom availability schemes already in operation against the criteria of ready accessibility and instruction in appropriate use. (para 4.12)**

Young People

- **Further advice and active encouragement be provided to education authorities by the Scottish Executive Education Department on how to deliver the curriculum objectives. (para 5.2)**
- **In order to ensure that this issue has a secure place within our schools, further central advice be issued to local authorities. (para 5.6)**
- **The training of teachers in this area of work be reviewed. (para 5.6)**
- **The position of personal and social education co-ordinator in schools be encouraged and its status reviewed. (para 5.6)**
- **Headteachers are provided with up-to-date information by education authorities about organisations providing sexual health education services and the quality of standards that should apply. (para 5.6)**
- **Pilot young people's centres be established at local level by health boards and local authorities, which might be linked to existing local facilities or Healthy Living Centres as these are developed. (para 5.9)**
- **Stimulating high aspirations among all young people in the conviction that this will encourage positive and responsible attitudes to sexual health. (para 5.10)**
- **The Executive considers the scope for integration of parenting support needs, in the area of sex education of their children in Family Centres, Healthy Living Centres and Community Schools, and continue to build upon existing primary school parent**

room initiatives, and secondary school and community parent programmes. (para 5.12)

- Safer sexual practices including condom use be promoted by health professionals and by schools in an appropriate context within a health education framework. For those who choose to be sexually active, health professionals should provide clear access to advice, services and condoms. (para 5.13)
- Health boards liaise with students' unions, colleges and universities towards achieving effective prevention. (para 5.14)

Injecting Drug Users

- Safe injecting behaviour ie: zero sharing, of all types of injecting equipment be advocated by all health professionals in contact with IDUs and drug users who are considered likely to become injectors. (para 6.10)
- Health boards and local authorities review the provision of harm reduction services, in particular needle and syringe exchange and methadone maintenance, in their areas and ensure that all injectors have reasonable access to such services, having regard to times of opening and the location of services relative to where IDUs reside. (para 6.10)
- Interventions to reduce drug use, and injecting initiation are designed and evaluated using, where possible, randomised control trial methods. (para 6.11)
- Peer educators who have injected in the past should continue to be recruited to work with putative injectors and young or new injectors. (para 6.15)
- That more research is commissioned into:
 - the precise mechanism for transmission of infections amongst IDUs;
 - why injecting continues to have so strong a pull compared with the other ways of taking drugs and what might be done to change this behaviour;
 - the social/sociological factors impacting so negatively on IDUs that continue to make the risks of injecting worth taking;
 - the variety of injection practices eg back-loading and front-loading, taking place in particular areas; employing current injectors to assist the research at appropriate sites; and
 - why there is such variation in the provision of clean needle and syringes to IDUs among different health board areas across the country. (para 6.18)
- A variety of interventions, including drug-reduction treatment, substitute prescribing and detoxification, should be made available to reduce an individual's dependence on heroin. (para 6.20)

- **Health boards and social work departments should ensure that therapeutic and rehabilitation services commissioned by them address key factors in relation to drug users' initiation into and persistence in injecting. (para 6.20)**
- **Drug users should be encouraged regularly to accept referral to therapeutic counselling. (para 6.20)**
- **Since thirty per cent of injectors, as reported to the Scottish Drug Misuse Database, have shared a needle and syringe in the previous month, health boards should review the effectiveness of needle and syringe exchange schemes in helping prevent IDUs sharing needles and syringes and other equipment. (para 6.20)**
- **Health boards should re-assess the return rate being achieved for used needles and syringes. (para 6.20)**
- **Therapeutic and rehabilitation services should encourage IDUs and their partners to adopt safer sex practices and reduced risk practices in relation to drug use. (para 6.20)**
- **More pro-active service delivery for women drug users should be a priority for service commissioners. (para 6.20)**
- **Social work departments should engage with local health promotion departments and other relevant agencies to develop appropriate health promotion/sexual health initiatives for young people looked after by the local authority. (para 6.22)**
- **Social work departments should ensure that staff have access to substance misuse training programmes and up-to-date information on drug use behaviour and trends in their area. (para 6.22)**
- **Social work departments should liaise with local health promotion departments and the Health Education Board for Scotland to ensure that up-to-date materials and resources are made available to service users and staff. (para 6.22)**
- **Social work departments should collaborate with health boards to develop programmes targeted at socially excluded young people engaging in high-risk drug-taking activities in order to prevent initiation into injecting drug use. (para 6.22)**
- **Increased efforts should be made by social work departments, social care agencies and health boards to develop joint-working protocols and joint care plans for drug users on substitute prescribing programmes to ensure adherence to treatment and prevent relapse or a return to injecting drug use. (para 6.22)**

