

ADAPTING YOUR PRACTICE

*Treatment and Recommendations
for Homeless Patients
with Chlamydial or
Gonococcal Infections*

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Health Care for the Homeless
Clinicians' Network

2003

DISCLAIMER

The information and opinions expressed in this document are those of the Advisory Committee for the Adaptation of Clinical Guidelines for Homeless Patients with Chlamydial or Gonococcal Infections, not necessarily the views of the U.S. Department of Health and Human Services, the Health Resources and Services Administration, or the National Health Care for the Homeless Council, Inc.

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PREFACE

Clinicians practicing in Health Care for the Homeless (HCH) projects* and others who provide primary care to people who are homeless or at risk of homelessness routinely adapt their medical practice to foster better outcomes for these patients.

Standard clinical practice guidelines often fail to take into consideration the unique challenges faced by homeless patients that may limit their ability to adhere to a plan of care. Recognizing the gap between standard clinical guidelines and clinical practices used by health care providers experienced in the care of individuals who are homeless, the HCH Clinicians' Network has made the adaptation of clinical practice guidelines for homeless patients one of its top priorities.

The Network Steering Committee and other primary health care providers, representing HCH projects across the United States, devoted several months during 2002-03 to developing adapted clinical guidelines for the treatment of chlamydial or gonococcal infections in homeless patients. The adaptations reflect their collective experience in serving homeless people with sexually transmitted diseases (STDs) and alert clinicians to the strong association between STDs and sexual abuse in this population.

We hope these recommendations provide helpful guidance to primary care providers serving patients who are homeless or at risk of homelessness, and that they will contribute to improvements in both quality of care and quality of life for these patients.

Patricia A. Post, MPA
HCH Clinicians' Network

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INTRODUCTION

Infections caused by *Chlamydia trachomatis* and *Neisseria gonorrhoeae* are the most commonly reported sexually transmitted diseases (STDs) in the United States (CDC, 2001). A history of sexual abuse, vulnerability to sexual assault, and risky sexual behaviors, including the exchange of sex for basic needs, place some people experiencing homelessness at increased risk for these infections. Homeless people of any age, gender or sexual orientation who engage in unprotected sex with an infected partner or multiple partners, by consent or against their will, are at high risk for STDs, which are among the health problems most commonly seen by clinicians serving this population (Kennedy et al., 1990).

Sexually transmitted diseases in homeless individuals may be a direct result of sexual abuse or assault. Physical/sexual abuse in family and other relationships has been identified as both a cause and a consequence of homelessness (Stein, 2002; Hirsch, 1989; Hagen, 1987; Stoner, 1983). In a study of homeless and poor housed women, 67 percent reported severe physical violence by a childhood caretaker, 43 percent reported childhood sexual molestation, and 63 percent reported severe violence by a male partner (Browne and Bassuk, 1997). Persons living on the streets or in shelters are often victims of assault, both physical and sexual. Those who are mentally ill or under the influence of drugs or alcohol are even more vulnerable to victimization, and less likely or able to seek help (Wenzel, 2001; Burroughs, 1990).

Early family sexual abuse is a predictor of sexually transmitted disease in homeless and runaway adolescents (Noell, 2001; Tyler, 2000). Homeless youth, sometimes known as runaways, throwaways or simply “street kids,” are often victims of physical and sexual abuse, before and after becoming homeless. Many engage in “survival sex” (exchanging sexual favors for food, shelter, or money), which increases the likelihood of sexually-transmitted diseases, as well as unintended pregnancies (Noell, 2001; Rew, 2001, 1996; Tyler, 2000). Developmental regression or neuropsychological dysfunction, commonly observed in homeless individuals regardless of age, gender, diagnosis or medical/psychiatric history (Gonzalez, 2001), may present barriers to changing behaviors associated with increased STD risk.

Clinical practice guidelines for people with sexually transmitted diseases who are homeless are fundamentally the same as for those who are housed. Nevertheless, primary care providers who routinely serve homeless patients recognize an increased need to take their living situations and co-occurring disorders into consideration when working with their patients to develop a plan of care. The treatment and recommendations in this guide were compiled to assist clinicians who provide care for homeless adults, adolescents and children. It is our expectation that these simple adaptations of established guidelines will improve treatment adherence and patient outcomes. The Centers for Disease Control’s Sexually Transmitted Diseases Treatment Guidelines is the primary source document for these adaptations (CDC, 2002). Recommendations found in the CDC guidelines are not restated in this document except to clarify a particular adaptation.

ADAPTING YOUR PRACTICE:

CASE STUDY: HOMELESS ADOLESCENT WITH CHLAMYDIA

A 18-year-old female presents to the clinic with the complaint of vaginal discharge for two weeks. She states that she was treated for a sexually transmitted disease when she was in Dallas three weeks ago. She states, "I think I had chlamydia," for which she was given Doxycycline. The instructions were to take one pill two times a day until the bottle was empty. "I took the pills for a couple of days and then my medicine was stolen."

The patient reports that she has been traveling and arrived in New Orleans "a couple of weeks ago," and has not had any contact with her family in "about a year." She reports sleeping in a "squat" at night with her "husband" and her dog. She states that during the day she goes out to "spange" on the streets in order to get money for food.

