Teen SENSE

Model Sexual Health Care Standards for Youth in State Custody

THE CENTER FOR HIV LAW & POLICY

TEENSENSE
Advancing the Sexual Health Rights of Youth in State Custody

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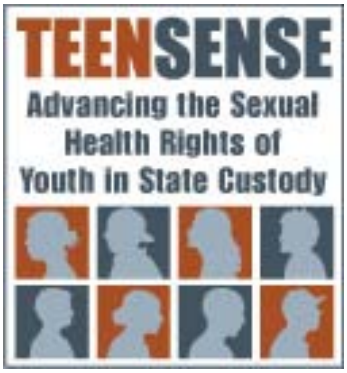
MODEL SEXUAL HEALTH CARE STANDARDS



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MISSION STATEMENT

The Center for HIV Law and Policy is a national legal and policy resource and strategy center for people with HIV and their advocates. CHLP works to reduce the impact of HIV on vulnerable and marginalized communities and to secure the human rights of people affected by HIV.

We support and increase the advocacy power and HIV expertise of attorneys, community members and service providers, and advance policy initiatives that are grounded in and uphold social justice, science, and the public health.

We do this by providing high-quality legal and policy materials through an accessible web-based resource bank; cultivating interdisciplinary support networks of experts, activists, and professionals; and coordinating a strategic leadership hub to track and advance advocacy on critical HIV legal, health, and human rights issues.

To learn more about our organization and access the Resource Bank, visit our website at www.hivlawandpolicy.org.

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Teen SENSE

A NATIONAL INITIATIVE TO BRING COMPREHENSIVE SEXUAL HEALTH CARE TO YOUTH IN STATE CUSTODY

Adolescents confined to foster care and juvenile justice facilities are overwhelmingly members of the communities most affected by, and at risk for, HIV/AIDS: low-income youth, Black and Latino youth, lesbian, gay, bisexual, transgender, and questioning youth (LGBTQ), and survivors of violence and other abuse. Empowering these populations to protect their rights and their health lies at the heart of the mission of the Center for HIV Law and Policy (CHLP). While these youth, across the spectrum of sexual orientation and gender, are at greater risk of HIV and other STIs, they overwhelmingly are denied access to appropriate and effective HIV prevention, sexual health education, and sexual and reproductive health care. Where care is provided, it too often ignores or isolates LGBTQ youth and their health needs. To address this crisis, CHLP launched the Teen SENSE (Sexual health and Education Now in State Environments) initiative, a sexual health and HIV prevention initiative grounded in the rights of youth to these services.

Teen SENSE advances the principle that respect and accommodation for all gender expression and sexual orientation is central to HIV prevention, sexual health and prevention from sexual abuse, and that all youth have the right to comprehensive, LGBTQ-inclusive health services that include sexual health care and education when they are confined in state facilities. Comprehensive, LGBTQ-inclusive sexual health care is vital to preserve health, reduce HIV and STI transmission risk, and increase the odds that severely at-risk youth will develop the essential skills and knowledge to protect their sexual health, develop self-respect, and foster tolerance.

Teen SENSE is a multidisciplinary initiative that has engaged experts in adolescent medicine, sexual health education, foster care, and juvenile justice to develop a complete advocacy model and coordinate its implementation. The Teen SENSE program has developed a federal and state legal framework that asserts the affirmative legal right of adolescents to comprehensive, scientifically accurate, LGBTQ-inclusive sexual health care services and education. We have developed model standards for comprehensive, LGBTQ-inclusive sexual health care, education/HIV prevention, and staff training to ensure the safety and sexual health of all youth in state custody. Teen SENSE establishes a powerful legal and human rights framework and the on-the-ground alliances that can make meaningful, appropriate, non-judgmental sexual health care and real HIV prevention a mandated service for youth in state foster care and detention facilities.

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TEENSENSE

MODEL SEXUAL HEALTH CARE STANDARDS: Focusing on the needs of LGBTQ Youth

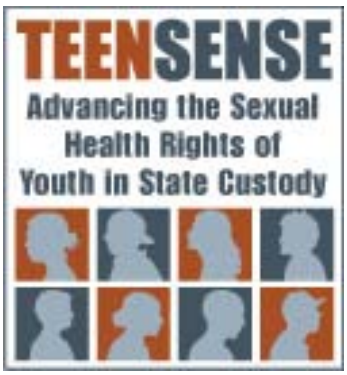
Executive Summary

The Teen SENSE Model Sexual Health Care Standards are designed to reflect the minimum requirements that facilities should meet in order to appropriately address the sexual health care needs of youth in the state's care. These Standards focus on sexual health care because youth in state custody are at higher risk of STIs, including HIV, yet services to address this risk typically have been inadequate or nonexistent. Youth in out-of-home care rely on the institutions where they are housed to address these needs. While the length of time that a youth remains in state custody may vary significantly, all state custody facilities should provide information on and medical attention to sexual health issues.

According to these standards:

- Youth in state custody should be given screenings that address both their physical and mental health, as well as examinations that include their sexual histories.
- Providers should provide information and treatment related to sexual abuse, pregnancy, and STI transmission and prevention.
- All youth should be offered testing for STIs, including HIV, and given proper follow-up counseling even if the tests are negative.
- Youth who are pregnant, gender non-conforming, or LGBTQ should not be treated differently or receive a lesser standard of care simply because they are in state.
- Facilities should also offer ongoing care and discharge planning related to sexual health.
- All medical care services should be conducted in a confidential, culturally competent, and inclusive manner.

The development and publication of these standards would not have been possible without the generous and sustained support of the MAC AIDS Fund, Broadway Cares/Equity Fights AIDS, the Arcus Foundation, and the Elton John AIDS Foundation.



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INTRODUCTION

What are the Model Sexual Health Care Standards?

These Model Sexual Health Care Standards ("the Health Care Standards") are the product of a comprehensive review of existing materials and an effort to combine the best and most inclusive practices and policies regarding sexual health care for youth in state custody into one document. The Health Care Standards reflect minimum requirements that facilities should meet in order to appropriately address the sexual health care needs of youth in the state's care. While the Health Care Standards are meant to be applicable to both state foster care and detention facilities, the difference in each custodial situation may give rise to differences in how the Standards will be met. Where the language is not clear, it should be understood that adjustments to care and procurement of treatment should be made for the specific situation and environment at hand.

The Sexual Health Care Standards are intended to be used by facility directors and staff, who have received training consistent with the *Staff Training Standards*, in planning medical protocols, for advocates of youth in care, and providers of healthcare for youth in state custody. These Health Care Standards have been specifically crafted to be useful for medical professionals; they include rationales and implementation suggestions.

The Health Care Standards focus on sexual health care and represent the first comprehensive set of standards that specifically address the critical sexual health care needs of youth in state custody. The focus is due to the high rates of sexual risk behaviors, low rates of condom use, and higher rates of STIs (including HIV) that juvenile detainees experience compared to youth not in state custody.[1] In one study, 20% of juvenile detainees tested positive for an STI.[2] Because of the focus on sexual health care, the Health Care Standards do not address more general issues such as environmental health and safety, medical care personnel credentialing and staffing, governance and administration, and pharmaceutical operations. For information on these best practices, the Sexual Health Care should be read in conjunction with other standards, such as the National Commission on Correctional Health Care's Standards for Health Services in Juvenile Detention and Confinement Facilities.

How were the Sexual Health Care Standards created?

The Sexual Health Care Standards integrate numerous writings on the health care needs of youth, particularly youth in state custody, and best practices for providing care that adequately meets their sexual health needs. Among the resources consulted are: the National Commission on Correctional Health Care *Standards for Health Services in Juvenile Detention and Confinement Facilities*, the American Medical Association *Guidelines for Adolescent Preventive Services*, the Region II Male Involvement Advisory Committee (Region II MAC) *Male Reproductive and Sexual Health Clinical Service Guidelines,* the Model Standards Project's *Creating Inclusive Systems for LGBTQ Youth in Out-of-Home Care*, World Professional Association for Transgender Health *Standards of Care for Gender Identity Disorders*, various

[1] Michelle Staples-Horne et al., *Juvenile Corrections and Public Health Collaborations: Opportunities for Improved Health Outcomes*, in PUBLIC HEALTH BEHIND BARS: FROM PRISONS TO COMMUNITIES 309 (Robert Greifinger ed., 2007).
[2] *Id.*

materials published by Physicians for Reproductive Choice and Health, and the New York State Office of Children and Family Services *Health Services for Children in Foster Care*.

Teen SENSE takes a comprehensive view of sexual health care, recognizing that medical care, education, and environment are all essential components of sexual health care. The Model Sexual Health Care Standards are one component of CHLP's Teen SENSE initiative. Teen SENSE has also published Model Sexual Health Education and Model Staff Training Standards. These three sets of standards should be read together as interconnected and related components of providing appropriate, comprehensive sexual health care for youth in state custody.

Teen SENSE has also developed a "legal road map," entitled *Juvenile Injustice: The Unfulfilled Rights of Youth in State Custody to Comprehensive Sexual Health Care*, which lays out the affirmative legal rights of juveniles in state custody to comprehensive sexual health medical services and staff training Standards. The legal road map and Model Standards are advocacy tools designed to be used together to bring regular, consistent, and comprehensive sexual and reproductive health care to the most at-risk, vulnerable, and underserved youth populations.

Considerations for Implementing the Sexual Health Care Standards.

The length of time that youth remain in state custody may vary significantly. Taking into consideration the health needs of youth who are only in state custody for a short period of time (possibly a few hours or one day) it is still important that they receive medical attention regardless of the short duration their stay. At a minimum, all youth must be provided with the following upon entering state custody: Standard 1 (Immediate Health Screening), Standard 2 (Receiving Screening for Transfers), Standard 3 (Initial Examination), and Standard 4 (Initial Mental Health Screening). The remaining standards should be implemented as per the time frame noted.

INITIAL HEALTH ASSESSMENT AND HEALTH MAINTENANCE EXAMINATION

Standard 1: Immediate Health Screening[3]

Each young person admitted to the state foster care system or youth detention facility must receive an initial health screening within 24 hours of arrival to rule out emergent health needs and contagious diseases, and to evaluate the need to continue current medication. When clinically indicated, the youth should be immediately referred to an appropriate health care facility, which should be noted on the receiving screening form. Immediate health needs should be identified and addressed. Potentially infectious youth should be isolated, but only where necessary. Staff members must promptly report suspected abuse of youth to the appropriate authorities. Youth arriving with signs of recent trauma must be referred immediately for medical observation, treatment, and mental health assessment and related services.

Rationale: This Standard serves to (1) identify and meet any urgent health needs of those admitted and (2) identify and meet any known or easily identifiable health needs that require medical intervention before the health assessment.

Implementation: The health screening should be conducted immediately upon each youth's admission to the facility or foster care system by an admitting staff member who is either a trained medical screener or a health care professional. It must be conducted using a form and language fully understood by the youth, who may not speak English or may have a physical or mental disability. Additionally, it must be conducted in a private setting to ensure confidentiality. Using a health-authority-approved form, the admitting staff member should inquire about and/or observe:

- Current and past illnesses, health conditions, or special health needs
- Past serious infectious disease
- Signs of physical abuse, including sexual abuse
- Recent communicable illness symptoms
- Past or current mental illness, including hospitalizations
- History of or current suicidal ideation
- Legal and illegal drug use and drug withdrawal symptoms
- Current or recent pregnancy
- Other health problems as designated by the responsible physician

If the initial screen indicates existing health issues or risks, the admitting staff member should provide a brief explanation and immediately notify the health care professional on duty, or locate and facilitate the appropriate care if the youth is not in a facility. The youth should remain under observation until the health care professional arrives and determines next steps. If no health issues are identified, the youth will be admitted to the detention facility or the foster care equivalent.

[3] See Nat'l Comm'n on Corr. Health Care, *Standards for Health Services* in JUVENILE DETENTION AND CONFINEMENT FACILITIES 60-63 (2004) [hereinafter NCCHC].

