A service to address the sexual health needs of the homeless population

Between 1991 and 2001, the clinical workload of genitourinary medicine services increased by 155 per cent, and diagnoses of sexually transmitted infections (STIs) increased by 61 per cent in England, Wales and Northern Ireland (Public Health Laboratory Service et al, 2002). However there is a paucity of data regarding the rate of sexually transmitted infections in the homeless population.

Against a backdrop of increasing numbers of diagnosed sexually transmitted infections and pressure on sexual health clinics nationally, homelessness presents a unique set of challenges to genitourinary medicine.

There is mounting evidence of unmet sexual health needs in the homeless population in terms of: the supply of information about, and testing for, sexually transmitted infections; condom supply and use; contraceptive advice; and cervical cytology.

Research has shown that this patient group is at an increased risk of acquiring STIs and blood-borne viruses (BBVs) compared with the general population (Noell et al, 2001; Ochnio et al, 2001; Hwang et al, 2000) (Box 1).

Local genitourinary medicine service The Victoria Clinic for Sexual Health is a busy sexual health, family planning and HIV outpatient clinic based in central London.

It is run by a multidisciplinary team of nurses, health advisers, doctors and support staff. The clinic provides specialist services tailored to the needs of the local population, including gay and bisexual men, and young people.

There are four homeless hostels within a two-mile radius of the clinic. However, the clinic team had become aware that although some hostel residents and street homeless people were accessing the service, overall uptake for this group was low.

Homeless people are notoriously poor users of primary care facilities (Crane and Warnes, 2001) (Box 2). They have unique and complex problems including high levels of drug and alcohol dependence, a high incidence of mental health problems, unstable domestic backgrounds and increased vulnerability to illness due to poor general health.

The group has been identified in the government’s National Strategy for Sexual Health and HIV (Department of Health, 2001) as a hard-to-reach group that should be targeted for HIV and hepatitis screening and vaccination. The Clinical Effectiveness Group guidelines on hepatitis A, B and C also support this (CEG, 2002).

Developing a service with a homeless hostel The Victoria Clinic for Sexual Health began to develop sexual health services in partnership with a local hostel for homeless people in 2001. The hostel has 143 residents from diverse ethnic backgrounds, and runs its own substance misuse unit. The clinic had been contacted by a community nurse who expressed concern that the sexual health needs of her patients, who were residents at the hostel, were largely unmet.

In response, the core team at the Victoria Clinic, which comprised a nurse practitioner, a staff nurse and a health adviser, liaised with clinic managers and the hostel’s staff and residents. The staff felt that residents needed more information and advice about BBVs.

In the context of barriers that homeless people face when accessing sexual health services, and residents’ risk factors for contracting STIs and BBVs, the team decided to focus on specific areas. In line with The National Strategy for Sexual Health and HIV (DoH, 2002), a core aim of the sexual health service is to reduce the number of undiagnosed HIV and hepatitis infections. The plan for achieving this was to:

- Discuss the problem of BBVs with hostel residents and staff, and provide a screening service;
- Facilitate referral to appropriate health care professionals for patients whose results require treatment or monitoring;
- Increase awareness of HIV and STIs through education, discussion, leaflets and posters;
implementing the service  it was decided that a weekly, two-hour clinic would be run at the hostel by a nurse practitioner, a registered nurse and a health adviser. the terms of the PGD for the administration of hepatitis A and B viruses. An existing patient group direction (PGD) for the administration of hepatitis A and B vaccines to at-risk groups was adapted and extended for use within the service.

designing was extended to include syphilis. This was considered important because cases of infectious syphilis increased by 207 per cent in England, Wales and Northern Ireland between 1991 and 2001 (PHLS et al, 2002).

It was identified that hostel staff required support and training on the issues that the service would address. The clinic team attended staff meetings and ran education sessions on a range of topics, including BBVs and HIV.

Implementing the service  It was decided that a weekly, two-hour clinic would be run at the hostel by a nurse practitioner, a registered nurse and a health adviser. The terms of the PGD for the administration of vaccines state that at least one team member must be trained in the treatment of anaphylaxis, a potential complication of vaccination. The service also had the support and involvement of a named consultant at the sexual health clinic.

The service began in July 2001. Each session begins with a handover by a nominated hostel staff member. Residents are able to self-refer to the service, and can either book an appointment or drop in. Residents can involve their key worker if they wish, and many chose to do so.

Residents give written consent for the key workers to be contacted in the event that results are positive. The implications of sharing information about health status are discussed with residents and hostel staff, and are documented in the residents’ notes.

Residents are informed about the confidentiality policy and the services offered. It can be inappropriate to offer everything to a patient at once, and residents can pick which services they wish to access. It is important that the service reflects the needs of those attending it.

Evaluation  Of the 190 hostel residents, 43 attended the sexual health service between July 2001 and July 2002. This number had more than doubled by February 2003. In the first year of operation, audit findings showed that:

- Thirty residents were screened for hepatitis A, 18 of whom had positive serology, which indicated immunity;
- Twelve residents were screened for hepatitis B, of whom eight had immunity through past exposure and one was an active infectious carrier;
- Twenty six residents were screened for hepatitis C, of whom 11 had a positive antibody, and four had a positive polymerase chain reaction (PCR) test, indicating active infection. These patients were referred to a hepatologist. Residents with a positive antibody but negative PCR hepatitis C result were advised that their PCR would be checked every six months to ensure that infection does not reactivate;
- All clients with a positive hepatitis C serology were current or ex-intravenous drug users (IVDUs). Two residents who had previously been IVDUs had negative hepatitis C results;
- Thirty residents continued with vaccination against hepatitis A and/or B after negative prevaccination serology;
- One resident tested positive for HIV, hepatitis A, B and an active infection of hepatitis C. He now accesses HIV care at the Victoria Clinic, and his care is also managed by the local hepatology team.

Throughout the year, efforts have been made to improve the sexual health services offered to victims of sexual assault, and a protocol is being devised.

Reflection  Although the original objectives have been met, there is still a lot to do. Staff in the substance misuse unit suggest that the service is not yet reaching some of the highest-risk residents.

A rolling programme of bi-monthly sessions on BBVs, STIs and testing is being arranged for hostel staff in the hope that by improving their knowledge they will feel more confident in raising or discussing these issues with residents.

It is hoped that our experience and knowledge of developing and running the service can be used in some of the other homeless hostels in the locality. A 21-day vaccination schedule for hepatitis B has been adopted (as an alternative to the six-month course), and it is hoped this will make it easier for residents to complete their course of vaccinations, and will increase uptake. The team also plans to introduce urine testing for chlamydia, and is investigating ways that comprehensive STI screening can be offered at the hostel.

Conclusion  This service is dynamic and is developing with the support and enthusiasm of the hostel and clinic staff, as well as becoming increasingly popular with hostel residents.