She denies abdominal pain, vaginal bleeding and fever. She denies taking any prescription medications except Valium periodically, which she buys on the street. She denies allergies to food or medications.

Medical history: Negative for heart problems, high blood pressure and diabetes. Induced termination of first pregnancy one year ago. Last Pap smear – "What's that?" Menarche age 12; regular menstrual cycles, denies cramps.

Sexual history: First welcomed sexual encounter: 12 years old; partners since first encounter: "a lot"; partners in the past 12 months: "I have no idea." Partners include males and females; she voices no preference. Client has exchanged sex for a place to sleep, food, liquor and drugs. Reported condom use is less than 50%. Engages in vaginal intercourse, oral intercourse with both male and female partners, and anal intercourse; uses sex toys with female partners. Partner risks: drug dealer; unknown for intravenous drug use, unknown for HIV infection.

Social history: Substance use/abuse: positive for ecstasy, heroin, cocaine, alcohol daily, cigarettes (about one pack a day for five years), marijuana daily, benzodiazepines.

Current Findings

Urine dipstick : +++ WBC , negative Nitrite, +++ RBC; Urine HCG: negative

Pelvic exam: external genitals: no lesions; BSU (Bartholin's gland, Skene's gland, urethra): WNL; cervix: friable, copious amount of yellowish discharge, +CMT (cervical motion tenderness), no lesions; vagina: no lesions, pooled discharge; uterus: WNL; adnexa: non-tender, no palpable masses.

Wet mount - WBCs > 10 per high powered field; RBCs: few; negative for trichomonas, clue cells.

KOH: no yeast, negative whiff test.

CASE STUDY: HOMELESS YOUNG ADULT WITH GONORRHEA

A 21-year-old woman presents for the first time at the clinic with complaint of cough, sore throat, and runny nose for three days.

History: The patient has been homeless for the past year, usually sleeping on the beach with her boyfriend of nine months.

Both the patient and her boyfriend regularly use alcohol and cocaine. She denies intravenous drug use but thinks her boyfriend may have used IV drugs in the past.

When asked about her relationship with her boyfriend, she says it is good. He is very protective of her and gets upset with her if she goes anywhere without him. He barely conceded to let her come to the clinic today. When asked, she admits that he has sometimes slapped or pushed her, but believes that she provoked this behavior. She says that she is “glad to have a man to protect her on the streets.”

This patient has not had a Pap smear in over two years. Her boyfriend is her only sexual partner for the past year, although she had three partners prior to him. She believes he has no other partners. They do not use condoms because he “doesn't like to use them.” She feels it would be “okay” if she got pregnant because then she would be motivated to change her life. Her last menstrual period was two weeks ago. She has had a little bit of yellowish discharge for “awhile.”

Physical exam: Unremarkable except for pelvic exam. The cervix is friable and there is yellow mucopurulent discharge coming from the os. Uterus and adnexae are nontender. Pap smear obtained and swabs for gonorrhea and chlamydia.

Diagnosis: Suspect gonorrhea and/or chlamydia.

Adults and Adolescents

Diagnosis and Evaluation

HISTORY

- **Sexual practices** Obtain detailed history of sexual practices at first visit (cf., Nusbaum, 2002). Responding to questions may influence behavior even if patient does not return for follow-up. Discuss medical confidentiality and its limits (e.g., in cases of child abuse, threat to self or others) with patient. Determine if patient has exchanged sex for money or drugs and whether s/he remembers what happened and with whom. Use written questions so patient knows it is standard procedure to ask them. Ask same questions of both males and females in a nonjudgmental way:
 - How old when had first welcome sexual experience, one that was not forced on you?
 - How many sex partners in lifetime? past year?
 - Were sex partners male? female? both?
 - Partner risks: HIV positive? Are partners having sex with other men and/or women?
Is partner a drug dealer?
 - Traded sex for drugs, money, place to stay?
 - Condom use/barrier methods, dental dams, etc?
 - Vaginal intercourse? Oral intercourse? Anal intercourse? Give and/or receive?
 - Use toys, dildos, vibrators?
- **Sexual abuse** Ask whether patient has been forced to have sexual intercourse against his/her will. Assess for violence, abusive relationships, and patient safety (e.g., whether knowledge of STD may precipitate abuse against patient or partner). Evaluate need to report assault/abuse. Ask if patient wants evidence collected to pursue legally. In the case of minors, disclosed sexual abuse histories must be reported to child protective services. Be knowledgeable about mandatory reporting requirements regarding consensual sexual activity and abuse in your state, and explain them to patient. (*For a summary of state reporting requirements for domestic violence or adult abuse, see: <http://endabuse.org/statereport/list.php3>. To look up statutory requirements for reporting child abuse in your state, see: <http://nccanch.acf.hhs.gov/general/statespecific/index.cfm>.)*
- **Exploitation** Consider possible exploitation of patient, especially if mental illness or developmental disability is suspected. (Partner's refusal to use a condom may be a form of exploitation.) Substance abuse and "survival" sex also increase risk for sexually transmitted diseases. Realize that adolescents may not understand or acknowledge that they are being exploited when exchanging sex for food, shelter or drugs.