Standard 2: Receiving Screening for Transfers[4]

A receiving screening for transfers must be performed by trained medical screeners or health care professionals on all youth received via intrasystem transfers as soon as possible, but no later than two hours after transfer.

Rationale: In transferring a young person from one institution to another, his or her medical care becomes the responsibility of the staff at the new location. Upon arrival, admitting staff need to ensure that no injuries were incurred during transport and that all existing health and medication needs are communicated to the medical staff. Requests for health records from outside medical providers and previous institutions should be made no later than end of the day of admission. If the admission was later in the day and it is not possible to contact previous providers and institutions, the request for health records should be no later than 24 hours after admission

Implementation: Within two hours of the transfer, the young person should undergo an initial screen. The admitting staff member should review the young person's medical record and proceed with the standards proposed in Standard 1. During the screen, admitting staff should identify any injuries that may have occurred while in transfer or additional health concerns not in the current medical record. If the screen suggests that injury occurred during the transfer process, the admitting staff should record his or her observations and contact the health care professional on duty immediately.

Standard 3: Initial Examination

All youth must receive a complete health assessment and health maintenance examination ("initial examination").

The initial examination must be completed within 12 hours of admission for youth who are:

- Known to have one or more chronic conditions; and/or
- Prescribed medications, but who have no acute problems requiring a medical encounter upon admission

The initial examination must be completed within seven days of admission for youth who are:

- Not known to have any chronic or acute problems/conditions; and
- Not prescribed medications.

Rationale: The initial examination serves as a true assessment of the patient's health status. Through the medical, sexual, and social history, health professionals can build a more comprehensive view of the patient's risk and health needs. Combined with the physical examination, providers become more informed about acute medical problems and need for additional medical tests. Periodic health screening through physical examination and selected laboratory testing provide an opportunity to detect a number of medical conditions in an early, often asymptomatic phase, which permits treatment before significant morbidity develops. Additionally, during the physical exam, youth may benefit from a clinician's reassurance that their physical maturation is normal.

[4] *Id.*, at 63-64.

Implementation: The initial examination must include the requirements set forth in Standards 6-29 including a medical history, social history; physical examination; STI and HIV counseling; offer of STI and HIV testing; contraception counseling; pregnancy counseling and offer of pregnancy test; and assessment of potential abuse, including sexual abuse. If the youth is in foster care and it is logistically feasible, he or she should be examined by his or her current doctor for the best continuity of care.

Standard 4: Initial Mental Health Screening

All youth must receive a mental health screening within 24-48 hours of admission. Youth with positive screens must receive a mental health evaluation within 14 days.

Rationale: The initial mental health screening is imperative to assess whether the young person is a danger to self or others. Additionally, the screen can uncover existing or undiagnosed mental health conditions requiring care and/or medication.

Implementation: Within 24-48 hours of arrival, a young person should have a mental health screening performed by a licensed social worker or licensed professional counselor. If mental health conditions and/or medication needs are identified, the young person should be referred to the staff psychologist or psychiatrist.

Standard 5: Information on Health Services[5]

Information about the availability of, and access to, health care services must be communicated both orally and in writing to youth within 24 hours of their arrival in the facility in a form and language they understand.

Rationale: Information about health care services is basic to the provision of care in correctional settings and with youth who have been displaced into foster care. Appropriate efforts should be made to ensure that youth understand how they can access such services.

Implementation: Within 24 hours of their arrival, youth should be given written information about how to access emergency and routine medical, mental, and dental health services, the fee-for-service program (if one exists), and the grievance process for health-related complaints. Written information may take the form of a handbook, handout, or postings in housing areas for youth in detention. Special procedures should be in place to ensure that youth with difficulty communicating (e.g., foreign-language speaking, developmentally disabled, illiterate, mentally ill, or deaf) understand how to access health services. Because the admission process may be stressful and overwhelming for incoming youth, it is good practice to provide a follow-up orientation to the health services program after they have settled into the facility or foster care routine.

Standard 6: Sexual History

The initial examination and subsequent annual examinations of youth from ages 11 and up must include a discussion of the youth's involvement in sexual behaviors, in connection with the STI, HIV, history of abuse, and pregnancy counseling recommendations set forth below in Standards 7 and 12-27. Inquiries should include the following issues:

[5] *Id.*, at 59-60.

- Sexual orientation
- Gender identity
- Age of initiation into sexual activity
- Frequency of sexual activity
- Types of sexual activity (oral, anal, and/or vaginal)
- Use of contraception and motivation for use
- History of forced or coerced sex
- Exchange of sexual activities for money or drugs
- Prior pregnancy, paternity, and outcomes
- History of STI testing
- Symptoms of STIs
- History of HIV testing and knowledge of own HIV status
- Sexual activity while intoxicated or under the influence of drugs

Staff trained to interview youth concerning sensitive topics should discuss these topics in a private, confidential, non-judgmental manner during the course of the examination, in a way that is accepting and normalizing of the full spectrum of sexual identity and behavior. Youth who identify as homosexual, bisexual, transgender, or questioning (LGBTQ) should be asked about feelings of social acceptance or isolation. This especially applies to youth who are in the process of coming out.

Rationale: Youth may be reluctant to provide information about sexual activity, even if they have concerns and fears. Many have symptoms of STIs but refrain from seeking care due to fear, embarrassment, or transience of symptoms. Others are unaware of their STI-status and the fact that many are asymptomatic. However, the high prevalence of unintended pregnancy and STIs among youth demands an aggressive approach on the part of providers. If the topic is broached in a confidential, non-judgmental manner, youth will likely be relieved to have the opportunity to disclose information for themselves and their partners. Information about sexual behavior, STIs, and past pregnancy allow physicians to determine proper medical care, provide information, and refer youth to appropriate support services if needed. Informed youth can significantly contribute to facilitating their partners' access to and use of STI prophylactics, such as latex barriers pre-exposure or antibiotics post-exposure and, for those engaging in sexual activities with members of a different sex, contraceptive measures.

Sexual orientation, and one's acceptance of his or her sexual orientation, is a part of one's identity, self-perception, and self-esteem. As such, it has obvious implications for sexual experiences and behaviors. Unfortunately, homophobia and discriminatory practices encourage youth to keep their behaviors secret. Providers should understand that behavior does not match identity and that youth who identify as heterosexual may engage in same-sex sexual contact, while youth who identify as homosexual may also be having sex with members of the opposite gender. Therefore, providers should use gender-neutral pronouns in discussing partners and discuss specific behaviors rather than identified orientation. Sexual orientation and sexual behavior are not necessarily one and the same.

Obtaining an accurate history in a manner that normalizes same-sex sexual activity has several purposes: youth feel accepted by their provider regardless of sexual orientation; youth who are discriminated against or feel isolated because of their sexual orientation can be referred to appropriate support services; and appropriate tests, such as pharyngeal or rectal cultures, can be more accurately determined.

Implementation: In transitioning from a medical to sexual history, providers should explain why sensitive and explicit questions are going to be asked. Providers should repeat assurances of confidentiality and should make youth aware of the exceptions to confidentiality. Confidentiality issues are subject to state law but often include notifying identified authorities in the cases of potential suicide, homicide, or other harm to self or others.. Providers should inform youth that they have the right to refuse to answer questions.

Providers should maintain awareness of how their own biases may be reflected in verbal and non-verbal cues. Specifically, providers should avoid assumptions and the use of clinical jargon throughout the interview. To obtain the most accurate and useful information, providers are encouraged to ask about specific sexual behaviors instead of asking if the patient is "sexually active." In discussing "Types of Sexual Activity," the provider shall take the opportunity to address and answer questions about safe-sex practices for each activity defined. A standardized questionnaire may also be used, as long as confidentiality is stressed; however, this practice is not recommended for questions about sexual orientation because it may yield unreliable results. If possible, health educators should review basic topics; otherwise, written and visual materials can be provided. This "preview" can de-sensitize youth and prepare them for answering questions during the evaluation.[6]

Standard 7: History of Abuse

Youth should be asked about a history of emotional, physical, or sexual abuse by staff trained to interview youth concerning sensitive topics. If abuse is suspected, youth should be assessed to determine the circumstances surrounding abuse and the presence of physical, emotional, and psychosocial consequences, including health risk behaviors. Youth who report symptoms of emotional or psychosocial problems should be referred to a psychiatrist or other mental health professional for evaluation and treatment. Practitioners should be knowledgeable on their state's mandatory reporting statute and be prepared to report abuse to the appropriate local or state child protection agencies.

In addition to on-site mental health care services, youth shall have easy, confidential access to outside advocates and professionals who provide services to survivors of sexual abuse, for emotional support and other services related to sexual abuse, through, at minimum, 1) written guides that include the addresses, telephone numbers, toll-free hotlines, website addresses, email addresses and contact persons for local, state and national legal and service organizations that assist survivors of sexual abuse and rape crisis centers; and 2) arrangements that ensure private, confidential communications between youth and these advocates and organizations.

Rationale: Youth who have been victimized as children may experience a resurgence of fear and anger when dealing with prospective sexual encounters. These emotions may interfere with the development of a healthy sexual relationship. Those who are ongoing victims of sexual abuse may present to the office or clinic with multiple STIs, pregnancy, and other health issues.

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[6] See generally American Medical Association, *Guidelines for Adolescent Preventative Services* 5 (1997), Recommendation 16, available at http://www.ama-assn.org/ama1/pub/upload/mm/39/gapsmono.pdf (last visited September 21, 2011). [hereinafter GAPS]; Region II Male Involvement Advisory Comm., *Guidelines for Male Sexual and Reproductive Health Services: A Tool for Family Planning Providers* 9-12 (2005) (on file with the Center for HIV Law & Policy) [hereinafter Region II MAC].

Implementation: Providers can inquire about sexual abuse or forced sex at the conclusion of the sexual history. It is important to establish rapport and trust with the patient; questions may be presented over several visits if necessary and feasible. If abuse is suspected, the youth should be assessed to determine the circumstances around the abuse and the consequences, whether they are physical, emotional, and/or psychosocial. Youth who report symptoms of emotional or psychosocial problems should be referred to a mental health professional for evaluation and treatment.[7]

Standard 8: Counseling on Anatomy

Youth should have a basic understanding of anatomy and physiology, including knowledge of one's body and how it functions; the essential and accessory organs of one's reproductive system; the stages of puberty; and how the body undergoes both hormonal and physical changes. Subsequent to this instruction, biological male youth should be taught how to perform testicular self-exams, and biological female youth should be taught how to perform breast exams. All adolescents should be taught how to use a condom.

Rationale: Youth must be taught how the body develops and functions in order to distinguish between healthy and unhealthy changes and to understand normal processes that occur during puberty. By understanding their own anatomy and that of their partners, youth can better protect themselves by choosing a method of STI and HIV protection and, where appropriate, pregnancy prevention. With counseling, they will be encouraged to seek out answers to questions and become involved with their own health maintenance. Youth must have access to scientifically accurate information in order to make informed choices about their sexual health care.

Implementation: This information can be presented during a group educational session or given at an individual patient-oriented genital exam and physical. Demonstrations on performing a self-examination, brochures, videos, and charts are also effective tools, but providers should be sensitive to the differences in reading capabilities of the youth in their care.[8]

Standard 9: Pubertal Development Exam and Counseling

Youth should be queried about pubertal development and asked about any concerns they may have about the timing and rate of maturation.

Rationale: Youth initiate the pubertal process at different times and proceed at different rates, which may cause anxiety and worry. Counseling and frank discussion can allow youth to alleviate concerns and identify problems that require additional medical attention.

