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How can primary care work more closely with sexual health services to deliver appropriate testing, prevention & care for STIs and HIV?

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A Tale of Two Cities?

BOOK THE FIRST. RECALLED TO LIFE

CHAPTER I

THE PERIOD

It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we were all going direct to Heaven, we were

the other way—in short, the period was so far from being complete that the crime with which it went out of do...
What can and should we be doing, on both sides?

- Who are the key populations as they appear in primary care (particularly general practice)?
- Where are the practical opportunities to prioritise them?
- How can we influence primary care productively, given our different cultures?
- What do we need to be doing in sexual health and HIV services to support the primary care task?
The world from a GP’s perspective

• Integration of physical, psychological/mental and social in the approach to the patient

• Much chronic care “pushed back” to GP

• Co-morbidity & healthy ageing major part of workload

• General services & incentivised work
Young people from a GP perspective

- Family context
- On a developmental journey
- A point in a long term relationship
- Mental, behavioural & physical health
- Safeguarding perspective - young carer? Substance use in family? Neglect?
Mental health and behavioural challenges in adolescence

Guilherme, Polanczyk 2015

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<tr>
<td>Any mental disorder</td>
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Worldwide pooled estimates of any mental disorders and specific disorders in children & adolescents. (MDD major depressive disorder, ODD oppositional defiant disorder, CD conduct disorder)
Back to STIs and HIV – some key opportunities?

Young people early in sexual experience

Primary and secondary prevention in HIV

Interaction assessment

Realistic treatment goals

Individualized management

Prioritization and patient’s preferences

Muth et al. BMC Medicine 2014, 12:223
http://www.biomedcentral.com/1741-7015/12/223
HPRU Theme B: how we are addressing “diagnosing the undiagnosed” in primary care

• Addressing the cultural and structural aspects of primary care
• Working with the primary care holistic perspective on health
• Focus on adolescence and early sexual health encounters
Study 1: Facilitators and barriers to chlamydia testing in general practice - systematic review

- Psychological theoretical model of behaviour: COM-B Model (Capability, Opportunity and Motivation, Behaviour)

- Protocol: *BMJ Open* 2017;7:e013588

- Patient, provider, service levels, and cross cutting factors

- Social context is critical, implementation should focus on: 1) normalisation, 2) communication, 3) infection specific information, and 4) mode of testing.
Study 2: Improving young people’s health via primary care - qualitative exploration

- Chlamydia testing in general practice and development of holistic approach to adolescent health

- Participants = 27 young people, 16-24 years old

- **Acceptability:** “I’d feel a bit weird if it felt like they were singling me out, but if they just kind of offered it as, hey, we’re just offering this for everyone type thing, I would feel absolutely fine about it” (Lauren, 22 years).

- **Trust:** “I would feel it’s more legit or whatever, more trusting if it’s coming from your GP. It’s somewhere you’ve been!” (Henry, 23 years).
Study 3: STI testing influences for young people in primary care - online questionnaire

- Guided by psychological model of behaviour, measured = STI knowledge, stigma, shame, medical embarrassment, injunctive norms, moral norms, perceived susceptibility and severity, self-efficacy, self-identity

- Participants = 600+ young people, 16-24 years

- Over 70% would accept STI test if offered in GP

- Self-identification, greater injunctive norms (i.e., perception of social approval), greater perceived susceptibility to infection, and fear of test results significantly predicted greater STI testing intention

Partially externally funded: NIHR School for Primary Care Research Grant FR11 Award 323
Study 4: STI testing in general practice for young LGBT+ people

- Data collection ongoing, to date, $N = 15$
  - (7 women, 7 men [including 2 transgender men], 1 gender fluid; 2 lesbian, 3 gay, 8 bisexual, 2 pansexual)

- “I just feel like sometimes it’s just they don’t really take it seriously, when like a woman has [sex] with other women primarily, because it’s just that they seem to think that it doesn’t, you don’t spread STIs that way, but you can do”. (Jo, 19, female, lesbian)

- “… for particularly trans people, STI tests can be quite intimate, and so can trigger dysphoria or negative feelings towards their – my anatomy, I guess.” (Tom, 18, male, trans, bisexual)
Ongoing studies

- **Study 5**: Approaches to young people’s health in general practice - qualitative interviews and focus groups with primary care staff

- **Study 6**: Factors associated with chlamydia retesting – online questionnaire with those who tested positive

- **Study 7**: Interventions to increase chlamydia testing in general practice - systematic review of efficacy and effectiveness
Derivation of a psychosocial clinical prediction rule to target sexual healthcare among women of reproductive age attending British General Practices

Natalie Edelman
NIHR Doctoral Research Fellow, Brighton & Sussex Medical School, Senior Research Fellow, University of Brighton

This is a summary of independent research funded by the National Institute for Health Research (NIHR)'s Doctoral Research Fellowship programme. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.
Sexual risk and substance use among 16-24 year old women (n= 269) attending General Practices

*Women were allocated as ‘at risk of unintended pregnancy in last six months’ if during that time period they reported 1+ male sexual partners and failed, inconsistent or non-use of contraception, and that they had wanted to avoid getting pregnant
How can we help primary care be more adolescent-welcoming, especially for sexual minorities?

- The waiting room
- The website
- The contraception/sexual health session offer

- Leaflet & online materials – a BASHH role here?
- Education – the needs of male-attracted males
- Modify chlamydia test offer to address minority needs
Taking us into HIV prevention and management

Primary prevention
• A key opportunity is signposting & educating young (perhaps not yet) MSM
• Well placed to have the first prevention conversation – how to do without stigma?

Secondary prevention
• How can we play to primary care strengths?
• Chronic disease and ageing are core business – but need specialist support
• GP information systems capture both longitudinal & cross-sectional perspectives
• Comorbidity is normalised & addressed through sophisticated yet familiar prompt systems
What do GPs say they want, to provide better HIV care?

- Bypass numbers for advice on HIV patients in their care – need a quick response to make a decision that does not send patient in
- BASHH/BHIVA guidelines that include guidance for the primary care setting, and its interface with specialist care
- Integration and push back to GP has allowed GPs to be more experienced in HIV – these partnerships must draw on GP experience in healthy ageing to educate & support specialists
Gaps in research and practice for the sexual health and GP communities to address

• Recognising adolescence as a transitional time when mental health, behavioural problems and family context can have a major impact on sexual health. Interventions?

• Vulnerability of adolescents beyond sexual and partner violence safeguarding. How can sexual health services engage and support?

• Supporting GPs and other services to welcome & signposts sexual minority needs early in life

• Making the GP portfolio career a two-way opportunity for sexual health
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