ADAPTING YOUR PRACTICE:

- **Prior STDs** Ask about history of STDs in both male and female patients. Infestations that are commonly sexually transmitted, such as lice and scabies, pose special challenges for homeless people, whose use of showers and laundry facilities may be limited by lack of funds, facilities or spare clothing.
- **Reproductive health** Obtain gynecological history including best possible menstrual history for females. Ask what method of contraception is used; if none, explore interest in pregnancy prevention.
- **Readiness to change** Assess patient's developmental level and readiness to change sexual behaviors. Find out what motives are for engaging in particular behaviors.
- **Partner history** Always ask whether partner needs to be treated. Also inquire about new or casual encounters. Transience of homeless people and lack of familiarity with sex partners complicates partner notification. Try to identify geographic areas where patient and partner(s) have been to determine risk for drug-resistant organisms.

PHYSICAL EXAMINATION

- **Preventive care** For female patient, do breast exam with pelvic exam to address preventive as well as acute care needs. For male patient, include testicular exam. Anticipate shyness and anxiety about sexual norms in adolescents; conscientiously respect their privacy and need for control. Eliminate rectal exam if not pertinent to clinical presentation.
- **Sexual abuse** Be sensitive to concerns, fears and safety needs of patients with a history of sexual abuse, who may be reluctant to have a rectal, pharyngeal, or pelvic exam. Consider using an assistant for exams of unclothed patients and clothed patients who seem emotionally disturbed, recognizing high prevalence of paranoia, delusions, sexual trauma, and posttraumatic stress disorder (PTSD) among homeless people.
- **Refused pelvic exam** Consider empiric treatment if patient has history of exposure (e.g., when partner has been diagnosed with chlamydial or gonococcal infection). Consider obtaining urine LCR for *C. trichomatis* and *N. gonorrhoeae* in lieu of pelvic exam. Consider self-administered vaginal swab for saline and KOH preparations when genital exam is refused.
- **Pharyngeal and rectal exams** Suspect chlamydial or gonococcal infection if pharyngeal and/or rectal symptoms are present and patient has history of exposure.

DIAGNOSTIC TESTS

- **Chlamydia/ gonorrhea** Screen for *C. trachomatis* and *N. gonorrhoeae* with every female pelvic examination if cervix is present, whether patient is symptomatic or not. (Males more likely to be symptomatic.) Use most highly sensitive and accurate screening method available and affordable, recognizing that time required to obtain lab reports is also an issue because of follow-up concerns.
 - **Nucleic Acid Amplification tests** Ligase Chain Reaction (LCR), Polymerase Chain Reaction (PCR), Transcription Mediated Amplification (TMA), and Strand Displacement Amplification (SDA) are preferred methods for diagnosis and screening. Advantages: highest sensitivity and specificity for chlamydial and gonococcal infections with both genital and urine specimens, and do not require invasive exam. Disadvantages: tests are costly and lab results may take up to two weeks. Treat empirically pending lab results. Urine LCR now preferred for males.
 - **Culture** can still be used if more sensitive, less invasive, more convenient diagnostic tests are not available or affordable. Bacterial culture test for gonorrhea is cheap and highly specific, but requires special handling and incubation. Cell culture for chlamydia no longer in common use, except in cases of child abuse or sexual assault. Culture is the only acceptable diagnostic test for medicolegal purposes. Treat empirically pending culture results.
 - **Other diagnostic tests** Direct Fluorescent Antibody (DFA), Enzyme Immunoassay (EIA), and Nucleic Acid Probe (NAP) are widely available, though less sensitive for both gonorrhea and chlamydia, but can only be used with genital specimens, making exam necessary.
- **Vaginitis** Consider obtaining specimen for wet mount on site, if possible, to screen for co-occurring trichomonas or bacterial vaginosis and assess degree of acute inflammation.
- **Other STDs** Screen for other sexually transmitted diseases if feasible, including human immunodeficiency virus (oral HIV testing optimal), syphilis (RPR or VDRL test), and hepatitis B. We recommend wide-based screening within financial means and patient willingness to be screened.
- **Pregnancy** If any suspicion of pregnancy, do urine testing. All pregnant women should be screened for both chlamydia and gonorrhea.
- **Pap smear** While results may be obscured by or reveal atypia attributable to inflammation, this may be a rare opportunity to uncover or prevent a serious condition in a homeless woman who would not otherwise be screened.

Plan and Management

EDUCATION, SELF-MANAGEMENT

- **Risk reduction** Assist client to identify and reduce personal risks for sexually transmitted disease. Emphasize risk of STDs with unprotected sex. Use a risk reduction approach; promote use of condoms and reduction in number of sexual partners. Employ interactive counseling focused on preventing transmission of disease, including description of risky behaviors and preventive methods. Counseling should be nonjudgmental, client-centered, and appropriate to client's age, gender, sexual orientation, and developmental level. For patients with substance abuse problems, offer referral for treatment and counseling; for injection drug users, offer access to clean needles when available.

Explain that no screening test result warrants unprotected sex. Encourage use of condoms and provide information on availability of condoms, either on-site or elsewhere. Learn techniques that sex workers use to protect themselves (e.g., “cheeking” a condom for oral sex). If high-risk sexual behavior is perceived as necessary to meet basic survival needs, try to engage patient for services and find another way of meeting underlying needs. If high-risk behavior is used to obtain a drug on which patient is dependent, continually offer detoxification/substance abuse treatment as an alternative.

