



National Institute of Justice

Research in Brief

Jeremy Travis, Director

April 1996

Issues and Findings

Discussed in this Brief: The findings of a 1994 survey by the National Institute of Justice (NIJ) and Centers for Disease Control and Prevention (CDC) of policies, programs, and data regarding HIV/AIDS and sexually transmitted diseases (STDs) in State and local juvenile justice detention centers and training schools.

Key issues: Although much research has been conducted among incarcerated adults on HIV/AIDS and sexually transmitted diseases, little has been done among confined juveniles. NIJ and CDC sponsored this survey of State and city/county juvenile justice systems to gather information about their HIV and STD education and prevention measures. Although youths have basic knowledge about how HIV and STDs are transmitted, confined juveniles often lack a sense of personal risk and its consequences when engaging in high-risk behavior.

Key findings: Although only about 1 percent of individuals diagnosed with AIDS between 1993 and 1994 were between 13 and 19 years old, many youths engage in high-risk behavior that puts them in danger of contracting HIV and STDs. Among the survey's findings:

- Many detention centers and training schools offer instructor-led

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HIV/AIDS and STDs in Juvenile Facilities

By Rebecca Widom and Theodore M. Hammett

Sexually transmitted diseases (STDs), including HIV/AIDS, pose serious challenges to administrators of both adult and juvenile justice systems. Although extensive literature exists on HIV/AIDS and sexually transmitted diseases among incarcerated adults,¹ little research has focused on HIV and STDs among confined juveniles. High rates of HIV risk behaviors have been documented among high school students and adolescents not in school.² Juveniles in confinement are likely to be disproportionately at risk for HIV, STDs, and other health problems linked to substance abuse, unprotected sexual contact, and poor access to preventive and primary health care. Although most training schools and juvenile detention centers currently report few confined juveniles with HIV or AIDS, HIV infection may be spreading among this population. Further, significant rates of STD infection and unplanned pregnancy among confined youths are cause for concern in and of themselves and as indicators of the prevalence of HIV-risk activities.

Thus, even though most terms of juvenile confinement are short, juvenile justice systems have an opportunity to help improve the health of an underserved and vulnerable segment of society. Moreover, intervention during confinement can benefit those whom juveniles will encounter once they are released.

The 1994 National Institute of Justice (NIJ) and Centers for Disease Control and Prevention (CDC) survey asked State and city/county juvenile justice systems to report on their policies, programs, and data regarding HIV/AIDS and sexually transmitted diseases. In order to gauge the accuracy of central office reports, samples of training schools in selected State systems also completed an abbreviated questionnaire that focused on policies regarding HIV/AIDS and STDs.

Forty-one State juvenile justice systems, 32 city or county detention centers, and 27 State training schools responded to the questionnaire. Responses to the NIJ/CDC survey do not constitute a random sample of juvenile justice systems or facilities. However, the data are extensive enough to support some preliminary findings. This Research in Brief outlines current knowledge regarding HIV and STD risk behaviors among youths, epidemiological data on HIV/AIDS and STDs from the NIJ/CDC survey and other sources, and NIJ/CDC survey findings on education, preventive measures, and testing policies.

Epidemiological data

Patterns of HIV/AIDS among adolescents in the United States. Relatively few adolescents have been diagnosed with AIDS in the United States; however, a

Issues and Findings

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education about HIV. Out of the total respondents to the survey, 53 systems provided complete data. Of these, approximately three-quarters offered HIV prevention counseling in juvenile facilities.

- Although some juvenile justice systems have comprehensive HIV education and prevention programs, many do not provide extensive information because of societal pressure and juvenile justice agency regulations against delivering explicit messages and distributing materials such as condoms.

- State systems, more than county and city systems, include such topics as safer sex practices, negotiating skills, self-perception of risk, the meaning of HIV/STD tests, and proper condom use in their education programs.

- Only 2 of the 73 systems that responded to the survey conduct mandatory HIV screening of all incoming juveniles (11 more systems screen pregnant girls). Most systems provide HIV, STD, and pregnancy testing on a voluntary basis and/or when juveniles exhibit clinical indications of disease or pregnancy.

- If voluntary testing is to be successful, it must be easily accessible and include provision of confidential services, extensive education, and quality medical care.

Target audience: Juvenile justice system administrators, State commissioners of corrections, State and local policymakers, health professionals, and researchers.

larger minority of people with AIDS have been diagnosed in their early twenties. Because an individual can be infected with HIV for 3 to 5 years or more before showing symptoms, many of those diagnosed with AIDS in their early twenties were probably infected with HIV as teenagers.³ Adolescent girls are more at risk for HIV infection than women in other age groups, and adolescents of color comprise a majority of adolescents with AIDS (see exhibit 1). Eighty percent of female adolescents with AIDS are African American and/or Hispanic.

