Protecting Sexually Active Teens Requires More Than a Trojan

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At the conclusion of this presentation, participants will be:

1. Better prepared to develop standardized work flows in their practice setting, identify key gaps in adolescent care, and apply collaborative strategies to reduce those gaps.

2. Able to demonstrate the use of basic principles of motivational interviewing in counseling adolescents on their sexual risk behaviors.

3. Able to identify ways to use data to determine disparities in their populations, direct resources, and demonstrate effectiveness.
Disclosure

As an inventor of the RAAPS risk screening tool, I have licensed the IP from the University of Michigan to market the web based version of the RAAPS tool.
OBJECTIVE # 1

Identifying and Reducing Gaps with a Standardized Approach
ADOLESCENT SEXUAL HEALTH

RISK FACTORS AND DISPARITIES
Today’s adolescents are engaging in risk behaviors at earlier ages and with more diversity.

- Tobacco use
- Alcohol and other drug use
- Sexual behaviors that contribute to:
  - Unintended pregnancy
  - STI’s, including HIV infection
- Dietary behaviors
- Physical activity
- Unintentional injuries and violence

CDC 2012
Behaviors such as…

– Early onset of sexual activity
– Multiple sexual partners
– Not using a condom during last intercourse
– Not using contraceptives
– Using drugs or alcohol prior to sex

…resulting in high incidence of:

– Sexually Transmitted Infections (STIs)
– Unintended Pregnancy
Disparities among adolescents who engage in risky sexual behaviors have been found in:

– LGBTQ Youth
– Racial Minority Youth
– Low Socioeconomic Status

Unaddressed disparities result in higher rates of STIs and pregnancy among these populations

Kalmuss, 2003; Valois, 1999
Research suggests these **risk factors** contribute to unsafe sexual decision making:

- Substance use prior to sex
- Depression and low self esteem
- Homelessness
- School failure and lack of future goals
- Sexting
- History of abuse
- Dating violence
Risk Factors: Substance Use

- The use of alcohol or drugs prior to sexual activity
  - Decreases the likelihood of condom use
  - Increases number of sexual partners
- Substance use prior to sex is more common among sexual minority groups
- Substance-using maltreated youths were less likely to use condoms vs. youths who did not use substances
Risk Factors: Depression

- Feelings of depression or hopelessness
  - Increases likelihood of engaging in sexual activity
  - Increases likelihood of pregnancy
- Among 10 and 11 year olds, incidence of early sexual behavior was higher among those with high levels of depressive symptoms
- Odds of having sex in the past week 2x higher for adolescents in low-income neighborhoods with high levels of hopelessness
- Severity of depression increases sexual risk behaviors

Parkes, 2013; Lehrer 2006
Homelessness greatly increases the likelihood of adolescents engaging in:

- sexual activity (survival sex).
- risky sexual behaviors (condom nonuse, increased number of partners, casual partners)
- abusive relationships

Many co-factors influencing sexual decision making in homeless youth

Both school failure and having a lack of future goals is a predictor of risky sexual behaviors among adolescents

- Schools as a stressor
- Disadvantaged schools have higher rates of teen pregnancy

Protective Factors among 9th-12th graders include:

- Academic achievement
- School connectedness

Atkins, 2012; DiClemente, 2007; Kirby, 2002; Kirby, 2004; Anda, et al., 2000
Sexting as a predictor of risky sexual behaviors:

- Young adults who “sext” were more likely to be sexual active than inactive.
- Associated with high-risk sexual behaviors (unprotected sex and multiple partners)
- Associated with recent sexual activity (within past 30 days)

• More common in sexual minority youth

• Dating violence more common in relationships where the adolescent has had multiple lifetime sexual partners

• Childhood maltreatment is a strong predictor of sexual risk behaviors later in life, including:
  – Early first intercourse
  – Poor use of contraception
  – High rates of pregnancy
ADOLESCENT SEXUAL HEALTH

EVIDENCE-BASED RECOMMENDATIONS
Teens have unique needs

- Heightened development and change
- Risky behaviors

Engagement matters – language, technology

With teens the **moment is now**:  