- **Medical care** Educate patient about importance of seeking medical care immediately when symptoms occur. Explicitly discuss possibility of having an infection without symptoms. If patient is at risk, stress that regular screening for STDs is part of reproductive health.
- **Dispel myths** about home remedies or protections against STDs with cultural sensitivity. For example, symptomatic males may try to cure themselves by scrubbing genitalia with bleach, lemon juice, alcohol, earth, aloe vera, or Vicks Vaporub. Some believe in the cleansing power of urine and apply it to sores and in eyes for conjunctivitis. These “remedies” are especially popular in some areas of Mexico. Many patients believe that STDs can be contracted from dirty toilets and common showers in shelters, that oral contraceptives protect against sexually transmitted disease, and that “you can tell who is likely to have an STD; if you don't see a sore, your partner isn't infected.” Explain that most STDs are asymptomatic, but can still have negative consequences; that STDs are infections associated with particular behaviors, not punishments for moral failings.
- **Case management** Provide case management to assure access to housing and other social services, recognizing that these interventions are also effective forms of STD prevention.
- **Safety** Help patient develop a safety plan if interpersonal violence/sexual abuse is suspected; explain adult and child abuse reporting requirements in your state.

(For a summary of state reporting requirements for domestic violence or adult abuse, see: <http://endabuse.org/statereport/list.php3>. For information about mandatory reporting requirements for child abuse or neglect in all 50 states, see: <http://nccanch.acf.hhs.gov/general/statespecific/index.cfm>.)

MEDICATIONS

- **Simple regimen** Simplify treatment regimen; use single-dose observed therapy whenever possible for gonorrhea, chlamydia and syphilis. Sometimes multi-dose, extended regimens cannot be avoided (e.g., in males with epididymitis).
- **Presumptive treatment** Treat patient and partner empirically pending lab results, even if partner is not seen in clinic, if this can be done safely, and if regulations/clinic policy permit. Design treatment regimen to cover common, co-occurring STDs.
- **HBV & HAV** Recognize that some homeless people are at high risk for hepatitis B and/or hepatitis A – especially IV drug users and their sexual partners (HBV), and men having sex with men (HAV). Assure that at-risk patients are immunized. For those who have been partially vaccinated, resume schedule whenever possible.
- **Resistant organisms** Recognize higher risk for drug-resistant organisms (e.g., quinolone-resistant *N. gonorrhea*) among highly mobile homeless patients with multiple, unknown sex partners. For patients unresponsive to standard treatment, consider non-gonococcal, non-chlamydial urethritis (e.g., ureaplasma and mycoplasma), which frequently respond to longer courses of macrolide antibiotics or doxycycline.

ASSOCIATED PROBLEMS/COMPLICATIONS

- **Rape** including unrecalled rape that occurred when patient was under the influence of alcohol and/or drugs.
- **Pregnancy** including ectopic pregnancy. (Always offer contraceptive options.)
- **PID** (pelvic inflammatory disease) – a serious complication of untreated STDs frequently seen in homeless women, which can result in infertility.
- **Reiter's Syndrome** – inflammatory arthritis which can be triggered by chlamydia or other infectious agents.
- **More florid disease** Homeless people often do not seek medical help until their disease is advanced and symptoms are florid. Poor hygiene, mental illness, substance abuse, and “survival sex” increase their risk for sexually transmitted diseases.

ADAPTING YOUR PRACTICE:

- **Nonadherence/ loss to follow-up** People who are homeless may place a higher priority on meeting basic needs than on obtaining needed health care or following through with prescribed treatment. Substance use disorders and mental illness further complicate adherence and follow-up. (Always approach patient encounter with a nonjudgmental attitude.)
- **Psychological factors** Recognize that lack of self-esteem or assertiveness skills, emotional/psychological needs, addictions, developmental disabilities, partner attitudes, and/or developmental stage may affect patient's sexual behavior and adherence to a plan of care. Homeless adolescents and youth are often developmentally less advanced than peers of same chronological age; concrete thinking predominates over abstract reasoning skills, according to providers who are experienced with this population. Homeless adults with mental illness or chronic substance use may have impaired reasoning and delayed social development that cause them to act like young adolescents. When discussing behavior change with these patients, focus on immediate concerns rather than possible future consequences.
- **Legal considerations** Many homeless youth are emancipated minors. Be aware of possible legal barriers to medical care of unaccompanied youth and limits of patient confidentiality. These vary from state to state (cf., English, 2002).

FOLLOW-UP

- **Contact information** At every visit, seek contact information for patient, family member or friend with a stable address, shelter where patient is currently staying, patient's case manager and health care providers, including telephone/cell phone numbers and mailing/email addresses.
- **Outreach** Use outreach workers for partner identification and to bring hard-to-reach individuals (especially adolescents) to the clinic. Provide diagnostic testing (e.g., urine screening) and treatment at outreach sites whenever possible.
- **Partner notification** Work with local public health department to facilitate partner identification, notification and treatment.
- **Incentives** Use incentives (phone cards, bus tokens, hygiene kits, free condoms, socks, fast food coupons) to encourage patients to return for lab results.
- **Peer-led groups** Initiate peer-led STD prevention/intervention groups; include lunch to attract participants.
- **Provider-patient relationship** Build positive, encouraging relationships with clients to increase likelihood of return for follow-up care.