Among the 239 males 13 to 19 years old in the United States diagnosed with AIDS in 1994, 26 percent were infected through sex with other males, 5 percent through injection drug use (IDU), 3 percent through sex with other males and injection drug use, and 5 percent through heterosexual contact.⁴ Among the 1,857 males 20 to 24 years old diagnosed with AIDS in the United States in 1994, approximately 80 percent were infected through sex with other men and/or injection drug use.⁵ Since more than half the adolescents diagnosed with AIDS in the United States were diagnosed in 1993 or 1994⁶ and in light of

documented risk activities among adolescents, an increase in the number of adolescents with HIV/AIDS is expected.

AIDS cases among confined juveniles. Respondents to the NIJ/CDC survey reported a cumulative total of 60 juveniles with AIDS (50 boys and 10 girls, 54 in State systems and 6 in city/county systems out of a total of 73 systems responding). Cumulative totals included cases among confined juveniles, those who had been released, and those who had died while confined. Only four currently confined juveniles with AIDS were reported: Three State systems and one city/county detention center each reported having one boy with AIDS. Four juveniles (three boys and one girl, two in State systems and two in city/county systems) had died from AIDS while confined.

Seven percent of the respondents did not know either how many juveniles with AIDS were currently in their systems, had died while confined, or had been released with AIDS. Maintaining records of the number of juveniles with AIDS released from juvenile systems appeared to be particularly difficult. Further, respondents reported almost no information on racial breakdowns among confined juveniles

Exhibit 1: AIDS Cases in the U.S., 1993 and 1994

	Ages 13–19	Ages 20–24	Total in U.S.
1993	586 (1%)	3,910 (4%)	103,228
1994	417 (1%)	2,684 (3%)	78,126
Percentage of adolescents with AIDS by race/ethnic background			
Caucasian	37%		
African American	42%		
Hispanic	19%		
Native American or Asian/Pacific Islander	2%		
People with AIDS by age and sex			
All Age Groups	14% female/86% male		
Adolescents	34% female/66% male		

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report: U.S. HIV and AIDS Cases Reported Through December 1994*, Year End Edition 6(2).

with AIDS. Of those systems that had detained youths with AIDS, approximately half of the cases were reported as race unknown.

HIV seropositivity⁷ among confined adolescents. Currently, HIV seropositivity among confined juveniles appears to be infrequent. Blinded studies of confined juveniles in Colorado, Texas, and San Bernardino County, California, found no HIV positive juveniles in their samples.⁸ Studies in Alabama and Illinois found HIV seropositivity rates of 0.7 percent and 0.1 percent, respectively. Screening of all incoming juveniles in New Mexico found no HIV positive adolescents among 1,053 boys and 260 girls tested. Similarly, screening of all incoming juveniles from September 1992 through October 1994 in Mississippi revealed only one girl to be HIV positive. All responses from other jurisdictions indicated that HIV testing for other purposes, including testing juveniles upon request and testing pregnant girls, resulted in less than 1 percent seropositivity among confined juveniles.

Risk behaviors among adolescents

Although relatively few adolescents with HIV have been identified, it appears that many adolescents have engaged in risky behavior. Most research on risk behavior among adolescents has focused on those in school, somewhat less has dealt with youths not in school, and very little has considered confined juveniles.

Studies to date on risky behavior among adolescents have produced somewhat disparate results, but they generally support the conclusion that sexual activity among adolescents has increased over time.

One study found relatively stable levels of sexual activity and drug use among adolescents between 1990 and 1993.⁹ Other research documented increases in sexual activity, rates of STDs, and unintended pregnancy among high school students since the 1970's and an increase in HIV infection among high school students since the 1980's.¹⁰ Survey data from a sample of 12,272 representative high school students across the United States led to the following estimates:

- Sixty-nine percent of high school students had sexual intercourse during the 3 months preceding the survey.
- Nineteen percent had sexual intercourse with four or more partners during their lifetimes.
- Of those currently sexually active, 46 percent used a condom during their previous sexual encounter.
- Two percent had used injection drugs.¹¹

Adolescents not in school, including confined juveniles, appear to be at even more serious risk. According to the CDC, “[o]ut-of-school adolescents aged 14 to 19 years were significantly more likely than inschool adolescents to report ever having had sexual intercourse (70.1 percent versus 45.4 percent) and to have had four or more sexual partners (36.4 percent versus 14.0 percent).”¹² Confined juveniles represent what may be a particularly at-risk subpopulation of adolescents not in school because of the overrepresentation among them of youths with histories of high-risk behavior and poor access to health care and prevention services.