- Lowest utilizers of healthcare services  
- More at stake than presenting symptoms
### Adolescent Screening Recommendations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Adolescent Risk Screening Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Medical Association (AMA)</td>
<td>Annual comprehensive screening for risky behaviors</td>
</tr>
<tr>
<td>American Academy of Pediatrics (AAP)</td>
<td>Annual screening psychosocial/behavioral assessment &amp; drug/alcohol use assessment</td>
</tr>
<tr>
<td>US Preventive Service Task Force: AHRQ</td>
<td>Screening for depression, tobacco use/prevention and STI</td>
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<tr>
<td>American Academy of Family Physicians (AAFPA)</td>
<td>Screening for sexual activity, depression, tobacco use</td>
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<tr>
<td>American College of Preventive Medicine</td>
<td>Annual comprehensive screening for risky behaviors – all visit types</td>
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</tbody>
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As humans we are forgetful – and we can’t possibly remember everything, every time.

We have subconscious biases – and we don’t ask the same questions to every teen

How we ask a question affects the answer we get

Sometimes the answer to one question means you don’t get to the next one
Current practice in pediatric care:
• 21% **always** use a standardized risk screening tool
• 33% occasionally use one
• 46% **never** use one

-- *In Conversation*
-- *Practice Specific*
-- *Paper-Based*
-- *Technology-Based*

*AAP Periodic Survey, 2008*
ADOLESCENT SEXUAL HEALTH

ROLE AND USE OF TECHNOLOGY IN IDENTIFYING SEXUAL HEALTH RISKS
• Teens are more honest when using technology interface than with paper-based survey or face-to-face interview.

• Tailored risk information

• Multi-lingual, health literacy options

• Data collection and analysis: individual and population over time
  - Track improvement of individual risks
  - Identify population trends and modify proactive education / interventions
• RAAPS was born at the University of Michigan
• Standardized and validated
• Addresses barriers to providing evidence-based risk screening
• **RAAPS Surveys:**
  • Standard (12-18yrs)
  • Older Child (9-11yrs)
  • College Age (18-24yrs)
  • Sexually Active
Incorporates an assessment of sexual behaviors and social factors that put teens at higher risk

**Intent:**

Identification of significant factors (sex health) + “Adolescent Friendly” questions =

Creation of a strong tool for identifying contributing factors to unsafe sexual activity
24 question youth-friendly, SH screening tool addressing:

- Sexual Attraction and Orientation
- Sexual Partner History
- Contraception Use
- History of STI/Preg & Testing
- Substance Use
- History of Abuse
- Depression
- Academic Performance

- Scientific validation in process
- Tool has been programmed into the RAAPS online system
• Teens are more honest when using technology – increases engagement
• Tailored risk information; geared to teens
• Multi-lingual, health literacy options
• Data collection and analysis; individual & population over time
The **last time** you had sex (vaginal or anal), did you use a “male” condom (type of condom that goes over a penis) or “female” condom (type of condom that goes inside a vagina or anus)?

- Yes
- No

The **last time** you had sex, did you (or your partner) use another form of birth control (pills, patch, ring, IUD, shot, other) instead of or in addition to condoms?

- Yes
- No
- The sex I have can’t result in pregnancy

Have you **ever** had sex (oral, vaginal, anal) with the **same gender** (sex with girls if you are a girl/guys if you are a guy)?

- Yes
- No

> NEXT
Thank You

Thank you for completing the survey. Please take a moment to read these health messages.

• You do not deserve to be treated badly, no matter what anyone tells you. Abuse can happen in lots of ways to all kinds of people, but it is never okay and it is never your fault! If you have been or are being abused, it needs to stop. Telling someone what happened to you can be very hard. It takes a lot of courage to talk about things that have happened, but you can do it! You are not alone and you should never feel ashamed. There are people who care about you, who believe you, and who want to help.

  ° Talk to somebody you trust such as a friend, family member, teacher, coach, or counselor for help.
  ° You may want to contact the police to report the incident.
  ° If you feel you are in danger tell a trusted adult right away.