CASE STUDY: HOMELESS INFANT WITH CHLAMYDIA

C.L., a six-week-old female African American infant, is brought to the HCH clinic by her mother for poor feeding. She was born in the emergency room of the local county hospital by precipitous vaginal delivery on November 15, 2001. Her birth weight was 2250 gm; she appeared to be somewhat small for gestational age (about 36 weeks) but vigorous, with Apgars of 8 and 9. She was sent to the neonatal intensive care unit for a sepsis work-up because of prolonged rupture of membranes, but all cultures were negative. She never required ventilatory support, was nipping well, and was discharged on the fourth day of life.

History: C.L.'s mother (G3P1SAb2) had three prenatal visits during the pregnancy. At the last visit, she was told that she was at 22 weeks gestation and her estimated delivery date was 12-15-01; so she "figured she didn't need to hurry" when labor began on 11-14-01, even though she knew her membranes had ruptured. She barely made it to the hospital in time to deliver the next day. The mother reports that she had been staying with her boyfriend until he was incarcerated, about two weeks before the baby was born. She then went to stay with an aunt and her children. After leaving the hospital, she took the baby there, but moved out when the aunt's boyfriend became irate because the baby was crying. They are now staying at the family shelter.

The mother knew she was supposed to take her baby in for a check-up one week after birth, but she delayed coming to the clinic because the appointment coincided with the argument with her aunt, and she decided she needed to find a place to stay first. Besides, the baby was "doing okay" then, taking up to an ounce of formula in each feeding and not crying too much. About one week later, the infant's eyes got "sticky and swollen looking." For the last couple of weeks, "she just hasn't wanted to eat," and has an aggravating cough. The mother thinks the baby has a cold that has been going around the shelter. She hasn't had a fever, but her eyes are still a little red.

While waiting in the examining room for the provider, the mother confides to the case manager that she is overwhelmed with caring for the baby by herself and has no social support system. She believes things will be better when her boyfriend gets out of jail. He said he wants to raise this baby with her, even though they have only been together for about three months. He is in jail for possession of cocaine. She knows he has had multiple partners, but believes that he will settle down with her as soon as he gets out. The baby coughs constantly during the interview, and the mother becomes increasingly frustrated and finally tearful.

Physical examination: The patient is a 3100 gm infant (5-10 percentile for age), fussy but consolable. Note is made of tachypnea (56-60) even when the infant is consoled. There is mild retraction noted, and a persistent cough. Some fine rales are appreciated but no wheezes. There is mild bilateral conjunctival injection with a small amount of purulent discharge. The remainder of the exam is unremarkable.

Assessment: Suspect chlamydia secondary to perinatal transmission.

Infants and Children Under 3 Years of Age

Diagnosis and Evaluation

HISTORY

- **Living conditions** Ask parent where family is living – on the street? in a shelter or motel room? in their car? staying with friends or relatives? In some cases, homelessness is a risk factor for sexually transmitted diseases; chlamydia and gonorrhea are commonly reported STDs in homeless patients.
- **Sexual history of mother** Ask mother about her sexual behaviors and partner(s) in a nonjudgmental way. (See recommendations for chlamydial/gonococcal infections in adults and adolescents, p. 5.)
- **Access to care** Inquire about parental/partner treatment for STDs.
- **Prenatal/neonatal care** Ask mother how many prenatal care visits she had and where child was delivered. Lack of prenatal care is a risk factor for neonatal chlamydia. Assess likelihood of ophthalmia prophylaxis to prevent maternal transmission of *N. gonorrhoeae* to neonate.

PHYSICAL EXAMINATION

No adaptation of standard guidelines recommended.

DIAGNOSTIC TESTS

For chlamydial/gonococcal conjunctivitis or pneumonia in an infant or child under age three years:

- **Cell culture** is preferred for conjunctival, pulmonary specimens; more sensitive and specific than non-DNA tests. Collect conjunctival cells, not just exudates. Tissue culture of nasopharynx if *C. trachomatis* pneumonia is suspected. (Culture required if child abuse is suspected.)
- **Non-DNA tests** Direct Fluorescent Antibody (DFA), Enzyme Immunoassay (EIA) or Nucleic Acid Probe may be used for conjunctival specimens. Only DFA is used for nasopharyngeal specimens. These tests are less sensitive than cell culture. (Not acceptable if child abuse is suspected because false-negatives and false-positives may occur.)

ADAPTING YOUR PRACTICE:

- **Nucleic Acid Amplification tests** Ligase Chain Reaction (LCR), Polymerase Chain Reaction (PCR), Transcription Mediated Amplification (TMA), and Strand Displacement Amplification (SDA) tests are not used with conjunctival, pulmonary, or nasopharyngeal specimens, nor are they admissible for medicolegal purposes if child abuse is suspected, although they are more sensitive, less invasive, and more convenient than other diagnostic tests.

