Screening for Chlamydia, Gonorrhea, and High-Risk Sexual Behaviors in Utah's Juvenile Justice Population: Results and Implications for Practice

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ABSTRACT

Compared with adults, sexually active adolescents are at higher risk of acquiring chlamydia and gonorrhea (CT/GC). Additionally, sex trafficking and sexual violence are serious public health problems. Before this project, no data on the sexual behaviors of adolescents within Utah's Juvenile Justice System had been gathered in a systematic manner that provided a population-based perspective.

From July 1, 2015, through December 30, 2016, nurses and staff in 18 Utah Juvenile Justice facilities screened all youth admitted to their facilities. For youth who met Centers for Disease Control and Prevention high risk criteria, urine screening for CT/GC was performed. We have screened 1,968 youth and detected 229 asymptomatic infections, with a treatment rate of 90%. Furthermore, we are able to map the location, sex, and age of youth in Utah participating in high-risk behaviors. We are connecting with experts to bring targeted interventions to these youth based on our findings.

J Pediatr Health Care. (2018) ■■, ■■-■■.

KEY WORDS

Adolescent, chlamydia, gonorrhea, juvenile justice, high-risk behaviors

INTRODUCTION

Participating in high-risk sexual behaviors can result in unintended health outcomes for many youth (Centers for Disease Control and Prevention [CDC], 2017a). Compared with older adults, sexually active adolescents aged 15 through 19 years and young adults aged 20 through 24 years are at higher risk of acquiring sexually transmitted diseases for a combination of behavioral, biological, and cultural reasons (CDC, 2017b). Chlamydia (CT) is the most commonly reported notifiable sexually transmitted disease in the United States (CDC, 2015a). In Utah, over 60% of reported CT cases are among persons 15 through 24 years of age (Utah Department of Health, 2017a). Gonorrhea (GC), though much less common, is also of particular concern because of its rising prevalence in the state, the severity of its sequelae, and its increasing drug resistance (Utah Department of Health, 2017b). Left untreated, both infections may cause pelvic inflammatory disease, potentially leading to infertility. Additionally, susceptibility to more serious infections such as HIV increases when an individual is infected with CT or GC. Finally, pregnant women can pass both infections to their infants during birth, resulting in neonatal pneumonia (CT) and neonatal ophthalmia (Alger, Lovchik, Heel, Blackmon, & Crenshaw, 1988; Andrews et al., 2000).

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Conflicts of interest: None to report.

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0891-5245/$36.00

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https://doi.org/10.1016/j.pedhc.2017.12.008

Youth in the correctional system are a high-risk population with many unmet physical and mental health needs (American Academy of Pediatrics [AAP], 2011). Admission to a correctional facility offers a prime opportunity to screen for medical concerns, including the largely asymptomatic sexually transmitted infections CT and GC. According to the CDC, "Prevalence rates for chlamydia and gonorrhea in the correctional setting are consistently among the highest observed in any venue" (CDC, 2011, para. 1).

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Additionally, domestic minor sex trafficking (DMST) and sexual violence are serious public health problems, placing a toll on the well-being of individuals, families, and communities (CDC, 2017c). Justice-involved youth are at high risk for sex trafficking (Office on Trafficking in Persons, 2017). The National Center for Missing and Exploited Children estimates that 1 in 6 runaways are likely sex-trafficking victims (National Center for Missing and Exploited Children, 2017a). Youth are still arrested for prostitution in some areas, although this is beginning to change (Mitchell, Finkelhor, & Wolak, 2010). One study in Ohio found that 21% of DMST victims had spent time in juvenile detention (Williamson, Perdue, Belton, & Burns, 2012). Consequences of DMST include chronic physical and psychological trauma, disease, and potentially death (National Center for Missing and Exploited Children, 2017b). National estimates on the frequency of DMST vary widely. Furthermore, these youth experience sexual violence at a higher rate than their peers in the community at large (AAP, 2011). Nationally, 6.7% of youth report ever having been physically forced to have sexual intercourse (CDC, 2016). Similar to DMST, sexual violence can lead to a host of physical, psychological, and social problems, including engaging in other high-risk behaviors such as drug use and criminal behavior (CDC, 2017c). Before the project described here, to my knowledge no data on the risky sexual behaviors of adolescents within Utah's Juvenile Justice System (UJJS) had been gathered in a systematic manner that provided a population-based perspective. The goals of this project were to do the following:

- educate youth by creating one-on-one time with a nurse who had been specifically trained to discuss sexual health;
- create an efficient system of data collection to learn the prevalence of CT/GC and other high-risk behaviors among UJJS youth;
- confidentially treat youth infected with either CT, GC, or both;
- minimize the impact of CT/GC by diagnosing and treating the infection in an asymptomatic state;
- decrease the prevalence of CT/GC in this population and the local communities; and
- learn the frequency and distribution of high-risk behaviors among the youth in the UJJS.

METHODS

This program encompassed 18 residential UJJS facilities throughout Utah. It included only residential programs with a nurse on site, and location or age were not barriers. Ages ranged from 12 through 21 years. Inclusion criteria were every youth admitted to a UJJS facility. Excluded were boys who reported no sexual activity. These youth were deemed to be at lowest risk and were excluded because of the financial limitations of the project. Further demographics are presented in Table 1. Each facility received supplies for screening, supplies for shipping the urine specimen, and medication for treatment. The project coordinator created a verbal screening tool using CDC- and UJJS-specific criteria. Urine screening would be offered to

- all females and transgender youth admitted to JJS, unless there was a record of previous screening within the prior 3 months and
- all males who were sexually active with two or more people or had sex with one person but who answered *yes* to the high-risk behavior Questions 2, 3, and 4 (again, unless they were tested within the prior 3 months).

The 3-month time frame was chosen based on the CDC recommendation for screening high-risk individuals (CDC, 2017d). Information obtained beyond the number of sexual encounters was behavior oriented, using questions about topics such as condom use, sex with someone not well known, forced sexual activity, and DMST.

All urine specimens were mailed to the state laboratory. The individual facility nurse and the project coordinator both received the results. The project coordinator entered results into the database for analysis. A nurse practitioner ordered treatment based on CDC guidelines and allergy limitations, and the medication was administered by the facility nurse. If a youth had been discharged from a facility before positive results being known, the health department was notified. Youth participating in risky behaviors were counseled on healthy behaviors by the facility nurses, who were trained in interviewing techniques and STI facts by the project manager. The project manager pro-

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