It takes a lot of courage to talk about things that have happened to you, but you can do it! There are people who care about you, who believe you, and who want to help you.

http://www.loveisrespect.org/is-this-abuse/types-of-abuse/what-is-physical-abuse
http://www.loveisrespect.org/wheel-video/anger-emotional-abuse
http://www.stayteen.org/dating-abuse
• EHR format for Documentation
• Evidence-based Suggestions for risk reduction
• Individualized Patient Health Education
• Referral Tracking
• Access to Data
Survey: RAAPS Sexually Active Language: English

1. Have you had 4 or more sex partners in your lifetime?
   - Yes

2. Have you had sex (oral, vaginal, anal) within the past 3 months?
   - No

3. The last time you had sex (oral, vaginal, anal), did you drink alcohol or use drugs before?
   - Yes

4. The last time you had sex (vaginal or anal), did you use a "male" condom (type of condom that goes over a penis) or "female" condom (type of condom that goes inside a vagina or anus)?
   - N/A

5. The last time you had sex, did you (or your partner) use another form of birth control (pills, patch, ring, condom, shot, other) instead of or in addition to contraception?
   - Yes

6. Have you ever had sex (sex with girls if you are a boy)?

7. Are you or do you think you or another sexual orientation?

20. In the past 12 months, have you lived with someone other than your parent or guardian because you were kicked out or didn't have a permanent place to stay?
   - Yes

21. Have you ever received in school suspension (ISS) or out of school suspension (OSS)?
   - Yes

22. On your last report card or semester grade report, did you get a "C" or better in all of your classes?
   - Yes

23. Do you have goals or plans for your future and feel that you can accomplish them?
   - Yes

24. If you needed it, do you have an adult that you can talk to about your sexual experiences, feelings or relationships?
   - Yes

For Office Use Only

- Evaluation: At Risk Counseled
- Needs Follow-up: 
- Counselor: Counselor...
- Referred To: Referred To...
- Referred To: Referred To...
- Signature: 
- Date: 02/24/2014

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Save & Health Messages as PDF
Save & Export as PDF
Save & Finish Later
Save & Close
Cancel
All students screened; RAAPS reports allow schools to:

• Identify highest risk youth
• Target youth for programming/interventions
• Monitor trends, behavior changes over time, and outcomes
• What are the greatest risks in your teen population?

• What subpopulations of increased risk exist within your population?

• Are you providing the right risk prevention counseling or programming to the right teen?

• What is the effectiveness of the risk counseling or intervention you are providing?
SMALL GROUP DISCUSSION
What’s your standard?

1. How do you assess adolescent sexual risk in your practice/program?
   A. It’s not standard practice
   B. A series of verbal questions based on my experience
   C. Some questions are included in our assessment/intake or evaluation
   D. Standardized – paper survey
   E. Standardized – electronic/online survey
   F. Standardized – in face-to-face Q&A or group discussion

2. How often do you assess adolescent sexual risk?
   A. At a patient’s first visit/first session in program
   B. Annually
   C. If exhibiting, or reporting, at-risk behavior
   D. All of the above (A-C)
   E. Every visit/contact
   F. Not Applicable
What’s your standard? Activity Worksheet

- Subpopulations that exist within your practice/program
- Significant risk factors that exist in your youth population

- What is your current adolescent sexual health risk screening process?
- How could/should it be modified or improved?
- How will changes in screening affect your programming or workflow?
- Who could partner with you to provide screening follow up or referral services?
- What does it take in your organization to facilitate change?
OBJECTIVE # 2
Demonstrate the use of motivational interviewing with sexually active teens
Motivational Interviewing

A client centered, directive counseling style that builds on intrinsic motivation to change.
Spirit
Collaboration

Evocation

Autonomy
Motivational Interviewing

- Gives information and control to the client (client centered counseling)
- Avoids lecturing, confronting or making demands.
- Avoids resistance by stating facts and allowing clients to make their own decisions
- Sets up discrepancies that clients can solve or grapple with
- Consists of posing questions and facilitating a process, rather than being definitive about next steps
General Principles of MI