Plan and Management

PATIENT EDUCATION/SELF-MANAGEMENT

- **Symptoms** Educate parent about signs and symptoms of chlamydial and gonococcal infections in infants. Conjunctivitis (red, sticky eyes) may be a symptom of either type of infection; cough with tachypnea is a symptom of neonatal chlamydial infection but not of gonococcal infection. Use written educational materials only if you are sure parent can read and understand them. Inquire nonjudgmentally about parent's literacy level in the language in which materials are written.
- **Treatment** Explain that infant, parent, and any infected partner(s) must be treated to prevent transmission and complications of infection. Tell parent that untreated chlamydial infections in children will lead to serious health problems affecting their eyes, ears and lungs.

MEDICATIONS

- **GI upset** Prefer antibiotic with minimal gastro-intestinal irritation. Infants often get candidal diaper dermatitis from diarrhea secondary to this side effect. Diarrhea is a more serious issue with homeless patients. Make provisions for extra diapers and a place for parent to cleanse infant.
- **Presumptive treatment** Treat empirically without lab results if there is high suspicion of infection, recognizing that patient may not return for follow-up.

ASSOCIATED PROBLEMS/COMPLICATIONS

- **Diarrhea** as a side effect of antibiotics is more difficult for homeless families to manage because of limited access to diapers and facilities for cleansing child. Maintaining adequate hydration can also be a problem if fluids are not readily available.
- **Lack of prenatal/post-partum care**, indicating need for case management and social supports for mother
- **Physical/sexual abuse** of parent as an adult and/or in childhood
- **Lack of financial resources** for medications, transportation, quality daycare
- **Lack of consistent follow-up** secondary to mobility

FOLLOW-UP

- **Outreach** Use outreach workers to locate infant for appropriate follow-up.
- **Test of cure** If mother says infant did not complete treatment regimen or missed a few days, repeat chlamydial culture and resume treatment. Greater likelihood of poor adherence and unpredictable follow-up increases risk of unresolved infection in homeless infants.

CASE STUDY: STD IN A HOMELESS CHILD NOT CONSENTING TO SEX

An outreach team (nurse practitioner, RN, and case manager) encounters a six-year-old female (the patient), her 22-year-old Hispanic mother, the child's maternal grandmother, and the grandmother's boyfriend. The family came to the city two months ago in search of work. For the past week, they have been staying together in a motel room. Before that, they "camped out" in their car.

History: The team learns from the patient's mother that the grandmother is using heroin, and that the grandmother's boyfriend "sometimes gets rough" with both women. When asked about the child's safety, the mother responds that the boyfriend "is good with my little girl, and sometimes he even baby-sits her while I'm out looking for work."

The case manager has engaged the grandmother separately, and learns that the six-year-old is not in school, that her mother "smokes crack and sometimes works the streets to pay for it," and that the grandmother's boyfriend "only gets violent when he's been drinking."

Physical examination: The child's mother asks the nurse practitioner to examine the six-year-old, who has been complaining of abdominal pain and has had a fever for the past few days. The mother also reports having noticed a yellowish discharge in her daughter's underwear. Upon physical examination, the child pushes the provider's hand away, but seems to have tenderness in the suprapubic area.

Assessment: Vaginal infection secondary to possible sexual abuse.

Plan: Refer patient to child protective services for forensic evaluation and treatment. Explore readiness of family to seek substance abuse counseling. Provide ongoing social support to family.

Children Not Consenting to Sex

Diagnosis and Evaluation

HISTORY & ASSESSMENT

- **Living situation** Ask where patient is living and with whom. Don't assume current family make-up has always been the same. Establish rapport with parent.
- **Unwelcome sex** In a separate interview, ask child about being touched against his/her will or being forced to have sexual intercourse.
- **Child safety** Carefully assess for possible sexual abuse. Ask who is participating in childcare, who watches child when parent is busy, who takes child to the bathroom. Ask parent about sexual behaviors of adult caregivers and partners. Don't assume physical or sexual abuse just because a homeless child has a chlamydial infection. Although a positive chlamydial culture beyond the newborn period indicates "probable" sexual abuse (Reese, 2001), chlamydial infection from perinatal transmission may occur in children up to three years of age. However, a positive gonococcal culture beyond the immediate newborn period is "certain evidence" of sexual abuse (Ibid.). Most chlamydial and gonococcal infections in children over age three are from sexual abuse, and for some homeless children, the risk of sexual abuse is high.

If sexual abuse is suspected, follow your state's statutory requirements for reporting child abuse. (For information about mandatory reporting requirements in all 50 states, see: <http://nccanch.acf.hhs.gov/general/statespecific/index.cfm>; and the National Clearinghouse for Child Abuse and Neglect Information: www.calib.com/nccanch/statutes/index.cfm. Hotline phone numbers for reporting suspected abuse and neglect are available at: www.acf.dhhs.gov/programs/cb/publications/rpt_abu.htm.) If provider is unsure whether to report sexual abuse, call a local specialist in child abuse, who can usually be found in regional children's hospitals. (See also: *Internet resources for medical practitioners, listed on page 22.*)

- **Identify risk of loss to follow-up** Assess risk that family may flee and patient may be lost to follow-up; base decision to refer to child protective services or the police on this assessment.
- **Psychosocial evaluation** Evaluate whole family unit, not just the child. Assess for mental stress and history of physical/sexual abuse; if the medical provider cannot do so, refer to someone who can. Assess risks to child from substance abuse/mental illness of a parent or other caregiver.