Implementation: Questions about development can be broached during the course of the physical examination. A standardized questionnaire may also be used, as long as confidentiality is stressed.[9]

Standard 10: Genital Exam

Youth should be examined for ano-genital lesions of the genital tract, abnormal growths, itches, or skin changes in the genital area, and bleeding or irritation. This assessment should include the

[7] GAPS, *supra* note 6, at 6 (Recommendation 21); Region II MAC, *supra* note 6, at 15.
[8] Region II MAC, *supra* note 6, at 21-22.
[9] See GAPS, *supra* note 6, at 3 (Recommendation 5); Region II MAC, *supra* note 6, at 9.

youth's history of ano-genital lesions as well as a thorough examination of the genital area. Careful consideration should be given to ano-genital lesions that may be very small or occur inside the anus. Youth should be made aware that ano-genital lesions are not necessarily indicative of sexually transmitted infections, but rather can be part of a more serious problem.

Any ano-genital lesions present must be investigated to ensure they are not of a serious type. Some associate conditions include pruritus ani (itching of the anus), eczema, folliculitis, tinea cruris (jock itch), intertigo (rashes), genital herpes, genital warts (including those associated with HPV and syphilis), pubic lice, cysts, and vaginal infections. Genital exams may be particularly sensitive for youth who are transgender, and care should be taken to use language relating to current genitalia, and to be aware of physical changes that may be taking place if the youth is on hormone therapy.

Rationale: A genital exam is necessary to diagnose and treat health and hygiene problems. Youth may not self-report ano-genital lesions because they may be unaware of them or because they may experience discomfort, embarrassment, low self-worth, or interference with sexual functioning. A comprehensive examination must be completed for clients who may feel uncomfortable talking to the clinician or may be unaware that they have ano-genital lesions.

Implementation for Male Genitalia: Preparation for the male genitalia exam should include:

- Warm hands first
- Make sure there is enough light
- Wear gloves
- Examine patient while he is standing up

The genital exam for adolescent male genitalia should include:

- Inspection:
  - Tanner staging (using a scale to define physical measurements of development based on external primary and secondary sex characteristics)
  - Pubic hair
  - Groin
  - Inner thigh
  - Prepuce
  - Glans
  - Scrotum
  - Discharge
  - Herpes lesions
  - Warts
- Palpation:
  - Testes
  - Epididymis
  - Vas Deferens
  - Inguinal hernia exam

Implementation for Female Genitalia: Preparation for the male genitalia exam should include:

- Warm hands and speculum first
- Make sure there is enough light

- Wear gloves

When indicated, a female genitalia exam should include:

- External exam/inspection of:
  - Tanner staging (using a scale to define physical measurements of development based on external primary and secondary sex characteristics)
  - Pubic hair
  - External genitalia
  - Urethra
  - Lymph nodes
- Speculum exam and inspection of vagina and cervix for discharge, cervical friability, strawberry cervix, foreign bodies, etc.
- Bimanual exam to assess:
  - Cervical motion tenderness
  - Adnexal tenderness
  - Uterine size or tenderness
  - Mass uterine

During the examination, any discomforts, abnormal growths, or itches should be recorded in the youth's medical records. If the lesions are sexually transmitted, information on ways the youth can protect himself or herself from acquiring further infections must be relayed. Youth should also be informed that some types of ano-genital lesions may be difficult to detect and may warrant several different types of detection procedures. They must be encouraged not to feel upset, angry, or ashamed of themselves or their partners. An understanding of the prevention, treatment, and management of ano-genital lesions is most essential. Youth should also be encouraged to check themselves periodically for any type of ano-genital lesions.

Standard 11: Genital Hygiene

All youth should be taught how to appropriately clean the genitalia and the proper bathing/hygiene requirements.[10]

Rationale: Proper genital hygiene is an important factor in preventing disease.[11]

Implementation: Youth should be counseled on proper hygiene for their genitalia and how to check for unusual bumps, discharge, and burning.[12] Youth with female genitalia should be counseled on what discharge is normal and what should be cause for medical attention. The particular risks of douching should be discussed in detail.[13] Youth with uncircumcised penises should be informed about: smegma, oily secretions that accumulate under the foreskin; balanitis, inflammation of the tip of the penis; and phimosis, the inability of the foreskin to pull down and expose the penis head

[10] Region II MAC, *supra* note 6, at 28.
[11] *Id.*
[12] *Id.*
[13] The effects of douching can include ectopic pregnancies, pelvic inflammatory disease, and changes in vaginal flora. See Jeffrey T. Kirchner, D.O., *Prevalence of Vaginal Douching Despite its Adverse Effects*, in AMERICAN FAMILY PHYSICIAN (2000), available at http://www.aafp.org/afp/20000201/tips/33.html (last visited September 21, 2011).

during erections and intercourse. Healthcare providers should feel comfortable in addressing genital-hygiene questions and concerns.[14]

Standard 12: STI Testing

Young men and women in state custody should be offered testing for:

- Chlamydia
- Gonorrhea
- Syphilis
- HPV

Rationale: Multiple studies and surveillance projects have demonstrated a high prevalence of STIs in youth in state custody. Testing for chlamydia, gonorrhea, and syphilis at intake offers an opportunity to identify infections, prevent complications, and reduce transmission in the community. It also indicates an increased risk for HIV. Untreated STIs result in damage to various other organ systems and the spread of infections to other sexual partners. Testing for the causative agent assures that proper treatment is provided.[15]

STIs disproportionately affect adolescent women. Because of immature cervical immaturity, this population is biologically more susceptible to infection. Additionally, in the majority of cases, STIs in young women are asymptomatic, which can lead to delays in testing and treatment. As a result, women face greater morbidity with untreated infection.

Implementation: Tests should be offered as part of a physical exam, and should include counseling on STI causes, treatment, and prevention. Pre-test counseling should specifically include the following information:

- How STI testing is performed
- The importance of STI testing for treatment
- A discussion of the proper use of latex condoms with water-based lubricants, other latex barriers, and abstinence
- Encouragement for youth to discuss concerns about STIs with their sexual partners and health care providers
- The only way to know if you or someone else is infected with an STI is from testing and a medical exam
- If you think you have an STI, you should stop having sexual intercourse and go to a health care provider for testing, and refer partners to a healthcare provider as well
- If you have been sexually assaulted, you should be tested for STIs
- A discussion of relevant state laws allowing youth to get confidential testing and treatment for STIs without adult consent.
- A discussion of one's right to confidentiality after submitting to an STI test, as well asthe state mandated reporting requirements to the local county or state health department or the Centers for Disease Control and Prevention (CDC)
- Confidentiality for youth in foster care and related obligations that need to be reported to a foster care agency. Youth are often concerned with what medical information foster care agencies may acquire from previous medical providers and youth shall be told that their medical

[14] *Id.*
[15] *Id.* at 40.

information may be shared with a foster care agency. Because youth may not want this information to be shared, youth should be made aware that providers do not have to be told that youth are in foster care and therefore providers are under no obligation to report information to the foster care agency.

Additional counseling must be provided in accordance with Standard 19. All youth should be offered testing and provided appropriate counseling for:

Chlamydia:

- *C. trachomatis* urogenital infection in women can be diagnosed by testing urine or swab specimens collected from the endocervix or vagina.
- Diagnosis of *C. trachomatis* urethral infection in men can be made by testing a urethral swab or urine specimen.
- Rectal *C. trachomatis* infections in persons that engage in receptive anal intercourse can be diagnosed by testing a rectal swab specimen.
- Culture, direct immunofluorescence, EIA, nucleic acid hybridization tests, and NAATs are available for the detection of *C. trachomatis* on endocervical and male urethral swab specimens NAATs are the most sensitive tests for these specimens and are FDA-cleared for use with urine, and some tests are cleared for use with vaginal swab specimens.
- The majority of tests, including NAAT and nucleic acid hybridization tests, are not FDA-cleared for use with rectal swab specimens, and chlamydia culture is not widely available for this purpose.
- Some noncommercial laboratories have initiated NAAT of rectal swab specimens after establishing the performance of the test to meet CLIA requirements.

Gonorrhea:

- Gram-negative diplococci can be considered diagnostic for infection with *N. gonorrhoeae* in symptomatic men. Gram stain should not be considered sufficient for ruling out infection in asymptomatic men.
- Gram stain of endocervical specimens, pharyngeal, or rectal specimens also are not sufficient to detect infection and, therefore, are not recommended.
- Specific diagnosis of infection with *N. gonorrhoeae* may be performed by testing endocervical, vaginal, male urethral, or urine specimens.
- Culture, nucleic acid hybridization tests, and NAAT are available for the detection of genitourinary infection with *N. gonorrhoeae*. Culture and nucleic acid hybridization tests require female endocervical or male urethral swab specimens. NAAT offer the widest range of testing specimen types because they are FDA-cleared for use with endocervical swabs, vaginal swabs, male urethral swabs, and female and male urine. However, product inserts for each NAAT vendor must be carefully examined to assess current indications because FDA-cleared specimen types might vary. In general, culture is the most widely available option for the diagnosis of infection with *N. gonorrhoeae* in nongenital sites (e.g., rectum and pharynx). Nonculture tests are not FDA-cleared for use in the rectum and pharynx. Some NAATs have the potential to cross-react with nongonococcal *Neisseria* and related organisms that are commonly found in the throat. Some noncommercial laboratories have initiated NAAT of rectal and pharyngeal swab specimens after establishing the performance of the test to meet CLIA requirements.

- Because nonculture tests cannot provide antimicrobial susceptibility results, clinicians should perform both culture and antimicrobial susceptibility testing in cases of persistent gonococcal infection after treatment.

Syphilis

- A serologic test for syphilis.

HPV

- Evaluation for human papilloma virus by visual inspection (males and females) and by pap test (females).[16]

All youth must be informed, in private, of their test results (both positive and negative) and receive appropriate post-test counseling and treatment in accordance with Standard 13. All test results must remain confidential in accordance with Standards 13 and 43.

Standard 13: STI Treatment

Following a diagnosis of an STI, a treatment plan should be instituted according to guidelines developed by the CDC. The use of condoms must be encouraged.[17] Treatment of common, uncomplicated STIs should be available on-site.[18] Post-diagnosis counseling should be provided.

The HPV vaccines shall also be discussed and offered to all biological female youth. The HPV vaccines prevents cervical cancer, other less common cancers, and most genital warts that are caused by HPV and are licensed, safe, and effective for use by women between the ages of 9-26 years old. The vaccines currently on the market, Gardisal and Cervarix, require three shots over a period of approximately nine months. If biological female youth start the treatment at the facility they must be aligned with follow up care to receive the remainder of the vaccine. Gardisil has also been tested and licensed for use in biological males 9-26 years old.[19] Biological male youth shall also be counseled and offered Gardisil to prevent transmitting HPV to sexual partners. It is imperative that post-vaccine counseling be provided so the youth know when to receive the next shot in the treatment and the importance of completing the three shot session. Youth shall also be counseled on the importance of safe sex to prevent contracting and transmitting other STIs.

Rationale: Untreated STIs result in damage to various other organ systems and the spread of infections to other sexual partners.[20] Multiple studies and surveillance projects have demonstrated a high prevalence of STIs in persons entering juvenile detention facilities (see Standard 12). Testing for chlamydia, gonorrhea, and syphilis at intake offers an opportunity to identify infections, prevent complications, and reduce transmission in the community.

Implementation: Those presenting with an exposure to STIs or symptoms of current infection should be provided immediate presumptive treatment and testing should be performed whenever

[16] GAPS, *supra* note 6, at 5-6 (Recommendation 17).
[17] *Id.*. See also, Centers for Disease Control and Prevention, *2010 STD Treatment Guidelines* (2010), available at http://www.cdc.gov/std/treatment/2010/default.htm (last visited September 21, 2011).
[18] Region II MAC, *supra* note 6, at 40.
[19] See, e.g. Centers for Disease Control and Prevention, *Vaccines: VPD-VAC/HPV/Vaccine FAQ* (2011), available at http://www.cdc.gov/vaccines/vpd-vac/hpv/vac-faqs.htm (last visited September 21, 2011).
[20] *Id.*

possible to confirm the diagnosis.[21] Diagnoses must not be disclosed to non-health care staff. Post-diagnosis counseling should include:

- Discussion of appropriate treatment and re-infection
- Discussion of abstinence from sex until patient and partner treatment
- Reinforcement of prevention through safe-sex practices or abstinence
- Discussion of the psychological strain of diagnosis

Treatment and dispensing of medication must be done in a confidential setting and must not be done in a way that makes it obvious what the medication is for; for example, facilities should not dispense all medication except STI medication in front of other youth, which would allow youth to infer whom is receiving STI medication by observing whose medication is dispensed privately. Thus, all medication should be dispensed privately. Youth in foster care should be counseled on how and where to receive their care and medications and given resources to receive this care without foster parent involvement if necessary.