Transmission by Other Routes

- **Antenatal screening for HIV should be offered routinely to all pregnant women. The offer should take the form of indicating to pregnant women that HIV testing is being done routinely, but that they can decline to be tested, if they wish. This has proved a more effective approach than simply offering a test. It is essential that every woman is given clear information about the HIV test – and the other antenatal tests that will be done – so that she can give her informed consent to allowing the tests to be done. She also needs to be given the opportunity to discuss any related issues with a suitably trained member of staff. (para 7.1.3)**
- **Continuation of the successful work done by health boards, local authorities and the voluntary sector in regard to the sex industry, including peer-education work and training for those who work with prostitutes. The provision of condoms in outreach work should also be encouraged. (para 7.2)**

Preventing hepatitis C infection

- **That the uses of earmarked HIV Prevention funding provided to health boards be extended to cover prevention of transmission of other bloodborne viruses, particularly hepatitis C, and mainly, but not exclusively, among IDUs. (para 8.5)**
- **That the Scottish Executive reviews the existing guidance governing the issue of needles and syringes to IDUs in the light of the apparent transmissibility of hepatitis C through other injecting paraphernalia. (para 8.5)**

Issues for the Scottish Executive

- **A medium-term broad target be adopted of continuing reductions in numbers of new infections in each of the main transmission groups. (para 9.1)**
- **That the Executive revisits the rationale for AIDS (Control) Act reports. (para 9.2)**
- **In the light of this report's conclusions and recommendations, that the existing earmarking arrangements should continue for the next 2 years ie. to March 2002, and then be reviewed. (para 9.3)**
- **Health boards review the current use of HIV prevention funds to ensure it reflects the epidemiology of HIV in their areas. (para 9.4)**
- **The Executive considers increasing the present level of funding in view of its real-terms reduction in recent years and in order to provide additional resources to facilitate implementation of this report's recommendations. (para 9.4)**

**HIV HEALTH PROMOTION STRATEGY REVIEW
SUB-GROUP ON INTRAVENOUS DRUG USERS**

Activity by Health Board Area	Health Board															
	Question	A&A	A&C	BOR	D&G	FIFE	FV	GR	GG	HIGH	LAN	LOTH	OR K	SHET	TAY	WI
1. Are specialist needle & syringe exchange facilities provided?	yes	yes	yes	yes	yes	yes	yes	yes	yes	no	yes	yes	yes	yes	yes	no
2. Do you have outreach facilities for needle and syringe exchanges?	yes	no	no	yes	yes	yes	yes	no	no	no	yes	no	no	yes	no	
3. Are community pharmacists involved in your needle & syringe exchanges?	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	no	
4. Estimated Nos. of needles and syringes distributed in latest year available?	45k	83,551	1,400	35,527	38,530	36k	262k	632,737	2,047	40,000	46,158~~	tba	1,779	15,620	0	
5. How many exchange facilities in your health board area?	17	7	2 1**	8	23	17	22	2	10	27	3	2	16	0		
6. Estimated number of IDUs in your health board area?	1-3k	n/k	60using facilities	n/a***	3,500-4,000	550	718	8,000	500mid range	3,000	2 - 3k	n/k	20#	tbc	##0	
7. Is substitute prescribing available?	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	
8. Does a specialist drug service operate in your area eg Community Drug Problem services?	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	no	yes	yes	no	