ADAPTING YOUR PRACTICE:

PHYSICAL EXAMINATION

- **General** Use every patient visit as an opportunity for a general physical examination, including height, weight, head circumference, and other screening recommended by standard clinical guidelines (e.g., *American Academy of Pediatrics guidelines: www.aap.org/policy/paramtoc.html*) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services required for children on Medicaid. (See: *Early and Periodic Screening, Chapter 05, State Medicaid Manual: www.cms.hhs.gov/manuals/pub45/pub_45.asp*.) Balance comprehensive care with meeting child's acute needs.
- **Forensic evaluation** Sexual abuse/assault evaluations are most appropriately provided at centers experienced in forensic interviewing and evaluation that are equipped to collect evidence and strictly maintain the chain of evidence. Examination provided in a clinic within 24 hours of a sexual assault (36 hours at most) precludes collection of forensic evidence. Once there is a reasonable suspicion of sexual assault or molestation of a child, medical provider can be most useful by facilitating referral of child through child protective services or the police.

DIAGNOSTIC TESTS

- **Cell culture** is required if sexual abuse is suspected. For medical issues, rapid tests (e.g., Nucleic Acid Amplification tests) are acceptable, but for legal issues the only sanctioned documentation of gonococcal or chlamydial infection is a culture.

No adaptation of standard guidelines recommended.

Plan and Management

EDUCATION/ SELF-MANAGEMENT

- **Prevention** Ask if there is a “safe haven” for child when mother is not present. Investigate availability of respite nurseries.
- **Abuse of parent** Develop a safety plan for abused parent to break the cycle of domestic/interpersonal violence. Know the mandatory reporting requirements in your state for adult abuse. (*For a summary of state reporting requirements for domestic violence or adult abuse, see: <http://endabuse.org/statereport/list.php3>*.)
- **Abuse of child** Offer support to parent whose child has been abused by someone else. Explain that social worker's role is to help family cope with this situation. Be knowledgeable about mandatory child abuse reporting requirements in your state and explain them to the parent.

*(To look up statutory requirements for reporting child abuse in your state, see:
<http://nccan.ch.acf.hhs.gov/general/statespecific/index.cfm>.)*

MEDICATIONS

No adaptation of standard guidelines recommended.

ASSOCIATED PROBLEMS/COMPLICATIONS

- **Sexual abuse of parent** Mental health support may be required for parental depression or post-traumatic stress disorder (PTSD) secondary to prior sexual abuse. Part of treating child is helping parent to avoid future physical or sexual abuse as well. Mother may need to be transferred to a safe place for protection from continued abuse.
- **Substance abuse** Parents with a history of drug abuse may fear that child will be taken away from them if sexual abuse is reported to child protective services.
- **Fear of authorities** Homeless people may also be nervous about any interaction with authorities who may have treated them badly in the past. Some parents also fear being reported to immigration officials.
- **Childcare** Homeless parents without access to childcare often leave their children with strangers.
- **Housing** In some shelters, single men, families and children all stay in same room. This increases risk for sexual abuse. Formerly incarcerated perpetrators of sexual abuse who become homeless when released from jail may interact with families in shelters and at food distribution sites.
- **Loss of child custody** Parent who loses custody of child may also lose access to shelter and benefits, but can't get child back until housing is obtained.

FOLLOW-UP

- **Referral of child** If there is evidence of sexual abuse, refer child to child protective services (CPS) and for specialized assessment and counseling. Emphasize that CPS can be a support system for parents, to help them obtain what they need for their child.
- **Referral of parent** Refer mother to counseling for prior sexual abuse.
- **Social support** Specify shelter options and other resources for parent who loses child to state custody.

PRIMARY SOURCES

CDC. Sexually Transmitted Diseases Treatment Guidelines, 2002: 1–7, 30–41, 69–74:
www.cdc.gov/mmwr/PDF/RR/RR5106.pdf.

CDC. Chlamydia in the United States, April 2001:
www.cdc.gov/nchstp/dstd/Fact_Sheets/chlamydia_facts.htm.

CDC. *Neisseria gonorrhoeae*, February 2000: www.cdc.gov/ncidod/dastlr/gcdir/gono.html.

OTHER REFERENCES

Browne A and Bassuk SS. Intimate violence in the lives of homeless and poor housed women: Prevalence and patterns in an ethnically diverse sample. *American Journal of Orthopsychiatry*; 67: 261–278, 1997, as cited in McMurray-Avila et al., 1998.

Burroughs J et al. Health concerns of homeless women. In Brickner, P.W. et al. (Eds.) *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: W.W. Norton & Co., 1990: 139–150.

Gonzalez EA et al. Neuropsychological evaluation of higher functioning homeless persons: A comparison of an abbreviated test battery to the mini-mental state exam. *Journal of Nervous and Mental Disease*; 189(3): 176–181, 2001.

Hagen JL. Gender and Homelessness. *Social Work*; 32(4): 312–16, 1987, as cited in McMurray-Avila et al., 1998.

Hirsch K. *Songs from the Alley*. New York: Ticknor & Fields, 1989, as cited in McMurray-Avila et al., 1998.

Kennedy JT et al. Health care for familyless, runaway street kids. In Brickner PW et al. (Eds.) *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: W.W. Norton, 1990: 82–117.