Standard 14: HIV Pre-Test Counseling: risk-assessment

All youth should be HIV risk assessed. Use a very explicit assessment checklist. Ask each youth: "What do you do to protect yourself from HIV/AIDS?"[22] The standard of care should be to offer counseling and voluntary testing to each youth (as set forth below in Standard 15). All youth should receive counseling on HIV prevention, including risk factors for HIV, HIV myths, and how to protect themselves against HIV (as set forth below in Standard 19).

Rationale: Reproductive health care settings are a critical conduit to HIV testing and counseling. According to the World Health Organization, at least 75% to 85% of the 39.4 million HIV infections worldwide have been sexually transmitted as of 2003.[23] Therefore, prevention should take place through both primary prevention and secondary prevention. An example of primary prevention would be encouraging HIV-negative youth to use condoms, avoid injection drug use, and not use shared needles. Secondary prevention would entail advising HIV-positive youth to practice safer sex techniques to protect themselves from re-infection, explaining the relative risks of different types of sex (e.g., oral versus anal, receptive versus insertive) to protect their uninfected partners, and explaining how to protect themselves from other STIs their partners may have. It is important to offer the test to all youth, because youth may not accurately report, estimate, or understand their risk.

Implementation: All youth should be given an HIV risk-assessment by asking questions during the taking of a medical history or by giving the youth a questionnaire to complete.[24] The risk-assessment should include questions concerning whether the adolescent has engaged in sexual behavior; has been sexually abused; has symptoms of HIV infection; has a history of STIs; has had unprotected sex with multiple sex partners or with partners in high-prevalence jurisdictions and communities (as many females are infected while in relationships with a single partner); has exchanged sex for money, food, housing, or drugs without using protection; has a history of tuberculosis; has injected drugs or shared needles (including needles for hormone injections or tattoos) or other equipment involved in

[21] *Id.*; GAPS, *supra* note 6, at 5-6 (Recommendation 17).
[22] Region II MAC, *supra* note 6, at 28.
[23] *Id.*
[24] *Id.*

piercing; has hepatitis C; has used non-injection illegal drugs; or has had a blood transfusion in any other country at a time when blood was not screened for HIV.[25]

It is also important to understand the youth's literacy skills and cultural sensitivities. Questions concerning sexual behavior or drug use cover sensitive areas. A substance abuse evaluation must be part of the risk-assessment, as abuse of alcohol or drugs impairs judgment in ways that can lead to higher risk behavior for acquiring HIV. Pre-test counseling should focus on teaching skills and not just facts. This includes teaching explicit safe-sex skills, instructing the adolescent on asking sexual partners about STIs and HIV, and being able to identify genital infections on their sexual partner.[26]

Standard 15: HIV Pre-Test Counseling: Informed Consent

HIV testing should be performed only after informed consent is obtained from the youth.

Rationale: Obtaining informed consent is a legal and ethical requirement for all medical procedures. Despite recent movements to eliminate informed consent requirements, standard practices among youth currently require that there be written informed consent so that youth completely understand for what they are being tested and treated. Because laws regarding informed consent, HIV testing, and treatment vary from state to state, practitioners should be versed in their jurisdiction's laws on informed consent and confidentiality. Practitioners should also educate youth about these laws.

Informed consent requires that a competent patient voluntary consent to treatment or testing after being informed of the nature of the treatment or testing, possible alternatives, and any risks or benefits to the procedure and its alternatives. It is a process of communication between physician and patient that results in the patient agreeing to undergo a medical procedure.[27] As part of informed consent, patients must have any and all questions answered to have a full understanding of the ramifications of any treatment or test before providing voluntary, informed consent.

HIV testing without a patient's informed consent is a particularly egregious violation of their human rights. Unlike many other STIs, HIV is a chronic, life-long condition that requires continual treatment and can lead to legal, social, and economic ramifications. Written informed consent provides documentation of informed consent as a safeguard against the abuse of patients' rights, ensures no one is tested without his or her consent, and helps avoid liability. For many youth, HIV testing may act as a portal to the health care system; ensuring that the experience is voluntary and respectful of their rights will help build a relationship of trust with the health care community and encourage youth to seek appropriate follow up testing and, for those who test positive, treatment.

Implementation: HIV testing should be offered following a risk-assessment and other pre-test counseling and written consent. Pre-test counseling should focus on available treatment and create a positive perspective about long-term prognosis. The pre-test counseling must include the following information in language and concepts that the adolescent can understand:

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[25] See N.Y. State Office of Children & Family Servs., *Working Together: Health Services for Children in Foster Care* 3-6 (2004), available at http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp (last visited September 21, 2011) [hereinafter WORKING TOGETHER].
[26] Region II MAC, *supra* note 6, at 28.
[27] Catherine Hanssens, THE CENTER FOR HIV LAW & POLICY, *Legal and Ethical Implications of Opt-Out HIV Testing*, (2007), available at http://www.hivlawandpolicy.org/resources/view/370 (last visited September 21, 2011).

- HIV testing is voluntary and consent can be withdrawn at any time by telling your health care provider
- The ways in which HIV testing is performed
- Your HIV test includes a test to see if you have an HIV infection and, if you are positive, additional tests to help your doctor decide the best treatment for you and help the health department with HIV prevention programs
- The importance of HIV testing for treatment
- A discussion of the proper use of latex condoms with water-based lubricants, other latex barriers, and abstinence
- Encouragement for youth to discuss concerns about HIV with their sexual partners and health care providers
- The only way to know if you or someone else is infected with HIV is from testing
- If you think you have HIV, you should stop having sexual intercourse and go to a health care provider for testing, and refer partners to a healthcare provider as well
- If you have been sexually assaulted, you should be tested for HIV
- A discussion of relevant state laws allowing youth to get confidential testing and treatment for HIV without adult consent
- HIV testing is important for your health
  - If your result is negative, you can learn how to protect yourself from infection in the future.
  - If your result is positive, you can take steps to prevent passing the virus to others.
  - You can receive treatment for HIV and learn other ways to stay healthy.
- HIV testing is especially important for pregnant women because an HIV-positive woman can pass HIV to her child during pregnancy, birth, or through breastfeeding
  - If you are pregnant and have HIV, treatment is available for you and to prevent passing HIV to your baby
  - If you have HIV and do not get treatment, the chance of passing HIV to your baby is one in four
  - If you get treatment, the chance of passing HIV to your baby is much lower
- If you test positive, the law protects you from discrimination based on your HIV status
- Relevant confidentiality, reporting, and partner notification laws must be discussed
- If you're HIV positive, the earlier you are assessed for treatment, the better your health with HIV will remain.
  - Also, effective treatment when appropriate also can reduce the risk that you will pass HIV to a sexual partner.
- A discussion of one's right to confidentiality after submitting to an HIV test and also the state mandated reporting requirements to the local county or state health department or the Centers for Disease Control and Prevention (CDC)

Standard 16: HIV Test Administration

Following pre-test counseling, all youth should be offered confidential HIV testing with the Rapid HIV Testing and confirmatory test. The option of anonymous testing should be available to youth who (for a variety of reasons, including pending criminal charges or fear of stigmatization) are not comfortable with testing otherwise.

Rationale: If undiagnosed and untreated, HIV can result in serious health problems and is more likely to be transmitted to other sexual partners.[28] Due to high rates of sexual risk behaviors and low rates of condom use, youth in state care experience particularly higher rates of STIs, including HIV.[29]

Implementation: Patients who provide written informed consent should be provided prompt and confidential HIV testing with Rapid HIV Testing and a confirmatory test within two weeks for youth who test positive. Testing must be accompanied by counseling as set forth in Standards 14, 15, and 17. Youth should be able to request this testing at any time. They should be provided with prompt counseling and testing in accordance with this Standard and Standards 14, 15, and 17. Regardless of the results, non-health care staff may not be told of a youth's HIV status without that youth's consent.

Standard 17: HIV Post-Test Counseling

All youth must be promptly informed of their test results—both positive and negative—in a confidential setting and provided appropriate post-test counseling. If youth test preliminary positive from the Rapid HIV Test, he or she must be told what a preliminary positive test means and why confirmatory testing is required. Youth who test preliminary positive must be provided with a confirmatory test to confirm the results.

Rationale: Post-test counseling provides critical information about the test results and the need for follow-up care such as treatment and additional testing. Youth who receive a positive test require counseling that explains what this test means and does not mean, the importance of additional testing, the next steps in their treatment, how to keep themselves healthy, and how to protect partners. These youth also need counseling to de-stigmatize and demystify HIV and to ensure that they are able to protect both their health and their rights, such as their right to keep their results confidential. Youth who receive a negative test result may not understand the significance of this result the "window period," or the importance of follow-up testing. Without such counseling, they may incorrectly assume that they do not have HIV or are not at risk for HIV or transmitting HIV.

Implementation: All youth who receive an HIV test must be provided, in a private and confidential setting, post-test counseling that includes:

- A comprehensive discussion of what their test results mean
- HIV prevention counseling

Youth who test positive must also receive counseling that includes:

- The need for a confirmatory test and when and how that test will be provided
- Treatment options and a discussion of "next steps" and follow up care in accordance with Standard 18
- Offer of follow-up counseling to deal with feelings (such as fears or concerns) about the test results
- The right not to be discriminated against
- The right to keep the test result confidential

[28] *Id.* at 40.
[29] Staples-Horne, *supra* note 1, at 309.

- Facility obligations to keep test results confidential and to prevent and respond to any discrimination (including ways in which the youth can report any violation of those obligations)

Standard 18: HIV Treatment

The provider and custodial facility should be prepared for positive HIV test results and develop a mechanism to provide treatment while the youth is still in custody or care, and appropriate follow-up on release into the community.[30] Facilities should offer a comprehensive package of health care and support services to meet the multiple needs of youth with HIV.[31]

Rationale: The primary goal for practitioners should be to provide appropriate care that minimizes HIV progression. The determination of HIV treatment and care should be made with the informed consent and understand of the youth, and where applicable, parent or legal guardian. Practitioners should be aware of the HIV confidentiality, treatment and consent laws in their jurisdiction regarding the treatment of minors. HIV treatment should be commenced if the clinician and youth find that ART and other HIV-related medication is appropriate. If untreated, HIV results in serious health problems and is more likely to be transmitted to other sexual partners.[32] Due to the high rates of sexual risk behaviors and low rates of condom use, youth in state care experience higher rates of STIs, including HIV.[33]

Implementation: Youth who are HIV-positive should receive medical care from specialized pediatric or adolescent HIV/AIDS providers that have 24-hour coverage, seven days a week. It is crucial that detention facilities and responsible foster care parties and families strictly adhere to the medication schedules that are prescribed for the youth. If a youth is not in a residential facility where medications can be routinely distributed, then other drug adherence tactics should be discussed and agreed upon with the youth and/or their foster care family. Facilities must have methods for monitoring and assuring that medication schedules are followed precisely as written. If adherence to the medication schedule is problematic, the prescribing practitioner should be consulted. The custodial facility must also provide the necessary supportive nursing and psychosocial services and training to the youth, including counseling for issues of loss and grief, and counseling to help youth assess the impact of HIV on their sexual development and exploration.[34]

Treatment and dispensing of medication must be done in a confidential setting and must not be done in a way that makes it obvious what the medication is for; for example, facilities should not dispense all medication except STI or HIV medication in front of other youth, which would allow youth to infer who is receiving STI or HIV medication by observing whose medication is dispensed privately. Thus, all medication should be dispensed privately.