STD and pregnancy testing results. According to recent research, some of

the highest rates of gonorrhea during the 1980's were found among adolescents 15 to 19 years old, and rates increased or remained the same among adolescents throughout the 1980's even while decreasing for other groups. Further, confined youths tended to have higher rates of STDs than adolescents in the community, indicating significant risk for HIV among confined youths.¹³

Slightly over half of the jurisdictions responding to the NIJ/CDC survey provided data on results from testing done on a routine or voluntary basis or when clinically indicated. Most systems reported testing juveniles who requested it or who exhibited symptoms. In contrast to rates of HIV infection under 1 percent, the mean reported rates were 2 percent (median 7 percent, standard deviation 5 percent) for syphilis and 14 percent (median 5 percent, standard deviation 22 percent) for gonorrhea.¹⁴ These estimates do not accurately indicate seroprevalence for gonorrhea or syphilis because some jurisdictions tested only adolescents who were most likely to have been exposed. However, because most systems reporting results tested a total of 400 to 500 juveniles, this indicates that a large number of confined juveniles have syphilis or gonorrhea.

Similarly, some juvenile systems tested confined girls who requested pregnancy tests or demonstrated clinical indications of pregnancy, while others reported conducting routine pregnancy testing. Among the systems that provided routine pregnancy testing, the mean pregnancy rate was 14 percent (total tested: 2,230). Among systems that provided pregnancy tests on request of the juvenile or upon clinical indications, the mean pregnancy rate was 19 percent (total tested: 1,091).

HIV and STD education and preventive measures

Information alone is not sufficient to induce or sustain changes in the often ingrained or addictive behaviors that place adolescents (and others) at risk for HIV infection. Effective HIV prevention requires addressing the complex circumstances in which high-risk behaviors occur and persist. Leading researchers have proposed a two-level prevention program comprising universal and targeted elements. The universal components include:

- Basic information on HIV/AIDS and risk-reduction methods.
- Efforts to reduce discrimination against people living with HIV.
- Removal of restrictions on access to condoms, sterile needles, and other materials needed to implement guidelines for safer behavior.

In addition, communities with a high prevalence or risk of HIV should receive intensive interventions addressing the “physiologic, emotional, interpersonal, and cultural contexts”

of behavior and emphasizing face-to-face communication, changes in social norms regarding sex and drug use, and distribution of materials necessary for safer behavior.¹⁵

Because of high rates of HIV risk behaviors among confined adolescents, juvenile facilities may be prime settings for intensive HIV/STD education. Further, since virtually all confined juveniles are eventually discharged, behavioral interventions could benefit not only the youths themselves but persons they encounter once released.

Prevention knowledge among adolescents. Research on adolescents’ knowledge of HIV and STD transmission has produced somewhat mixed results. One study found similar and impressive levels of knowledge about HIV transmission among confined youths and adolescents in school but also found differences in the particular knowledge between the two groups and in their motivation to act on what they knew. Although both confined and inschool youths recognized that sexual intercourse could

lead to HIV transmission, confined adolescents were not as motivated to change their behavior, and youths in school were more likely to identify condom use as a way to prevent transmission.¹⁶

Another study found significant differences in perceived risk and personal consequences between confined and nonconfined adolescents. Because confined youths are more likely than other adolescents to have lived in poverty, they may simply need better access to health services to obtain basic information.¹⁷ However, their lack of a sense of personal risk and responsibility is of equal concern.

Types of HIV education and prevention programs

Most systems responding to the NIJ/CDC survey reported providing instructor-led education, audiovisual materials, and written materials, but only a few offer peer education programs (see exhibit 2). Rates of agreement between systems and their facilities were generally quite high (see exhibit 3).

Instructor-led programs. In many juvenile training schools, HIV/STD education is offered as part of the health component of the regular education curriculum. However, the turnover in the population may mean that many youths are not exposed to the portion of the curriculum dealing with HIV and STDs.

A particularly well-conceived HIV/STD education program is offered by the Massachusetts Department of Youth Services (MDYS).¹⁸ Two full-time educators, funded through CDC’s HIV prevention cooperative agreement with the State’s Department of Public

Exhibit 2: HIV/AIDS Education and Prevention for Confined Juveniles

Testing Policies	State Juvenile Justice Systems (N=41)		City/County Detention Centers (N=32)	
	Number of Systems	Percent	Number of Systems	Percent
Instructor-Led Education ^{a, b}	38	93	27	84
Peer Education Programs ^b	10	24	5	16
Audiovisuals ^b	35	85	25	78
Written Materials ^b	37	90	25	78

^a Instructor-led education involves the participation of a trained leader in some substantial part of a session.

^b Programs provided in at least one facility in the system.

Source: NIJ/CDC questionnaire responses.

Exhibit 3: HIV/AIDS Education and Prevention for Confined Juveniles: Results of the Validation Study (VS)

	Systems in VS with This Policy (N=18)	Facilities in VS (N=27)	Percent in Agreement
Instructor-Led	4	6	100
Mandatory for All Incoming Juveniles	11	15	73
Mandatory for All Releasees	6	6	67
Peer-Led	0 ^a	n/a	n/a
Prevention Counseling	3	5 ^b	100
Audiovisual Materials	4	6	100
Written Materials	4	6 ^c	100

^a Although no systems in the validation study reported peer education in all facilities, three systems reported having peer education programs in some of their facilities.