Acitivity by Health Board area	Health Board															
	A&A	A&C	BOR	D&G	FIFE	FV	GR	GG	HIGH	LAN	LOTH	OR K	SHET	TAY	WI K	
9. Are share care arrangements for IDUs between specialist services and GPs operating in your area?	yes	yes	partly*	yes	no	yes	yes	yes	yes	yes	yes	yes	no	no	yes	no
10. Do you have arrangements for IDUs to take up detoxification and rehabilitation facilities?	yes	yes~	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	no	yes	###yes	no
11. Are there local monitoring/surveillance facilities?	yes	no^	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	no	yes	yes	yes
12. Are health promotion materials targeted at IDUs available in your area?	yes	no	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
13. Do you fund non-statutory agencies for drug prevention activities?	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	no	no	yes	no

* GPs –yes, Pharmacists –no

** one service with a number of outlets including pharmacies, fixed sites and outreach work

*** 462 people seen at the statutory service in 1997/98 (some will be double counts and re-admissions. Whilst not all IDUs, the majority were injecting. This is a treatment figure and not an estimate of the number of IDUs in the area.)

~figures for needles, syringes totalled 64,764

#also many occasional IV users

##small number on a visiting basis

arrangements in place but clients have to be sent to areas outwith Tayside

~includes outpatient and inpatient detox and outpatient and inpatient rehabilitation

^currently under discussion

DRUG MISUSE SERVICE ACTIVITY BY LOCAL AUTHORITY SOCIAL WORK DEPARTMENTS

A questionnaire was sent to each of the thirty-two local authority Social Work Departments in Scotland. This summary of the responses provides a snapshot of the position within departments in July/August 1999.

Summary

Completed questionnaires were received from 30 of the 32 Scottish local authority social work departments. Responding departments included the four major cities.

- The majority of departments (26) addressed the needs of drug users and injecting drug users (IDUs) in their Joint Community Care Plan.
- Responses to the question on budgets revealed considerable variation in what was included in the figure given.
- Most of the departments (25) had developed drug misuse policies in conjunction with other agencies in their areas and most policies (25) were based on a harm-reduction approach.
- Under half (13) of the 30 departments operated specialist drugs/substance misuse teams.
- Half of the departments (15) provided a social work input to a multi-disciplinary specialist drug service in their area.
- The numbers of staff within departments having a specific remit for drugs and substance misuse ranged from none to 120.
- Twenty departments had a staff training programme on drug/substance misuse, most of which (17) addressed health promotion for IDUs.
- The majority (19) of departments reported having specific assessment and care management arrangements for drug users in general. Fewer (14) had specific arrangements for IDUs.
- Less than half (14) of the departments had agreed protocols with local health services for assessment and care management of drug users on substitute prescribing programmes.
- Almost every authority responding (29) had arrangement for drug users/IDUs to access registered residential rehabilitation and detoxification either in their own area or in neighbouring area.
- Most departments (20) provided drug prevention programmes for looked-after young people. It was also common practice (22) to provide sexual health prevention programmes for looked-after young people.
- Health promotion materials targeted at injecting drug users are commonly available via local social work services (21).

Services

- Therapeutic counselling, outreach for young IDUs, drug prevention activities were commonly provided and/or purchased by departments.
- Detox or crisis short-stay residential facilities was rarely directly provided (1) but were purchased by two-thirds (21) of the responding departments.
- Day rehabilitation programmes were directly provided by 4 departments and purchased by 15.
- Few departments purchased or provided specific services for women drug users (9 provided, 7 purchased) or for drug-using prostitutes (6 provided, 6 purchased).
- The most common expectation that departments had of service provided or purchased was that they would address sexual health issues with IDUs and their partners (17 expected this of provided services and 16 of purchased services).

- Most departments (20) reported having monitoring arrangements for directly provided services while even more (25) had such arrangements for services they purchased.

HIV HEALTH PROMOTION STRATEGY REVIEW GROUP MEMBERS

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