Standard 19: HIV and STI Counseling

Every youth should be assessed for: their knowledge of HIV and STIs; the presence of symptoms in self or partner; the existence of multiple sexual partners for self or partner; the treatment of either

[30] *Id.* at 310.
[31] WORKING TOGETHER, *supra* note 25, at 3-4.
[32] See Region II MAC, *supra* note 6, at 40.
[33] Staples-Horne, *supra* note 1, at 309.
[34] See WORKING TOGETHER, *supra* note 25, at 3-4.

for an STI; whether barrier methods (i.e.: condoms) are used.[35] Counseling should be provided that explains: how HIV is transmitted in clear and precise language, the precise routes and related relative risks of different sexual acts, the consequences of the becoming infected and living with HIV, and the fact that latex condoms and water-based lubricant are effective in preventing STIs, including HIV; reinforcement of responsible sexual behavior for youth who are not currently sexually active and for those who are using condoms, other latex barriers, low-risk and lower-risk sexual conduct, and birth control effectively; and counseling on the need to protect themselves and their partners from pregnancy, STIs, HIV, and sexual exploitation. Latex condoms to prevent STIs, including HIV infection, and appropriate methods of birth control should be made available, as should instructions and training on how to use them effectively.[36] Myths and exaggerated beliefs about the risks of HIV transmission should be addressed and debunked.

Rationale: Many youth lack knowledge about STIs and HIV, including how they can contract and transmit them, how STIs and HIV affectt their health, and the effective measures for their prevention. Many STIs disproportionately affect youth. Youth in the United States have higher STI rates than teenagers in other developed countries because they have more sexual partners and lower levels of condom use.[37] Due to the high rates of sexual risk behaviors and low rates of condom use, youth in state care in particular experience higher rates of STIs, including HIV.[38] They need information and education about STIs and HIV, including how to avoid infection and transmission, where to obtain and how to use condoms correctly, and how to talk about STIs and HIV with their partners.[39]

Implementation: These questions should be included on the medical history completed by the clinician.[40] A skilled provider should review the information in detail. An opportunity for questions and discussion must be offered.[41] Counseling services may be provided directly by the facility or by agreements with health-related community organizations. Regardless, such services must be readily available and provided by professionals trained and experienced in family planning education, gynecological care, and contraception for adolescents.[42] Counseling can occur individually or in a group setting.[43]

Standard 20: Condom Use and Availability

Condoms, both male and female versions, should be made available to all youth, with all youth made aware of their availability. Youth should be instructed that condoms provide protection from some STIs as well as pregnancy. They should be informed and instructed in the correct use of condoms and educated about any common misconceptions.

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[35] Region II MAC, *supra* note 6, at 27.
[36] GAPS, *supra* note 6, at 4 (Recommendation 9).
[37] Jacqueline E. Darroch, et al., ALAN GUTTMACHER INST., *Can More Progress Be Made?: Teenage Sexual and Reproductive Behavior in Developed Countries* 6 (2001), available at http://www.guttmacher.org/pubs/eurosynth_rpt.pdf (last visited September 21, 2011).
[38] Staples-Horne, *supra* note 1, at 309.
[39] See Region II MAC, *supra* note 6, at 27.
[40] *Id.*
[41] *Id.*
[42] WORKING TOGETHER, *supra* note 25, at 3-7.
[43] Region II MAC, *supra* note 6, at 27.

Rationale: As aforementioned, teenagers in the United States have higher STI rates than teenagers in other developed countries, most likely due to greater sexual partners and lower levels of condom use.[44] Each youth needs to know that condoms offer protection against some STIs, including HIV infection. Condoms are essential when there are multiple partners or the sexual history of a partner is not known.

Implementation: A clinician or counselor should first demonstrate proper application and removal of a condom by employing the use of an anatomical model. The professional should then observe the youth place and remove the condom from the model.[45] This education should include information on the use of water-based lubricants for anal sex as a means of making condoms more effective. The following questions will help address condom-specific issues: Do you know that they make a condom for women? Have you ever used a male or female condom with your partner? Do you ever have trouble putting on a condom?

Standard 21: Substance Abuse and Sexual Behavior Counseling

Youth should be informed of the adverse physiological effects of substance use on sexual development and functioning. Emphasize the importance of responsible sexual behavior with drug and alcohol users, even infrequent, as they are more likely to have unprotected sex.

Rationale: Adolescents who drink or use drugs are more likely to initiate sex at a younger age, to have unprotected sex, to have sex with multiple partners, and to contract STIs.[46] Moreover, use of alcohol, tobacco, and other drugs ("ATOD") can cause other health problems.

Implementation: Youth should be educated on predominant types of ATOD use and their physiological consequences on sexual function and development. Educational materials on ATOD use and abuse should be made available at the clinic.[47]

Standard 22: Contraception Use and Availability

Youth should be informed in the nature and proper use of female hormonal and female barrier methods of contraception. They should be instructed on the effectiveness of these methods and on any major significant side effects and related danger signals. Any misconceptions should be addressed. All youth should have access to forms of contraception and assistance that allow them to choose a method that will protect them and their partner from pregnancy, STIs, and HIV. Special care should be taken to introduce all contraceptive choices.

Rationale: All sexually active youth must take responsibility in assuring that contraceptive measures are used correctly and consistently. They must choose the best method of contraception and STI protection for themselves and their partners.

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[44] Darroch, *supra* note 37, at 6.
[45] Region II MAC, *supra* note 6, at 26.
[46] Kaiser Family Foundation, *Fact Sheet: Substance Use and Sexual Health Among Teens and Young Adults in the U.S.* (2002) citing *Dangerous Liaisons: Substance Abuse and Sex, National Center on Addiction and Substance Abuse at Columbia University* (1999); AIDS Institute Guidelines*, Substance Use and Dependence Among HIV-Infected Adolescents and Young Adults* (2009), available at http://www.hivguidelines.org/clinical-guidelines/hiv-and-substance-use/substance-use-and-dependence-among-hiv-infected-adolescents-and-young-adults/ (last visited September 21, 2011).
[47] GAPS, *supra* note 6, at 4 (Recommendation 10); Region II MAC, *supra* note 6, at 24-25.

Implementation: This information can be presented to youth during a group educational session or a private counseling session. Brochures, videos, and charts can be effective tools.[48] There should also be resources for providers with directories that can refer patients to locations for contraceptive services and family planning access.

Standard 23: Emergency Contraception

Assess each youth about his or her understanding of the process of fertilization and establishment of a pregnancy. Provide all youth with accurate, complete information on how emergency contraception works and its availability. Young people shall also be informed on the local and state programs on availability of emergency contraception.

Rationale: Many young men and women are unaware of emergency contraception. In the event of a sexual assault or contraceptive failure, emergency contraception provides a second chance to prevent pregnancy.[49]

Implementation: This information can be presented during interviews upon the medical intake process by providing information on how youth can obtain emergency contraception while in custody or in their foster care placements and when they leave custody.[50] Providers can discuss the option of obtaining a prescription to have on hand for emergencies if they are under the age of 17.[51] Youth should be questioned about their need for post-coital contraception due to contraception failure, sexual assault, sexual spontaneity in relationships.

Ways to engage youth include: Do you ever have unprotected sex with someone of a different sex? Have you ever had a condom break? Do you practice withdrawal as a form of birth control? Do you know how pregnancy occurs? Each client must be instructed that emergency contraception is the only method a couple can use to prevent pregnancy after unprotected vaginal intercourse with someone of a different sex or after a contraceptive "accident." Youth need to know that this form of contraception (which is more commonly referred to as the Morning After Pill or Plan B) can be used up to 120 hours (5 days) after unprotected sex. However, it is most effective if taken within the first 48 hours. Females should be instructed on how emergency contraception may affect their cycles.

Youth should also be aware of what the local and state laws are regarding accessing emergency contraception. Some states allow accessing emergency contraception with a doctor's prescription while others require a prescription. Youth must be made aware of their state's related policies.

Standard 24: Pregnant Youth

Females who test positive for pregnancy must be provided with unbiased and comprehensive options counseling (as set forth in Standard 25) within 24 hours of the diagnosis. Females who test positive for pregnancy should also be assessed for sexual trauma on diagnosis of pregnancy.[52] If the pregnancy is continued, prenatal care should be provided in coordination with public health

[48] Region II MAC, *supra* note 6, at 26.
[49] Staples-Horne, *supra* note 1, at 311.
[50] Region II MAC, *supra* note 6, at 26; Staples-Horne, *supra* note 1, at 311.
[51] Region II MAC, *supra* note 6, at 26.
[52] Staples-Horne, *supra* note 1, at 310-11.

agencies, without significant travel from the facility they are currently residing and consistent with the American College of Obstetrics and Gynecology (ACOG) Standards for reproductive health and the birth process.[53] If the pregnant youth is discharged from the facility or state care prior to delivery, she should be provided information and referral for continuing obstetric care. If a confined youth decides to terminate the pregnancy, the custodial facility should ensure that the termination is obtained at the earliest gestation possible within the confines of state law on abortions.[54]

Rationale: Studies have revealed that a significant number of young women confined in the juvenile justice system or in state care are pregnant.[55] They clearly have health needs specific to their pregnancy. The options and standard of care for young women should not be diminished simply because they are in state custody.

Implementation: A facility should have standards and procedures in place to provide immediate assistance to a pregnant youth in its custody. Options counseling must be provided within 24 hours of pregnancy diagnosis to ensure that options are not foreclosed to the youth due to her being in custody. Should the youth choose to terminate the pregnancy, the facility must have standards and procedures to ensure that , this can be achieved at the earliest gestation possible. Coordination with outside health providers, as well as transportation to and from outside facilities, may be necessary and thus standards and procedures should exist to ensure this coordination can be achieved as swiftly as possible. Outside public health providers should also be located nearby to avoid trauma for the pregnant youth who may be shackled in accordance with agency transportation policies.

Standard 25: Pregnancy Options Counseling

Each youth should be instructed and informed about all options available for management of an intended or unintended pregnancy.[56] Females who test positive for pregnancy must be provided with unbiased and comprehensive options counseling regarding their ultimate choice regarding the pregnancy within 24 hours.

Rationale: All youth, male and female, should understand the options for an intended or unintended pregnancy, as both males and females have a role in the pregnancy.[57]

Implementation: Females should be given options counseling within 24 hours of a positive diagnosis. For males, general information can be presented during a group educational session or a private counseling session. Counseling should include discussion of: the youth's concerns, fears, and wishes; whether she wants to involve the fetus' father in the planning; whether he or she wants to involve his or her parents/guardians or other family members in planning; an objective review and discussion of the alternatives and their implications, including adoption of the baby, pregnancy termination, parenthood, living arrangements, school attendance, and education; and the resources available in the facility and in the community to help him or her implement each alternative.[58]

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[53] *Id.* at 311; WORKING TOGETHER, *supra* note 25, at 3-9.
[54] Staples-Horne, *supra* note 1, at 311.
[55] *Id.* at 310.
[56] Region II MAC, *supra* note 6, at 27.
[57] *Id.*.
[58] *Id.* at 311; WORKING TOGETHER, *supra* note 25, at 3-9.

This counseling should explain to the youth the procedures in place to ensure her decision is respected and assisted. She should understand her rights to continue or terminate the pregnancy without pressure or threats from any other person or institution. She should also be comprehensively counseled on adoption options, including familial and open adoption. The counseling should describe to the youth any and all confidentiality laws protecting her should she choose to terminate the pregnancy and whether, under state law, parental notification or consent is required for youth in state custody. If such notification or consent is required, the youth should also be counseled in the judicial or executive bypass procedures available to her and provided assistance in using such a procedure if she chooses to do so.