Principle 1 – EXPRESS EMPATHY

A non-judgmental attitude in which the counselor tries to see the world from the client’s perspective

Ex: A 12 year old who is cutting and in a peer group of cutters…”It must be hard to try to stop cutting when all of your friends are still doing it.”
Principle 2 – DEVELOP DISCREPANCIES

The counselor recognizes inconsistencies between current status and important goals or between current behavior and important values

Ex. “You work hard at being a good mom and you smoke marijuana everyday to help you with the stress.”
Principle 3 – ROLL WITH RESISTANCE

Ambivalence is normal. Advantages of change may be seen, yet client’s may also have concerns about changing

Ex: “I respect your decision to not use condoms, I am not going to tell you what to do. Tell me what you don’t like about using them? What if…..”
Principle 4 – SUPPORT SELF-EFFICACY

Supporting the client’s belief that he or she can carry out the necessary actions and succeed in changing their behaviors.

Ex: “You have a great plan for cutting down on your smoking and have thought through all the things that might get in your way. It sounds like this will work for you!”
Motivational Interviewing Strategies

Open ended questions
Affirmations
Reflections
Summaries

I would like to talk to you about contraception.
Is that OK?
Open-Ended Questions:

Who    What    When    Where    How    Why

Fully Open Questions:

- What do you think about...
- Tell me about...
- How do you decide when to...
- Help me understand...

Key Questions:

- Given what you told me, what do you think you will do next...
- Where would you like to go from here....
- What if you tried...
- What would it take...
In order to encourage and support the client during the change process, the MI counselor frequently affirms the client in the form of statements of appreciation or understanding ~ i.e. – “It took courage to do that.” “That’s a really good idea.”
Not “I” Statement....”You” Statements

• You have...
• You are...
• You feel...
• You believe...
Reflective Listening – Overview

- The essence is making a guess as to what the speaker means
- Statements rather than questions
- “Continue the paragraph” – not just reiteration
- It is an active process (counselor decides what to reflect or ignore, what to emphasize, preferentially reflects change talk)
Client presents after having unprotected sex.....

- **Repeat** – repeating an element of what the client said.
- **Rephrase** – staying close to what the client has said with some rephrasing and synonyms

- “You’ve had sex and didn’t use protection.”
- “You never intended to have sex without using protection.”
• **Paraphrase** – Inferring or guessing at the meaning of what the client has said and reflecting this back

• **Reflect feeling** – Emphasizing the emotional dimension through feeling statements and metaphors

• “You want to figure out a way to keep yourself safe.”

• “It’s scary to think you might have HIV.”
Reflection Activity

1. “I want to be a good dad…”

2. “Drinking isn’t something I do everyday…”

3. “I am using condoms sometimes…”

You know, I probably would do better in school if I didn’t drink so much.
Summaries

• Shows the client that the counselor has been listening
• Links material together and helps emphasize certain points.
• Can reinforce “change talk”
• Helps to end talking points without losing material or ending a session
Video Clip!

OARS Coding

http://www.youtube.com/watch?v=c9x7w0kWApY&feature=related
OBJECTIVE # 3

Identify disparities, direct resources, & demonstrate effectiveness with data.
RAAPS DATA – 2011 To 2013

TEEN RISKS: DATA & TRENDS
What are the greatest risks in your teen population?
Top 15 Reported Adolescent Risk Behaviors in 2013

Of the risks among teens across the US – the top behaviors affect at least 1 in 9 of our adolescent population!