^b In systems reporting that some facilities provide prevention counseling, only one facility reported not providing prevention counseling.

^c In systems reporting some or all facilities provide written materials, all facilities reported providing written materials.

Source: NIJ/CDC questionnaire responses.

Health, cover HIV and STD issues in the context of a comprehensive sexuality education program.

As part of the site visits conducted for this study, sessions conducted by one of the MDYS educators were observed at three Massachusetts juvenile facilities: a long-term care facility and a shelter care facility for boys, and a short-term detention center for girls.

The MDYS educator was both respectful and sensitive to the youths’ diverse learning levels, emotional states, and cultural backgrounds. Rather than lecturing, she used an innovative, interactive style that was youth-centered. The educator spent significant time bonding with her students and listening to their concerns. She appeared to develop trusting relationships with the youths, even during one-time sessions in detention facilities.

In longer term facilities, the educator offered a series of four 1½-hour sessions.

During the first session, the youths selected issues they wanted to address. This approach, while taking into account the juveniles’ feelings and concerns, was also flexible enough for the educator to cover important points she had prepared. She also created exercises and materials addressing the topics selected by the adolescents. In an environment with little opportunity for choice, this educator has found an important way to win the youths’ support for the program by offering them the chance to voice their preferences.

Another important feature of the MDYS four-session series was a visit from an HIV-positive guest who, rather than simply relating his/her story and drawing appropriate lessons about risk behavior, was interviewed by the juveniles. The youths “owned” the session and could ask any questions they wished as long as they were respectful of the guest. In the observed session, the youths asked many candid and important questions, and the guest responded with

valuable information they could apply to their own lives. The MDYS educator noted that the interview session did not work well unless the youths were given a previous session on interviewing skills and an opportunity to consider and discuss questions they might ask of the guest.

Finally, the Massachusetts program places a heavy emphasis on educating staff. In addition to building support for the program, education in HIV and sexuality issues better equips staff to provide information and followup in the facility during the majority of hours when the HIV educator is not present.

Peer-led programs. Several juvenile systems have implemented HIV peer education programs. In New Mexico, HIV prevention education is part of a peer drug and alcohol prevention education program, started 7 years ago as part of the Drug-Free Schools Program.¹⁹ Approximately 20 confined juveniles act as peer educators each year. In one session in this series, confined juveniles learn how HIV is transmitted and how to practice safer sex, discuss their fears of HIV, and receive referrals for HIV testing.²⁰

In Los Angeles County, the Peer HIV Education Research Project (PHERP) was designed to compare the effectiveness of peer and adult educators.²¹ Peer educators team-teach classes with adult teachers and cover prevention and transmission of HIV, including safer sex and injection practices, alcohol and drug abuse, STD symptoms and treatment, and negotiation skills regarding condom use. Students participate in role-playing exercises and listen to a guest speaker discuss what it is like to be HIV positive. At the beginning and end of the program,

participants are surveyed on their HIV knowledge.

Three peer educators were trained and team-taught HIV prevention classes, and the project coordinator was able to report some preliminary evaluation results. Her initial assumption was that peer educators would be much more effective than adult educators, but initial evaluation results suggest that each type of educator has different strengths. Although differences were quite small, peer-led groups showed more positive changes in attitude and behavior, while adult-led groups demonstrated higher levels of HIV-related knowledge.²²

Written materials. In order to implement effective HIV prevention education, a system must provide appropriate materials that confined youths are able to read and understand. Participating systems reported using HIV education materials with an average of a sixth-grade reading level. Four jurisdictions reported using materials with reading levels of tenth to twelfth grades, and one reported using materials with a third-grade reading level.

Since people of color are overrepresented in confined populations and among adolescents with AIDS, culturally specific HIV prevention materials should be available to meet their needs. Similarly, confined juveniles whose first language is not English should have access to HIV prevention materials in their primary language. Materials specifically addressing issues facing girls also should be available. Juvenile justice systems have had mixed success in this regard (see exhibit 4).

Topics covered in HIV and STD education. To date, most HIV prevention programs in juvenile facilities

Exhibit 4: Systems Providing Multicultural HIV Prevention Materials

	State Juvenile Justice Systems (N=40) ^a		City/County Detention Centers (N=31) ^a	
	Number of Systems	Percent	Number of Systems	Percent
African American	19	48	12	39
Latino	22	55	14	45
Asian/Pacific Islander	7	18	4	13
Girls	28	70	19	61
Available in Spanish	12	30	8	26

^a One State system and one city/county detention center did not answer this question. Percentages are based on the number of respondents who answered the question.