Youth in state care but not in custody should similarly be provided with options counseling as soon as possible, and should be given additional resources on how to carry out their wishes for the pregnancy within the context of foster care. In particular, they should be counseled on their rights to obtain a termination, adoption, and/or prenatal services without regard for the wishes of their foster family or other possible pressures.

Standard 26: Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Health Concerns

Providers should be aware of the health concerns of LGBTQ youth and should be aware of the relevance of sexual orientation and gender identity on the youth's health status.[59]

Rationale: LGBTQ youth face distinct health challenges, including an increased risk for substance abuse, sexually transmitted disease, sexual assault, and, sometimes seen in the case of young gay males, eating disorders. LGBTQ youth routinely face societal discrimination and isolation as a result of their sexual orientation and gender identity. As a result, they commonly suffer from the effects of chronic stress, which can lead to increased levels of depression and anxiety.[60] Many LGBTQ youth experience feelings of severe isolation. In fact, LGBTQ youth are two to three times more likely to attempt suicide than their heterosexual peers and account for up to 30% of all completed suicides among teens.[61]

LGBTQ youth are particularly vulnerable to sexual victimization while in state custody. According to the 2010 Department of Justice Bureau of Justice Statistics Special Report on Sexual Victimization in Juvenile Facilities, from 2008 to 2009 at least one in ten youth was sexually abused; at least one in ten youth experienced staff sexual misconduct; and LGBTQ youth were ten times more likely to be sexually victimized than heterosexual youth.[62] Because LGBTQ youth are traditionally marginalized in these facilities, it is particularly important that there be a medical staff

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[59] See generally Physicians for Reproductive Choice & Health, *Gay Lesbian Bisexual Transgender and Questioning Youth* (2009), available at http://www.prch.org/arshepdownloads (last visited September 21, 2011) [hereinafter PRCH-LGBTQ]; Staples-Horne, *supra* note 1.

[60] Shannan Wilber et al., *The Model Standards Project: Creating Inclusive Systems for LGBT Youth in Out-of-Home Care* 6 (2006), available for a fee at https://netforum.avectra.com/eweb/shopping/shopping.aspx?site=cwla&webcode=shopping&shopsearch=lgbt&shopsearchcat=top100products&prd_key=ab74a953-7209-49cf-bc9a-ad5221ea2d41; also on file with Center for HIV Law & Policy.

[61] Region II MAC, *supra* note 6, at 25.

[62] Bureau of Justice Statistics, *U.S. Dep't of Justice, Special Report: Sexual Victimization in Juvenile Facilities Reported by Youth 2008-2009*, 11 (2010), available at http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=2113 (last visited September 21, 2011).

and a medical support system that recognizes the existence and needs of these youth if they are to safely report and be treated for sexual misconduct.

Implementation: While following the requirements set forth in Standard 3, providers treating youth should inquire into sexual behavior and attraction. Where appropriate, they should discuss and inquire into areas in which the youth's sexual behavior could lead to increased health risks. This discussion includes assessment of and referral for mental health concerns (as set forth in Standards 4, 28, and 29), assessment of substance abuse, and the providing of safe-sex counseling.[63] There should also be a discussion of whether the youth is facing abuse, harassment, or other types of discrimination within the detention facility or foster care system. If youth are facing abuse, harassment, or other types of discrimination, appropriate action must be taken immediately to assure their safety and to address the abuse.[64] The remedial action must address the harassment and discrimination by targeting the perpetrators and ensuring a safe environment, rather than by targeting or isolating the LGBTQ youth.

Standard 27: Transgender Youth Health Concerns

"Transgender youth" or "gender nonconforming youth" refers to all those who challenge the socially-accepted definitions and boundaries of sex and/or gender. Transgender youth may be contemplating or already be in the process of transitioning from one gender to another.
The health needs of transgender youth must be discussed and addressed in an open, nonjudgmental manner. Providers must also recognize and address the unique physical and mental health needs these youth may have, and the rights of transgender youth to health care related to their gender identities.[65]

Rationale: Puberty is a difficult time for youth struggling with their gender identities because they lack support systems to make sense of their physical changes. These changes may shame or repulse transgender youth, prompting them to attempt to alter their appearance by concealing or injuring unwanted body parts or using hormones without the oversight of a doctor. Transgender youth also are at higher risk for alcohol and substance use to cope with feelings of depression or anxiety. Moreover, fear of ridicule, rejection, or harassment prevents many transgender youth from seeking services in the health care system. As a result, transgender youth may not receive health care on a consistent basis, much less care that addresses their unique health needs.[66]

Implementation: Communication, plans for transition, STI screening, safety and mental health, the use or discontinuation of hormones, silicone injections, ongoing care, and more must all be discussed with youth and addressed by providers. Providers should create a respectful and nonjudgmental environment for gender nonconforming youth. They should encourage a dialogue with youth on their health needs. For example, providers should respect the youth's gender identity and expression, including calling transgender and gender nonconforming youth by the name and

[63] PRCH-LGBTQ, *supra* note 59, at 45-49, 54-55, 57.
[64] Staples-Horne, *supra* note 1, at 314.
[65] Some states, like New York, have case law related to the treatment and care of transgender young people in state custody. See, e.g., Sylvia Rivera Law Project, *Settlement Reached in Case of Trans Youth Against Juvenile Services*, available at http://srlp.org/Rodriguez (last visited September 21, 2011)
[66] WORKING TOGETHER, *supra* note 25, at 3-12.

pronoun that they prefer as well as allowing them to dress in accordance with their identified gender.[67]

Providers should identify a timeline and plans for transition and discuss the possibility of involving the youth's parents. Providers should also determine the youth's perceived safety at the facility, and at home, school, or in their neighborhood.

It is important that providers have experience or training, in addition to cultural competency, when working with transgender youth. Providers may not feel comfortable performing genital exams and other medical exams on transgender youth due to personal biases or other elements. It is imperative that practitioners are trained on the particular health needs of transgender youth, not only to be comfortable treating youth but also to ensure that youth are receiving complete medical attention.

Providers should also discuss issues such as social isolation, abuse, depression, and anxiety. Long-term mental health counseling should be provided. Counseling for transgendered youth should be provided by mental health professionals with experience in transgender issues. This discussion should also address whether the youth is facing abuse, harassment, or other types of discrimination within the facility or the foster care system. If youth are facing abuse, harassment, or other types of discrimination, appropriate action must be taken immediately to assure their safety and to address the discrimination.[68] Housing and safety of youth is a key issue and should also be addressed.

When addressing the health needs of these youth, providers should discuss the use of hormones to change appearance, including the risks of the unsupervised use of hormones.[69] The provider should assess whether the patient is obtaining or plans to obtain hormones and, if so, what his or her source is. The provider should discuss the risks of obtaining street hormones, the fact that such hormones are often less pure, and the risks of sharing needles. The general risks and side effects of estrogen and testosterone injections should also be discussed. The provider should introduce the idea of parental consent at 16 years old.[70]

Sudden discontinuation of hormone use often leads to undesired regression of hormonally-induced physical effects and a sense of desperation that may lead to depression, anxiety, and suicidal thoughts or acts.[71] Providers should explain these physical effects to youth who were using hormones before entering state custody, should assess the youth for these changes, and should refer them for counseling where appropriate.

The provider should assess whether the youth is injecting silicone. The provider should discuss the risks of injections and its long-term effects, and should advise them to stop.

A plan for ongoing care that addresses the youth's transition process should be promptly made and put into effect in accordance with Standard 35.

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[67] Wilber, *supra* note 60, at 4.
[68] Staples-Horne, *supra* note 1, at 314.
[69] WORKING TOGETHER, *supra* note 25, at 3-12.
[70] The Endocrine Society, *Clinical Guidelines: Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline* (2009), available at http://www.endo-society.org/guidelines/final/upload/Endocrine-Treatment-of-Transsexual-Persons.pdf (last visited September 21, 2011).
[71] *Id.*

The provider should discuss with male-to-female patients the risks of smoking, particularly tobacco, while taking estrogen. The provider should discuss with female-to-male patients the need for pap smear and pelvic exams, as well as continuing pregnancy risks.

Standard 28: Mental Health Screening

Youth should be asked about behaviors or emotions that indicate recurrent or severe depression or risk of suicide. If suicidal risk is suspected, youth should be evaluated immediately and referred to a psychiatrist or other mental health professional, or else should be hospitalized. Non-suicidal youth with symptoms of severe or recurrent depression should be evaluated and referred to a psychiatrist or other mental health professional for treatment.

Rationale: Depressive disorders can have far-reaching effects on the functioning and adjustment of adults and youth. Co-occurring mental and addictive disorders are common. In youth there is an increased risk for substance abuse and suicidal behavior associated with depression. Suicide is a complex behavior that can be prevented in many cases by early recognition and treatment of mental disorders.

Implementation: During physical examination, the diagnostic evaluation should include a complete history of symptoms, including questions about drug and alcohol use as well as thoughts about death and suicide. A history should also include questions about whether other family members may have had a depressive illness and, if treated, what treatments they may have received and which were effective. A diagnostic evaluation should also include a mental status examination to determine if speech, thought patterns, or memory have been affected, as sometimes happens in the case of a depressive or manic-depressive illness.

With youth in particular, it is important to establish a sense of rapport and trust. Explain to the youth the confidentiality requirements as well as any relevant reporting requirements. A psychosocial inventory tool like BiHEADS (Body image, Home, Education, Activities, Drugs, Sex, sexual abuse, and suicide) may be used. Risk of suicide can also be determined by discussing declining school grades, chronic melancholy, family dysfunction, sexual identity issues, physical or sexual abuse, alcohol or other drug abuse, previous suicide attempts, suicide ideation, or suicide plans. It should be noted that men are less likely than women to admit to depression and that doctors are less likely to diagnose and treat it. Depression typically shows up in men as feeling irritable, angry, and discouraged, rather than feeling hopeless or helpless.[72]

Standard 29: Mental Health Services for LGBTQ Youth

LGBTQ youth should have access to supportive, inclusive, and nonjudgmental mental health services. LGBTQ youth should never be subjected to "reparative" therapy or other interventions designed to change a person's sexual orientation or gender identity.[73]

Rationale: While all youth in out-of-home care require access to mental health services as a result of their marginalized status, this need is heightened for LGBTQ youth, who often face societal discrimination and isolation as a result of their sexual orientation and gender identity. LGBTQ youth commonly suffer from the effects of chronic stress as a result of this discrimination and isolation,

[72] GAPS, *supra* note 6, at 6 (Recommendation 20); Region II MAC, *supra* note 6, at 16.
[73] Wilber, *supra* note 60, at 6.

which can lead to increased levels of depression and anxiety.[74] Many LGBTQ youth experience feelings of severe isolation, and they are two to three times more likely to attempt suicide than their heterosexual peers; they account for up to 30% of all completed suicides among teens.[75]

Implementation: The initial mental health interview discussed in Standard 4 must include an interview that identifies and evaluates risks that LGBTQ youth face. The interviewer should use inclusive language and avoid assumptions about sexual orientation, sexual activity, and gender identity. Youth suffering from anxiety, depression, or harassment should be evaluated and referred to a psychiatrist or other mental health professional for treatment in accordance with Standard 37. It is preferable that ongoing mental health care be provided by a mental health professional with experience working with LGBTQ youth.

[74] *Id.*
[75] Region II MAC, *supra* note 6, at 25.

ONGOING CARE

Standard 30: Health Care Services for Youth with Special Needs

A proactive program must exist to provide care for special needs youth who require close medical supervision or multidisciplinary care.[76] Special needs youth include those with chronic conditions that require regular care. This includes youth with physical disabilities, pregnant youth, youth with serious communicable diseases, and youth with serious mental health needs.

Rationale: The facility is responsible to provide ongoing care that meets the individual needs of each youth; youth with special needs therefore require ongoing health services that meet these needs.