- Fail to wear a helmet: 54%
- Have had sex: 38%
- Sexually active teens who fail to use protection during sex: 32%
- Are sad or depressed: 26%
- Struggle with anger management: 25%
- Poor diet: 20%
- Fail to use a seat belt: 18%
- Were bullied or harassed in the last month: 16%
- Inadequate physical activity: 14%
- Have used tobacco in the last 3 months: 13%
- Report serious worries: 13%
- Have carried a weapon for protection: 13%
- Have used alcohol in the last 3 months: 12%
- Have used drugs in the last 3 months: 12%
- Have been physically or sexually abused: 11%

Data shows mental health issues (including anger management, depression, and bullying) rank higher than the “usual concerns” of teen risks: drugs and alcohol.
What Do You Need to Know? Utilizing Data Effectively

- What are the greatest risks in your teen population?
- What subpopulations of increased risk exist within your population?
RAAPS DATA – 2011 To 2013

DATA BY AGE
• Teens aged 15+ are significantly more likely to have engaged in risky behaviors

• Sexual activity and use of alcohol, tobacco, and drugs increase by more than 400% between 10-14 and 15+
RAAPS DATA – 2011 To 2013

DATA BY GENDER
Gender

Fail to use protection during sex
1 out of 3 girls

Sad or depressed
1 out of 3 girls

Bullied or harassed
1 out of 5 girls

Physically or sexually abused
1 out of 7 girls

Suicidal thoughts or actions
1 out of 9 girls

Girls are at nearly twice the risk of boys.
Gender

RAAPS U.S. Data _ 2011-2013

NEGATIVE TRENDS

Use of contraception decreased 22%

Sad or depressed
1 out of 3 girls
25%
33%
17%

Bullied or harassed
1 out of 5 girls
20%
11%

Physically or sexually abused
1 out of 7 girls
14%
7%

Suicidal thoughts or actions
1 out of 9 girls
11%
8%

Girls are at nearly twice the risk of boys.
RAAPS DATA – 2011 To 2013

DATA BY PAYOR
NEGATIVE TRENDS

Use of contraception
decreased by similar rates among both Insured and Uninsured teens.

Rates of sexual activity
increased significantly among uninsured population

Use of contraception
35%

Rates of sexual activity
17%
Ever had sex
• What are the greatest risks in your teen population?
• What subpopulations of increased risk exist within your population?
• What is the effectiveness of the risk counseling you are providing?
RAAPS MI School Based/Linked Health Center Data: 2011-2013

SAMPLE OUTCOMES: MI SBLHCS
Child and Adolescent Health Center (CAHC) Program:

- Celebrating 25 years!
- Currently funding 62 School-based and School-linked Health Centers and 9 School Wellness Programs in Michigan
- All sites understood that annual standardized risk assessment was required for compliance with MPRs.
- RAAPS was electronic and could provide a site specific and program wide data base.
State and Program Level

• Provides annual program wide aggregate data for reporting purposes to all required and other stakeholders

• “Fits" Governor's metrics requirements to remain as a funded budget item

• Informs CAHC strategic planning, i.e. additional trainings or technical assistance

• Informs Medicaid Administrative staff
Local Level

• Direct programs and services to those in greatest need
• Provides change in practice/programming rational
• CQI project material/ measure change over time individual and group
• Leverage additional $$s by using data for other grants and funding opportunities
• Informing and educating all stakeholders
SBLHC Outcomes

- **MI Positive Trends**
- **MI Negative Trends**
- **MI SBLHC Outcomes**

**INCREASE**
- **Distracted Driving** (alcohol/drug use or texting) with 66% increase
- **Contraception Use** with 39% increase

**DECREASE**
- **Exercise** with 14% decrease
- **Disordered Eating** with 70% decrease

- 27% increase
- 14% decrease
- 76% increase
- 26% decrease
SBLHC Outcomes

- MI Positive Trends
- MI Negative Trends
- MI SBLHC Outcomes

**INCREASE**
- Self-harm: 15% (15% increase)
- Bullied or Harrased: 11% (11% increase)
- Serious Worries: 3% (3% increase)

**DECREASE**
- Sad or Depressed: 7% (7% decrease)
- 72% (72% decrease)
- 64% (64% decrease)
- 70% (70% decrease)
- 50% (50% decrease)
Ensure all teens are screened for sexual risk behaviors using a standardized approach

– Identify contributing risk behaviors
– Provide risk reduction counseling/programming, resources and referrals

Utilize the data on your population to:

– Make programming decisions
– Justify your program costs
– Showcase your outcomes of improved behaviors and positive impact on STI and pregnancy rates
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