Source: NIJ/CDC questionnaire responses.

have emphasized provision of information. Practical risk-reduction techniques have been insufficiently addressed in juvenile and adult systems' HIV education programs, often because authorities have been reluctant to teach about proscribed behaviors such as sex and drug use and to provide the means to render such activities safer. (Similar concerns have also limited HIV prevention programs for nonconfined adolescents.) Providing effective HIV prevention programs to confined juveniles is made difficult by a central tension: The best programs are explicit about precautionary and preventive measures, yet public opinion and the regulations of juvenile justice agencies often prohibit such explicit messages. Additionally, most systems forbid distribution of materials, such as condoms and bleach, needed to put HIV prevention messages into practice.

Discussing sex with youths is always complicated and controversial, which is why the CDC has encouraged input from parents and communities in developing HIV prevention curriculums for public schools.²³ Obtaining meaningful input from the parents of confined juveniles

into education for these youths may be more difficult. However, because HIV prevention depends on individual behavior, frank and honest discussion of how HIV is transmitted is essential.

Although some juvenile justice systems have implemented comprehensive HIV education and prevention programs, many systems have only minimal programs. Some justify this lack of programs by citing the very low HIV seropositivity among confined youths, but this disregards evidence of substantial levels of high-risk behaviors and STD infection in these populations.

All but one responding State system and most city/county systems reported covering basic HIV and STD information in their education programs. Many more State systems than city/county systems reported covering such topics as safer sex, the meaning of tests for HIV or STDs, negotiating skills, condom use, and self-perception of risk (see exhibit 5). The fact that juveniles remain in city/county detention centers for much less time than in State training schools may explain some of this discrepancy. In light of the research cited above, however, topics

Exhibit 5: Topics Covered in HIV and STD Education

	State Juvenile Justice Systems (N=41) ^a		City/County Detention Centers (N=32) ^a	
	Number of Systems	Percent	Number of Systems	Percent
Basic Information	40	98	23	74
Meaning of HIV Test	37	90	19	63
Meaning of STD Tests	39	95	24	80
Safer Sex Practices	40	98	24	77
Negotiating Skills	33	83	16	52
Condom Use	37	90	22	73
Tattoo Risk	39	98	16	52
Alcohol/Drug Issues	40	98	22	73
Self-Perception of Risk	36	88	18	60
Barriers to Change	35	90	16	52
Referrals	35	88	19	66

^a Some respondents did not answer the questions pertinent to the items listed in the table. The percentages given are based on the number of respondents who answered each question.

Source: NIJ/CDC questionnaire responses.

HIV and STD testing policies

HIV mandatory screening. Few jurisdictions have implemented mandatory mass screening for HIV. Instead, most provide voluntary testing and/or test for HIV when juveniles show clinical symptoms of disease (see exhibit 6).

Only two State systems (5 percent) reported mandatory screening of incoming juveniles. No city/county juvenile detention centers reported screening all incoming juveniles, which is not surprising in light of the high rate of turnover in these facilities. Juvenile justice systems may have several purposes in mind in implementing mandatory mass screening policies. They may screen to isolate infected individuals. Of the two systems that reported screening all incoming juveniles, only one housed juveniles with HIV disease²⁴ apart from other juveniles. Two other systems segregate juveniles with AIDS but did not report

such as self-perception of risk and efficacy of prevention activities seem particularly important.

Condom distribution. Only two jurisdictions (Alameda and San Mateo counties in California) reported making condoms available to confined juveniles for use within the facility, and only one additional jurisdiction (Miami, Florida) reported future plans to distribute condoms. However, 40 percent of State systems and 32 percent of city/county systems reported that they made condoms available to juveniles upon release. Although none of the systems in the validation study reported distributing condoms, one facility within one of the systems did report doing so.

Exhibit 6: Summary of Correctional Policies on HIV Antibody Testing of Confined Juveniles^a

Testing Policies	State Juvenile Justice Systems (N=41)		City/County Detention Centers (N=32)	
	Number of Systems	Percent	Number of Systems	Percent
Mandatory Testing of				
All Incoming Juveniles	2	5	0	–
All Releasees	0	–	0	–
Pregnant Girls	8	20	3	9
Testing Available to				
All Confined Juveniles on Request	39	95	27	84
Testing if Clinical Indications ^b	34	83	28	88
Other Testing ^c	19	46	20	63

^a The categorization is not mutually exclusive.

^b Clinical signs or symptoms of HIV infection or AIDS.

^c Examples of other policies include court order and high-risk conduct.

Source: NIJ/CDC questionnaire responses.