Implementation: The youth must be provided with a treatment plan tailored to his or her individual needs. The treatment plan must be individualized, multidisciplinary, and based on an assessment of the youth's needs, and include a list of long- and short-term goals as well as the methods by which these goals will be pursued. Treatment plans for youth with mental health conditions should incorporate ways to address their problems and enhance their strengths, involve youth in their development, and include relapse prevention risk management strategies. Each youth identified with a need for special care, chronic, or convalescent care will be scheduled to see the physician, physician's assistant, or nurse practitioner at least monthly. The mid-level provider may see the youth if he or she is stable. The physician must evaluate the youth at least quarterly.

Standard 31: Emergency Care

The out-of-home facility must provide 24-hour emergency medical, mental health, and dental services.

Rationale: Emergency care is necessary to deal with sudden, serious health needs. Planning ahead for emergencies can help minimize negative outcomes.

Implementation:
All staff responsible for the supervision of youth will respond to health-related situations within a four-minute response time. Medical staff should be available to provide emergency medical care for youth 24 hours per day, 7 days per week. The on-site medical staff should jointly establish training that includes:

- Recognition of the signs and symptoms of a medical emergency;
- Action(s) required in potential emergency situations;
- Administration of first aid and CPR;
- Methods of obtaining assistance;
- Signs and symptoms of mental illness, retardation and chemical dependency; and
- Procedures for the transfer of youth to medical facilities or health care providers

In the event of a medical emergency, any staff who discover a youth appearing to be unconscious or in medical distress should immediately provide assistance, first aid, CPR, or take other measures

[76] NCCHC, *supra* note 3, at 97.

appropriate to the observed emergency. Health care staff should be immediately notified of any youth who appears to be unconscious or in medical distress. Health care staff should immediately respond to the scene with the medical emergency response bag, emergency medication box, pulse oximeter and oxygen. Necessary medical care should be provided, to include immediate movement to a hospital. When necessary, emergency medical services (911) may be initiated. As time permits, the on-call physician should be contacted. Emergency care should never be delayed in life-threatening situations.

Standard 32: Annual Exams

All youth remaining at a secure facility over one year should receive an annual physical examination that complies with Standards 3-29.

Rationale: Annual exams are necessary to address emerging and ongoing health needs.

Implementation: Annual exams should comply with the requirements set forth in Standards 3-29. Youth should be given at least 24 hours notice before their annual exam to allow them to prepare questions.

Standard 33: Access to Care

All youth should have prompt access to health care services set forth in Standards 3-29 upon request.

Rationale: Access to health care is necessary to address emerging health needs, including new symptoms or difficulty complying with treatment. Youth may also need counseling on health care needs in order to maintain their health and ensure they properly prevent or treat health care issues such as STIs, HIV, or pregnancy. Sexual abuse or harassment may also generate new physical and mental health concerns. Failure to promptly address these concerns may exacerbate health problems.

Implementation: Youth should be scheduled for requested services within 24 hours of a request, and requested services should be scheduled within two weeks of the request. All health care services should comply with the requirements set forth in Standards 3-29.

Standard 34: HIV Care

Care should be supervised by an HIV specialist who will recommend, initiate and change therapeutic regimens as medically indicated. Facilities should provide youth living with HIV access to a chronic disease program that includes a treatment plan that complies with Standard 18 and regular clinic visits in which the clinician monitors progress, consults with the youth, and, when appropriate, changes the treatment. The program must include patient education for symptom management.[77]

Rationale: Teaching proper management of HIV is essential for positive health outcomes. Youth with HIV benefit from regular clinic visits for evaluation and management by health care practitioners, preferably pediatric or adolescent medicine providers with HIV expertise. By reviewing the patient's history and progress over time, the clinician can optimize the treatment plan. Regular visits and a treatment plan also help ensure compliance by allowing the youth and health care

[77] *Id.* at 100-02.

provider to address obstacles to compliance such as medication side effects, or a youth's inability to take the medication in a private, confidential setting. Addressing these concerns is critical to ensuring that there is a treatment plan that addresses his or her individual needs and that this plan is being supported by other staff. Teaching youth how to cope with the disease and help prevent complications is also valuable for successful transition to community care.

Implementation: Once goals of therapy have been reached and the patient is stable, routine follow-up care for HIV should be arranged as follows:

HIV Care Quarterly Visit

- Lab – CD4, viral load, complete metabolic profile, and complete blood count if on antiretrovirals; more frequently if toxicity symptoms exist
- Review medication regimen – adherence, reasons for possible non-adherence, side effects
- Interval history – review of symptoms
- Exam – skin, mouth, lymph nodes, chest, abdomen, weight
- Physicians should be sensitive to problems that may interfere with a youth's ability to adhere to a prescribed treatment regimen, and should work with the youth to come up with solutions. If side effects make adherence difficult, a different treatment plan will be necessary. Physicians should also ask the youth whether he or she is given appropriate opportunities to take the medication in private and whether confidentiality is being respected—these issues may interfere with adherence.
- Issues and the importance of confidentiality and respect for patient wishes must be considered along with the legal requirements of the jurisdiction.

Annually

- Routine follow up care should be arranged for any person infected with HIV[78]
- Review medication regimen
- Interval history
- Complete physical exam
- Dilated retinal exam
- PAP smear every 6 months for youth with female genitalia
- Dental exam

Standard 35: Transgender Youth

The management of medical (e.g., medically necessary hormone treatment) and surgical (e.g., genital reconstruction) transgender issues should follow standards developed by the World Professional Association for Transgender Health, Inc.[79] Determination of treatment necessary for transgender patients should be on a case-by-case basis.

[78] AIDS Info, *Adult and Adolescent Guidelines* (2011), available at http://aidsinfo.nih.gov/Guidelines/GuidelineHTML.aspx?GuidelineID=7&docID=1 (last visited September 21, 2011); New York State Department of Health AIDS Institute , *HIV Clinical Resource: Ambulatory Care of HIV Infected Adults*, (2010), available at http://www.hivguidelines.org/clinical-guidelines/adolescents/ambulatory-care-of-hiv-infected-adolescents (last visited September 21, 2011)

[79] See World Professional Association for Transgender Health, *Standards of Care* (2001), available at http://www.wpath.org/publications_standards.cfm/ (last visited September 21, 2011).

Rationale: Transgender youth have continuous and emerging health care needs that must be addressed promptly and continuously to avoid physical and mental health complications (see Standard 27)

Implementation: Correctional health staff must be trained in transgender health care issues, and outside providers should be located for youth in foster care. Alternatively, they should have access to other professionals with expertise in transgender health care to help determine appropriate management and provide training in transgender issues. Diagnosed transgender patients who received hormone therapy prior to incarceration should have that therapy continued without interruption pending evaluation by a specialist, absent urgent medical reasons to the contrary. Transgender youth who have not received hormone therapy prior to incarceration should be evaluated by a health care provider qualified in the area of transgender health to determine their treatment needs. When determined to be medically necessary for a particular youth, hormone therapy should be initiated and sex reassignment surgery considered on a case-by-case basis. Regular laboratory monitoring should be conducted according to community medical standards.[80]

Standard 36: Sexual Assault

Any confined youth reported or believed to have been sexually assaulted shall be immediately referred to the on-site health care staff for initial screening. Appropriate first aid or emergency care shall be provided and the youth shall be sent to a hospital for further examination, treatment, and collection of forensic evidence.

Rationale: Studies have shown that sexual assault is a serious and common problem for youth in state custody. A recent U.S. Department of Justice study found that nearly one in eight of the youth who participated in the survey reported sexual abuse at their current facility during the previous year.[81] LGBTQ youth reported being sexually abused by another inmate at a rate more than ten times higher than that of youth who identified as heterosexual. Victimized youth usually endure repeated sexual abuse and frequently by multiple perpetrators. Sexual assault, besides being criminal and a violation of youth rights, creates enormous health concerns for youth, including trauma and injury, STIs, HIV, pregnancy, and mental health issues such as Post Traumatic Stress Disorder.

Implementation: Victims of sexual assault must be either referred to a community facility for treatment and the gathering of evidence or be treated in-house. If the youth is in foster care, he or she must be taken to an emergency medical facility immediately, with preference given to a doctor or medical professional with whom the youth feels comfortable. A qualified health care professional must conduct an examination and medical and sexual health history to document the extent of physical injury and determine whether referral to another medical facility is indicated. *With the victim's consent*, the examination must include the collection of evidence from the victim using a kit approved by the local legal authority. Prophylactic treatment, including emergency contraception and follow-up care for STIs, HIV, or other communicable diseases must be offered to all victims in accordance with Standards 5, 12-20, and 22-25. Following the physical examination,

[80]Endochrine Society, *supra* Note 70; See generally Nat'l Comm'n on Corr. *Health Care, Position Statement: Transgender Health Care in Correction Settings* (2009), available at http://www.ncchc.org/resources/statements/transgender.html (last visited September 21, 2011).
[81]Bureau of Justice Statistics, *supra* Note 62.

there must be an evaluation by a qualified mental health professional for crisis intervention and long-term follow up. In the case of confined youth, a report must be made to the correctional authorities to effect a separation of the victim from his or her assailant in their housing assignment. In the case of youth in foster care, their living situation must be assessed for safety and post-trauma support. There must be an assessment of the victim for potential suicide and/or anxiety disorders or other mental health problems, and a treatment plan for counseling should be created and enacted. Reports as required by law must be filed with the appropriate law enforcement, child protective, and other agencies. Medical evidence may be collected from the victim only with the victim's consent.

A follow-up appointment will be made within three days for the youth with a physician or mid-level provider. At the follow-up appointment, the youth's physical and emotional status will be assessed. The provider will review the records from the outside medical facility to determine if all medical aspects of the evaluation were completed.

Standard 37: Mental Health Care

On-going mental health care services must be available to all youth who require and/or request them.

Rationale: Mental health care is necessary to ensure that youth with mental health problems are able to maintain their best level of health. Youth in state custody are at higher risk for mental health problems. Appropriate treatment is necessary to fulfill the obligation of protecting youth health and safety, as well as rehabilitating youth.

Implementation: Facility behavioral health staff have primary responsibility for the development of behavioral health treatment plans for youth with ongoing mental health treatment needs. Youth on psychotropic medications will be scheduled for monthly mental health chronic care visits completed by a clinician of at least the level of a Registered Nurse. The psychiatrist will evaluate the youth according to the Standards. For youth in foster care, a plan for mental health care and regular treatment should be devised and implemented by the youth, their mental health professionals, advocates, and care providers.

DISCHARGE PLANNING

Standard 38: Discharge Planning[82]

Discharge planning that appropriately meets the health needs of youth must be provided for youth who will be leaving the facility imminently.

Rationale: Discharge planning is necessary to ensure that youth's health needs are met during the transition to a community provider. Health care staff have a responsibility to ensure ongoing patient care with community providers. Without appropriate discharge planning, youth may be unable to access or maintain appropriate treatment or prevention services. Failure to provide appropriate discharge planning not only compromises the health of the youth, but also the health of the communities which they eventually join. Programs in which health staff contact youth to help them prepare for release are effective in both providing necessary health services and in contributing to medication adherence. Studies indicate that establishing therapeutic relationships with community health staff prior to release and making preparations for return to the community that focus on transition issues also contribute to decreased recidivism.

Implementation: Discharge planning begins on admission and continues throughout the youth's stay. Use of a standardized form facilitates comprehensive discharge planning. Health staff should work closely with any child welfare worker, probation, and parole staff, all while ensuring the youth's confidentiality rights are protected. Only with the youth's permission (or with that of the legal guardian where required) may health staff share necessary information and arrange for transfer of health summaries and relevant parts of health records to community providers or others assisting in planning or providing services upon release. Health staff must coordinate plans with the youth's legal guardian as appropriate, while ensuring that the youth's confidentiality rights are protected. Health staff must arrange for a sufficient supply of current medications to last until the youth can be seen by a community health care provider and arrangements or referrals must be made for follow-up services with community providers. The discharge planning should be explained to the youth, who should also be provided with a written explanation in addition to the names and contact information for community health care providers and sexual health care resources that can provide diagnoses, treatment, and counseling for sexual health care needs.