McMurray-Avila M, Gelberg L, Breakey WR. Balancing act: Clinical practices that respond to the needs of homeless people. Symposium on Homelessness Research sponsored by HUD/HHS, 1998: <http://aspe.hhs.gov/progsys/homeless/symposium/8-Clinical.htm>.

Noell J et al. Childhood sexual abuse, adolescent sexual coercion and sexually transmitted infection acquisition among homeless female adolescents; *Child Abuse and Neglect*; 25(1): 137–48, Jan 2001.

Nusbaum M and Hamilton C. The proactive sexual health history, *Am Fam Physician*; 66(9): 1705–1712, November 2002: www.aafp.org/afp.

Rew L et al. Sexual abuse, alcohol and other drug use, and suicidal behaviors in homeless adolescents; *Issues in Comprehensive Pediatric Nursing*; 24(4): 225–40, Oct-Dec, 2001.

Rew L. Health risks of homeless adolescents: Implications for holistic nursing. *Journal of Holistic Nursing*; 14(4): 348–359, December 1996, as cited in McMurray-Avila et al., 1998.

Stein JA, Lesslie MB, Nyamathi A. Relative contributions of parent substance abuse and childhood maltreatment to chronic homelessness, depression, and substance abuse problems among homeless women: mediating roles of self-esteem and abuse in adulthood. *Child Abuse Negl*; 26(10): 1011–27, 2002.

Stoner M. The plight of homeless women. *Social Science Review*; 57: 565–81, December 1983.

Tyler KA et al. Predictors of self-reported sexually transmitted diseases among homeless and runaway adolescents. *Journal of Sex Research*; 37(4): 369–77, 2000.

Wenzel SL, P Koegel P, and Gelberg L. Antecedents of physical and sexual victimization among homeless women: a comparison to homeless men. *American Journal of Community Psychology*; 28(3): 367–390, 2001.

Wright JD. The health of homeless people: Evidence from the National Health Care for the Homeless Program. In Brickner PW et al. (Eds.) *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: W.W. Norton, 1990: 15–31.

SUGGESTED RESOURCES

English A et al. *State Minor Consent Laws: A Summary*. 2nd Edition. Chapel Hill, NC: Center for Adolescent Health & the Law, 2002 (in press); 211 North Columbia Street, Chapel Hill, NC 27514; 919 968-8850; english@cahl.org.

Kraybill K. *Outreach to People Experiencing Homelessness: A Curriculum for Training Health Care for the Homeless Outreach Workers*. National Health Care for the Homeless Council, June 2002: www.nhchc.org/Publications/.

McMurray-Avila M. *Organizing Health Services for Homeless People*. ISBN: 0971165092; 2nd Edition. Nashville: National Health Care for the Homeless Council, Inc., 2001.

Melnick SM and Bassuk EL. *Identifying and Responding to Domestic Violence Among Poor & Homeless Women*. The Better Homes Fund, February 2000: www.nhchc.org/Publications/domesticviolence.htm.

Miller WR and Rollnick S. *Motivational Interviewing: Preparing People to Change Addictive Behavior*. ISBN: 1572305630; 2nd Edition. New York: Guilford Press, 2002.

National Health Care for the Homeless Council. *Health Care for the Homeless: An Introduction*. 22 minute video and user's guide, June 2001. To order: www.nhchc.org/Publications/.

National Health Care for the Homeless Council. *Health Care for the Homeless: Outreach*. 21 minute video, June 2001. To order: www.nhchc.org/Publications/.

Reese R and Ludwig S, Eds. *Child Abuse: Medical Diagnosis and Management*. Lippincott Williams & Wilkins Publishers; ISBN: 0781724449; 2nd Edition, 2001.

ADAPTING YOUR PRACTICE:

WEBSITES

American Academy of Family Physicians	www.aafp.org
American Professional Society on the Abuse of Children	www.apsac.org
Centers for Disease Control	www.cdc.gov
Child Abuse Prevention Network	http://child-abuse.com
Mandatory Reporting of Child Abuse & Neglect State statutory requirements	http://nccanch.acf.hhs.gov/general/statespecific/index.cfm/
National Center for Youth Law	www.youthlaw.org
National Clearinghouse on Child Abuse & Neglect Information, Administration for Children and Families/ U.S. Dept. of Health & Human Services	www.calib.com/nccanch
National Health Care for the Homeless Council & Health Care for the Homeless Clinicians' Network	www.nhchc.org
Prevent Child Abuse America	www.preventchildabuse.org
Society for Adolescent Medicine Journal of Adolescent Health	www.adolescenthealth.org/html/publications.html

ABOUT THE HCH CLINICIANS' NETWORK

Founded in 1994, the Health Care for the Homeless Clinicians' Network is a national membership association that unites care providers from many disciplines who are committed to improving the health and quality of life of homeless people. The Network is engaged in a broad range of activities including publications, training, research and peer support. The Network is operated by the National Health Care for the Homeless Council, and our efforts are supported by the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and member dues. The Network is governed by a Steering Committee representing diverse community and professional interests.

To become a member or order Network materials, call 615 226-2292 or write to network@nhchc.org. Please visit our Web site at www.nhchc.org.