Exhibit 7: HIV Antibody Testing of Confined Juveniles: Hierarchical Categorization with Validation Study Results^a

	State Juvenile Justice Systems (N=41)		City/County Detention Centers (N=32)		Validation Study (VS) (N systems=18) (N facilities=27)		
	Number of Systems	Percent	Number of Systems	Percent ^b	Systems in VS with This Policy	Facilities in VS	Percent in Agreement
Mandatory Testing ^c	9	22	3	9	2	3	33
Voluntary	31	76	26	81	11	18	89
Clinical Indications ^d	1	2	2	6	0	–	–
Missing or Other ^e	0	–	1	3	5	6	n/a
Total	41	100	32	99	18	27	–

^a Includes actual and planned policies. This is a hierarchical categorization: Jurisdictions and facilities that do mass screening are placed in the uppermost category, regardless of whether they also test for other purposes. Those that offer voluntary or on-request screening but do no mass screening are placed in the voluntary category regardless of whether they also test when clinically indicated.

^b Percentages do not add to 100 because of rounding error.

^c Includes mandatory mass screening of all incoming juveniles, releasees, and/or pregnant juveniles.

^d Clinical indications include lowered CD4 (T4) counts, opportunistic infections, and TB positivity or active TB.

^e Five systems with six facilities participating in the validation study did not respond to the system questionnaire. Four of the facilities in these systems reported a policy of voluntary testing; the other two reported mandatory screening.

Source: NIJ/CDC questionnaire responses.

mass screening policies. Others might implement mass screening policies in order to ensure early detection and treatment of HIV disease. However, in part because of discrimination against people with HIV disease and in part because of the cost of mass screening policies, most jurisdictions prefer to educate confined youths and allow them to choose whether or not to be tested for HIV.

None of the responding jurisdictions reported screening releasees. However, eight (19 percent) State systems²⁵ and three (9 percent) city/county systems²⁶ reported a policy of screening all pregnant girls. All of the city/county detention centers with this policy were located in California, whose State system also reported mandatory testing of all pregnant girls.

This will be an important policy to monitor in view of recent evidence that treatment of HIV-positive pregnant women with zidovudine (ZDV) reduces the risk of perinatal transmission. Most facilities participating in the validation study reported testing policies consistent with those reported by their systems; however, facilities and systems with policies of testing on request showed higher rates of agreement than those with mass screening policies (see exhibit 7).

Voluntary HIV testing. It is often assumed that persons who know they are at elevated risk for HIV or believe they are infected will volunteer for HIV testing. However, many high-risk individuals may not come forward to be tested out of fear of the results.²⁷

Early treatment—including prophylaxis for *Pneumocystis carinii* pneumonia or other opportunistic infections, immunizations, and counseling regarding diet and food preparation to avoid food-borne pathogens—may lengthen and improve the quality of life for HIV-infected juveniles.

Voluntary HIV testing for juveniles may be complicated by parental consent requirements. Having to acknowledge high-risk behavior to their parents may discourage juveniles from pursuing voluntary testing. Thirty-seven State systems (90 percent) and 25 city/county systems (78 percent) reported that juveniles do not need parental consent in order to be tested for HIV infection. Only five States (California, Colorado, Iowa, Michigan, and Washington) explicitly allow minors to

consent to HIV testing.²⁸ To implement successful voluntary HIV testing programs, administrators must consider how to make testing accessible in addition to providing confidential services, extensive education, and quality medical care.

Confidentiality and disclosure. Ensuring confidentiality of HIV test results is one of the most important ways to encourage youths to be tested, but this can be complicated and extremely difficult. Although by official policy only 25 percent of systems notify parents or guardians of their children’s HIV status, parents often have general access to their children’s medical records. Parents have good reasons for wanting to know the HIV status of their children, particularly if their children are at high risk for HIV infection. Adolescents, however, may also have valid concerns about informing their parents of their HIV status. Juvenile justice systems should carefully consider all ramifications before informing parents or guardians of HIV status without the consent of the juvenile. In many jurisdictions, such disclosure without consent may be illegal.

Almost all systems reported a policy of notifying the juvenile (96 percent), her or his doctor (85 percent), and the local public health department (80 percent) of HIV status. Half or more systems also reported policies of notifying other medical staff (63 percent), institution management (50 percent), and spouses or sexual partners of HIV-infected youths (49 percent). A partner notification policy might mean that the confined juvenile notifies the partner(s) directly, that juvenile justice staff notify the partner(s), or that public health authorities are notified and follow up with the partner(s). Only 20 percent of responding systems reported a policy of notifying nonmedical juvenile justice staff. Validation study results on notification policies show a high rate of agreement between central offices and individual facilities.

HIV pretest and posttest counseling

Pretest and posttest counseling are critical components of programs dealing with HIV in juvenile justice systems. Fifty-nine percent of State systems and 22 percent of city/county systems reported providing HIV pre-

vention counseling in some or all of their facilities. (There may have been uncertainty regarding the meaning of the survey questions that dealt with “HIV prevention counseling.” The questions were intended to refer to ongoing prevention counseling, but most systems probably answered in terms of pretest and posttest counseling.) Overall, questionnaire responses indicate that approximately two-thirds of all facilities provide HIV prevention counseling.