[82] NCCHC, *supra* note 3, at 83-84.

COMMUNICATION WITH PATIENTS

Standard 39: Age, Culturally, and Developmentally Appropriate Services

Preventive services and counseling provided should be age and developmentally appropriate.[83] Providers should be sensitive to individual and socio-cultural differences, exercising cultural competency in addition to cultural humility.[84] "Cultural competency" refers to a set of congruent values, behaviors, attitudes, and practices that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.[85] Building on cultural competency, "cultural humility" puts the onus on the provider to self-evaluate how personal biases may affect service delivery.[86]

Rationale: The concept of cultural competency brings culture into the discussion of the manifestation of disease and notions of health. It encourages providers to learn about the cultures of patients served and fosters respect for cultural differences and diversity. It underscores that culture is dynamic and includes a wide array of identities and backgrounds. It also honors the fact that young adults have a culture unto themselves—recognition of this increases knowledge of how culture influences behaviors and health outcomes and can help providers understand and communicate with adolescent patients. Cultural humility encourages providers to assess how their own bias may manifest in clinical care.[87]

Implementation: To incorporate cultural competence in clinical practice, clinicians can use the "LEARN" model:

- Listen with understanding to the patient's perception of the problem
- Explain your perceptions of the problem and your strategy for treatment
- Acknowledge and discuss the similarities and differences in these perceptions
- Recommend treatment while remembering the patient's cultural parameters
- Negotiate agreement, ensuring medical treatment fits into the patient's cultural framework[88]

To incorporate cultural humility, providers should ask themselves:

- How do you react when confronted with a patient situation that does not fit your expectations?
- Does the situation provoke feelings of anxiety and discomfort?
- Are you able to assess what is going on within yourself as well as within the patient?[89]

Where providers are working in juvenile justice facilities, they should ask these additional questions:

- Am I able to put aside whatever feelings I may have on what this young person may have done to become a juvenile offender?

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[83] GAPS, *supra* note 6, at 3 (Recommendation 2).
[84] *Id.*; See Physicians for Reproductive Choice & Health, *Cultural Competency and Adolescents* (2009), available at http://www.prch.org/arshepdownloads (last visited September 21, 2011) [hereinafter PRCH-CULTURAL COMPETENCY].
[85] *Id.* at 25.
[86] *Id.* at 29.
[87] *Id.* at 29-32.
[88] *Id.*. at 26.
[89] *Id.* at 32.

- Am I able to see this individual as a patient first and foremost?

Standard 40: Effective Youth Communication

Providers should be experienced in treating youth and should be aware of the communication skills that can facilitate or hinder an interview with a youth.[90]

Rationale: The vast majority of youth want information from their healthcare providers regarding pregnancy and STI prevention. However, very few providers actually ask their patients about sexual activity, and even fewer take a full history due to lack of training or personal discomfort.[91] Youth must feel comfortable before disclosing and discussing health behaviors with their providers.

Implementation: Providers should use the following tools for effective communication:

- Use a non-judgmental, non-moralist approach to questioning
- Provide explanations as to why personal questions are being asked
- Use verbal cues and language a youth will understand
  - Use non verbal cues, such as tone, proximity, and gestures, to communicate effectively
  - Use active listening and responding, convey understanding and empathy, elicit and validate emotions
  - Use open-ended questions and allow time for a response
  - Use gender-neutral language when discussing sexuality and relationship issues
  - Discuss privacy policies before asking sensitive questions
  - Disclose reporting requirements to youth early

Providers should avoid the following communication mistakes:

- Making judgmental statements (e.g., "You should...")
- Using medical jargon
- Asking sensitive questions with others in the room
- Ignoring emotions
- Making or breaking eye contact not consistent with the patient's culture
- Using culturally inappropriate language
- Using gender stereotypes
- Using gendered pronouns

Standard 41: LGBTQ-Inclusive Interviewing

Each client, irrespective of sexual identity or behavior, should be informed of the full spectrum of behavior and desire. Staff should focus on normalizing the spectrum, including same-sex, opposite-sex, and solitary-sex behavior and desires.[92] Providers should avoid making assumptions about the gender of a youth's partners, should use inclusive language in interviews, and should ensure that

[90] *Id.*. at 25.
[91] See, e.g., Region II MAC, *supra* note 6, at 9.
[92] *Id.* at 25.

interviews are inclusive of LGBTQ issues.[93] Providers should not minimize or deny an adolescent's sexual orientation or gender identity as merely a "phase" through which the youth will pass .[94]

Rationale: Many health care providers, for reasons ranging from lack of training to unaddressed bias and assumptions, too often fail to provide sensitive medical care to LGBTQ youth. LGBTQ youth therefore may tend to decline to disclose their sexual orientation or gender identity out of fear of discrimination.[95] As a result, the health needs of this population often remain unmet. HIV risk-assessments may be incorrect where young men who have sex with men or young women who have sex only with women decline to disclose this information for fear of judgment. Providers may screen youth for STIs incorrectly based on the assumption that youth engage only in heterosexual activity. Providers may also make assumptions that LGBTQ youth engage only in same-sex behavior when this may not be the case (see Standard 42).

Moreover, youth who have questions about how to practice safe sex with same-sex partners may not feel comfortable asking for this information. This is particularly troubling, given that young men who have sex with men have high rates of HIV infection due to high-risk sexual behavior. Further, failure to provide a supportive, nonjudgmental environment can prevent teens from disclosing problems of isolation, anxiety, and depression. Negative social and emotional factors are often associated with being gay. As aforementioned, many LGBTQ youth experience feelings of severe isolation, and LGBTQ youth are two to three times more likely to attempt suicide than their heterosexual peers. Failure to create a supportive environment in medical care can increase isolation and have real health consequences for LGBTQ youth.

Implementation: During examination and interviews, providers should use inclusive language and avoid assumptions about an adolescent's sexual behavior or orientation. For example, providers should use gender-neutral pronouns when asking adolescents about their sexual partners or romantic interests.[96] When discussing sexual activity and health risks, providers should relate them to sexual behavior rather than sexual orientation. For example, rather than ask if a patient is gay, straight, or lesbian, providers should ask the following questions: Have you ever had a sexual relationship with a boy? What about with a girl?

Providers should also be sensitive to gender identity, asking whether patients think of themselves as male, female, both, or another gender. Providers should determine what pronoun patients use to describe themselves.[97]

Standard 42: Sexual Behavior and Identity

Providers should understand that sexual orientation does not necessarily match sexual behavior; adolescents who identify as "straight" may experiment with same-sex partners, and those who identify as "gay" or "lesbian" may have had sexual intercourse with members of the opposite sex, and may continue to do so in the future.

[93] Wilber, *supra* note 60, at 6.
[94] *Id.*
[95] *Id.*
[96] Wilber, *supra* note 60, at 6.
[97] PRCH-LGBTQ, *supra* note 59, at 17.

Rationale: Providers who speak in terms of identity rather than behavior may make unwarranted assumptions about a youth's sexual activity, and therefore may miss opportunities to address health concerns.

Implementation: Providers should discuss sexual behavior rather than identity. Providers should discuss pregnancy prevention and the availability of emergency contraception to all youth, explaining their reasoning for doing so.

CONFIDENTIALITY AND REPORTING

Standard 43: Reporting and Protecting Confidentiality

In conducting all of the above standards, health providers should be aware of local laws about the reporting of abuse to appropriate state officials, in addition to ethical and legal issues regarding how to protect the confidentiality of the minor patient.[98]

Rationale: Patient confidentiality—of both written health records and verbally disclosed information—must be maintained in order to comply with legal and ethical obligations.

Implementation: Health records must be stored under secure conditions separate from custody records. Access to health records and health information must be controlled by the health authority. If records are transported by non-health staff, they must be sealed. Maintaining confidentiality of health records and information must be included in the orientation program for health staff and must be reviewed periodically.

Health services staff are to be reminded not to discuss patient health information in front of other staff or other youth, including those working in or near the health services area. Non-health staff who observe or overhear a clinical encounter must be instructed that they are required to maintain confidentiality. The facility should have documentation that staff with access to health records have been instructed in the need for confidentiality, including written policies and procedures, memoranda to staff, minutes of meetings, and reviews during roll call or in-services.

The health authority must maintain a current file on the rules and regulations covering the confidentiality of medical information and the types of information that may and may not be shared under local, state, and federal law. Local, state, or federal laws may allow certain exceptions to the confidentiality requirements, and health services staff are required to inform youth at the beginning of a health care encounter when these exceptions apply.

[98] GAPS, *supra* note 6, at 6 (Recommendation 21); NCCHC, *supra* note 3, at 15-16.

INFORMED CONSENT AND THE RIGHT TO REFUSE TREATMENT

Standard 44: Informed Consent

All health examinations, treatments, and procedures must be governed by the principle of informed consent and must comply with legal requirements for informed consent in the applicable jurisdiction.[99]

Rationale: Youth have the right to make informed decisions regarding their health care. Obtaining informed consent is both a legal and ethical obligation of health care providers.

Implementation: Informed consent laws regarding youth consent and confidentiality vary from state to state and as such practitioners should be versed in the laws in their jurisdiction. Generally, informed consent is the agreement by which a patient agrees to a treatment, examination, or procedure after he or she receives the material facts about the nature, consequences, and risks of the proposed treatment, examination or procedure, the alternatives to it, and the prognosis if the proposed intervention is not undertaken.[100] Clinicians should educate young people about informed consent. Practitioners should also clearly document all decisions related to consent to treatment or testing.

The youth, parent, or legal guardian should have the opportunity to ask questions and receive answers to those questions before giving consent. Policies and procedures should specify informed consent requirements, including circumstances where written informed consent is required. The informed consent of next of kin, guardian, or legal custodian applies when required by law. Practitioners should also clearly document all discussions regarding consent and related medical options.

For invasive procedures or any treatment where there is some risk to the youth, informed consent must be documented in a written form containing the signatures of the patient, legal guardian if required, and health services staff witness. Even where a youth has given "blanket" consent for treatment, written consents are still required for invasive procedures, diagnostic tests, dental extractions, and for HIV testing in accordance with Standard 16.

Staff must be trained to understand and comply with informed consent requirements, and to understand the limited number of exceptions to the requirements (such as life-threatening conditions that require immediate medical intervention for the safety of the patient and emergency care of patients who do not have the capacity to understand the information given), and how to distinguish these exceptions from other medical care.

Standard 45: Right to Refuse Treatment

A youth may refuse specific health evaluations and treatments in accordance with the laws of the jurisdiction.[101]

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[99] NCCHC, *supra* note 3, at 136-38.
[100] American Medical Association, *Informed Consent* (n.d.), available at http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.page (last visited September 21, 2011).
[101] *Id.* at 138-39.

Rationale: The logical corollary to the right to informed consent set forth in Standard 44 is the right to refuse treatment. Health care providers have the legal and ethical obligation to respect and protect patients' right to refuse treatment.

Implementation: A patient's refusal of care must be an informed decision, with the consequences explained to the youth. Refusal of treatment at any time does not waive the youth's right to subsequent health care. Youth may not be punished for exercising the right to refuse treatment, even when the treatment at issue is a public health matter. In situations where the refusal may seriously jeopardize the patient's health, the individual should be brought to the medical clinic and the risks and benefits of the proposed treatment explained. The health professional can then answer any questions the patient may have. If the patient wishes to decline treatment, he or she should be counseled about the possible consequences of the refusal. Notification of the patient's legal guardian is not required unless the refusal poses a substantial risk to the youth or the youth has a court-appointed guardian where notification is required. Some refusals may result from system disincentives (e.g. holding sick call at a time that conflicts with other important programming) and must be addressed by providing alternatives so that the disincentives are lessened or eliminated.