In order to maintain confidentiality, counseling must be individualized. By offering increased individual attention, such counseling can encourage youths to express their feelings honestly. However, limited resources among juvenile justice systems often preclude offering this service. Sixty-two percent of State systems and 38 percent of city/county systems reported providing individual HIV counseling. More than half of the participating State juvenile justice systems reported providing HIV counseling that covered the meaning of HIV antibody test results, safer sex practices, condom use, effects of alcohol and drug use on HIV risk, self-perception of risk, and/or referrals to other services.

Exhibit 8: Summary of Policies on Testing Confined Juveniles for STDs

	Syphilis		Gonorrhea		Chlamydia	
	State (N=41) ^a	City/County (N=32) ^a	State (N=41) ^a	City/County (N=32) ^a	State (N=41) ^a	City/County (N=32) ^a
All Incoming						
Girls	30 (81%)	10 (32%)	23 (64%)	14 (44%)	21 (60%)	6 (20%)
All Incoming						
Boys	26 (65%)	10 (32%)	13 (33%)	9 (28%)	11 (28%)	2 (7%)
All HIV						
Positive Juveniles	21 (66%)	9 (35%)	17 (53%)	8 (31%)	15 (48%)	4 (16%)
Clinical						
Indications	35 (95%)	29 (91%)	36 (95%)	29 (94%)	35 (95%)	30 (94%)
Voluntary	31 (84%)	31 (97%)	30 (81%)	32 (100%)	29 (81%)	30 (94%)

^a Some respondents did not answer the questions pertinent to the items listed in the table. The percentages given are based on the number of respondents who answered each question.

Source: NIJ/CDC questionnaire responses.

STD testing and notification

Many more systems perform routine screening for syphilis, gonorrhea, and chlamydia than for HIV (see exhibit 8). STD testing on request and in cases of clinical symptoms also appear at least officially available in the vast majority of juvenile justice systems.

Similarly, more systems require that sexual partners be notified of a juvenile's syphilis, gonorrhea, or chlamydia infection than of HIV infection. Approximately 80 percent of participating systems reported having policies requiring sexual partner notification of syphilis and gonorrhea infection, and 75 percent of systems reported having a policy requiring sexual partner notification of chlamydia infection. However, only 5 percent of State systems and 13 percent of city/county systems said they officially require notification of parents or guardians when a confined juvenile tests positive for an STD.

Pregnancy testing. Sixty-four percent of State juvenile justice systems, compared with 19 percent of city/county systems, reported routine pregnancy testing policies. This difference may be due to youths' short length of stay in detention centers. However, 94 percent of all systems, both State and local, reported testing girls demonstrating symptoms of pregnancy, and 94 percent of all systems reported providing voluntary pregnancy testing.

Conclusion

Many juveniles in confinement have engaged in activities that place them at elevated risk for HIV and STDs. Nevertheless, HIV has not yet become as widespread as STDs among adolescents in detention centers and training schools. Thus, a unique opportunity

exists to prevent HIV infection, improve public health, and provide important preventive and therapeutic services for youths who may have no other means of accessing them. Most juvenile systems have implemented some form of prevention program, including HIV/STD education, but there is still considerable work to be done to improve education and prevention. If juvenile justice systems do not seize this opportunity, HIV infection among confined juveniles will likely escalate. In order to take full advantage of this opportunity, more juvenile systems should make counseling, education, and voluntary HIV testing available. Further research, especially on the prevalence of HIV and STDs among confined juveniles and on the efficacy of various behavioral interventions, would also be of value.

Notes

1. Hammett, T., R. Widom, J. Epstein, M. Gross, S. Sifre, and T. Enos, *1994 Update on HIV/AIDS and STDs in Correctional Facilities*, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 1995.

2. The following reports were cited in DeClemente, R.J., M.M. Lanier, P.F. Horan, and M. Lodico, "Comparison of AIDS Knowledge, Attitudes, and Behaviors among Incarcerated Adolescents and a Public School Sample in San Francisco," *American Journal of Public Health*, 81(5) (May 1991): 628–630; Alexander-Rodriguez, T., and S.H. Vermund, "Gonorrhea and Syphilis in Incarcerated Urban Adolescents: Prevalence and Physical Signs," *Pediatrics*, 80 (1987):561–564; Bell, T.A., J.A. Farrow, W.E. Stamm, C.W. Critchlow, and K.K. Holmes, "Sexually Transmitted Diseases in Females in a Juvenile Detention Center,"

Sexually Transmitted Diseases, 12 (1985):140–144; and Council on Scientific Affairs, "Health Status of Detained and Incarcerated Youths," *Journal of the American Medical Association (JAMA)*, 263 (1990):987–991.

3. Centers for Disease Control and Prevention (CDC), "Guidelines for Effective School Health Education to Prevent the Spread of AIDS," *Morbidity and Mortality Weekly Report (MMWR)*, 37(S-2) (January 29, 1988):1–14.

4. Of males 13 to 19 years old diagnosed with AIDS in 1994, 48 percent were at risk through hemophilia/coagulation disorder or receipt of a blood transfusion, and 13 percent did not have a risk category reported or identified. CDC, *HIV/AIDS Surveillance Report: U.S. HIV and AIDS Cases Reported Through December 1994*, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 6(2) Year End Edition.

5. Ibid.

6. Ibid.

7. HIV seropositivity indicates the presence of HIV antibodies in the blood.

8. Blinded epidemiological studies and mass screening both avoid selection bias, which provides the best estimates of seroprevalence.

9. "Trends in Sexual Risk Behavior Among High School Students—United States, 1990, 1991, and 1993," *MMWR*, 44(7) (February 24, 1995): 124, 131–132.

10. "Selected Behaviors that Increase Risk for HIV Infection, Other Sexually Transmitted Diseases, and Unintended Pregnancy Among High School

Students—United States, 1991,” *MMWR*, 41(50) (December 18, 1992):945–950.

11. *Ibid.*

12. “Health Risk Behaviors Among Adolescents Who Do and Do Not Attend School—United States, 1992,” *MMWR*, 43(08) (March 4, 1994):129–132.

13. Morris, R.E., C.J. Baker, and S. Huscroft, “Incarcerated Youth at Risk for HIV Infection,” in *Adolescents and AIDS: A Generation in Jeopardy*, ed. R.J. DeClemente, Newbury Park, CA: Sage Publications, 1992:52–69.

14. On average, systems reporting results on syphilis seroprevalence tested approximately 500 juveniles. On average, systems reporting results on gonorrhea seroprevalence tested approximately 400 juveniles.

15. DesJarlais, D.C., N.S. Padian, and W. Winkelstein, “Targeted HIV-Prevention Programs,” *New England Journal of Medicine*, 331 (November 24, 1994):1451–1453.

16. DeClemente, R.J., M.M. Lanier, P.F. Horan, and M. Lodico, “Comparison of AIDS Knowledge, Attitudes, and Behaviors among Incarcerated Adolescents and a Public School Sample in San Francisco,” *American Journal of Public Health*, 81(5) (May 1991):628–630.

17. Morris, Baker, and Huscroft, “Incarcerated Youth at Risk for HIV Infection,” 52–69.

18. For information on the Massachusetts program, contact Gary Shostak, Director of Health Services, Massachusetts Department of Youth Services, 27–43 Wormwood Street, Suite 400, Boston, MA 02210.

19. For more information on the New Mexico program, contact Dorothy Martinez, Children, Youth, and Families Department, P.O. Box 38, Springer, NM 87747.

20. Dorothy Martinez, New Mexico State Juvenile Justice System, personal communication, May 12, 1995.

21. For more information on the Los Angeles County program, contact Maureen Valentine, Peer HIV Education Research Project Coordinator, Los Angeles Juvenile Court Health Services, 1925 Daly Street, Los Angeles, CA 90033.

22. Jace Anderson, Peer HIV Education Research Project Coordinator, personal communication, May 12 and 16, 1995; and Morris, R.E., C. Baker, J. Anderson, and M. Valentine, “A Comparison of Peer, Adult, and Mixed (Adult and Peer) HIV Prevention Educators for Probationary Youth,” abstract presented to the Society for Adolescent Medicine, 1996.

23. CDC, “Guidelines for Effective School Health Education to Prevent the Spread of AIDS,” *MMWR*, 37(S–2) (January 29, 1988):1–14.

24. HIV (human immunodeficiency virus) disease refers to the spectrum of disease from the incubation period (usually with no obvious symptoms but HIV seropositivity) to the stage of serious disease (active AIDS—acquired immunodeficiency syndrome).

25. Arkansas, California, Illinois, Michigan, Mississippi, South Carolina, Tennessee, and Wyoming.

26. Alameda, Riverside, and Ventura, California.

27. Behrendt, C., et al., “Voluntary Testing for HIV in Prison Populations

with a High Prevalence of HIV,” *American Journal of Epidemiology*, 139 (1994):918–926.

28. Morris, Baker, and Huscroft, “Incarcerated Youth at Risk for HIV Infection,” 62.

This research was conducted by Abt Associates Inc. The study team consisted of Rebecca Widom, research assistant, and Theodore M. Hammett, vice president.

Prepared under contract OJP–89–C–009 to Abt Associates Inc. from the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. Findings and conclusions of the research reported here are those of the authors and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

The National Institute of Justice is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, Bureau of Justice Statistics, Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime.

NCJ 155509

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