

HIV and Institutional Youth: Questions and Answers



Table of Contents

Introduction	05
Demographics and Trends	07
Prevention Considerations	12
Treatment Considerations	14
Case Manager's Checklist on HIV/AIDS and Incarcerated Youth	19
Conclusion	21
Resources	22
References	24

Prepared by the National Minority AIDS Council (NMAC), Division of Technical Assistance, Training, and Treatment, and The Zaplin Group, sponsored by the Centers for Disease Control and Prevention (CDC).

Introduction

Young people involved with the criminal justice system are at risk for HIV infection, while those who are already HIV-positive face a lifetime of challenges. HIV/AIDS service providers working with youth, both when they are institutionalized and when they reenter the community, have an opportunity to intervene with one of the most at-risk and challenging populations in the HIV/AIDS service sector. Juveniles can also be among the most rewarding populations to work with because the opportunity for growth and positive change is so great.

Target Audiences: The purpose of this booklet is to provide basic information to better enable faith- and community-based organizations (F/CBOs) and juvenile justice personnel to provide effective HIV/AIDS prevention and treatment services to the millions of youth in the juvenile justice system. This booklet will also be useful for educating juveniles directly about why they may be at high risk of contracting HIV and other sexually transmitted diseases (STDs) as well as presenting treatment considerations for those juveniles already infected.

Organization of the Booklet: This booklet provides answers to some frequently asked questions about institutionalized juveniles and HIV/AIDS. These questions are grouped into three general topics: 1) demographics and trends, 2) HIV/AIDS prevention considerations, and 3) HIV/AIDS treatment considerations. It also offers case studies throughout to highlight issues for institutional and F/CBO case managers. The final portion of the booklet contains a checklist for HIV/AIDS case managers and a list of resources and suggested further reading.

Use of Terms: Throughout this booklet, the term “institution” refers to those facilities that house juveniles involved in the justice system such as juvenile detention centers. While a portion of the population of prisons, jails and police lockups may include juveniles, those populations are largely covered by the other NMAC booklets targeted at adult offenders and are not discussed here. The terms “juvenile delinquent,” “youthful offender” and “minor” refer to a person who is under age 18 and found to have committed a crime but not sentenced as an adult (the age cutoff is usually below 18, but several states have reduced the age of criminal responsibility to as low as 14 under certain circumstances).

Demographics and Trends

How Many Young People Are in the Justice System in the United States?

Between 1960 and 2005, juvenile court delinquency caseloads increased more than 300%. Of the 1,697,900 delinquency cases processed in 2005, 73% involved males while 27% involved females. Of these cases, 57% involved individuals younger than 16 years old. Between 1985 and 2005, delinquency caseloads involving person (assault, robbery, rape and homicide), drug, and public order offenses more than doubled; in contrast, the property offense caseload decreased 15%.¹ The racial trends between 1997 and 2005 show that the delinquency caseload decreased for Caucasian (White) youth and American Indian youth (14% each), but increased slightly for Asian American youth (3%) and African American (Black) youth (2%) (Figure 1).¹

Case Study: Raoul

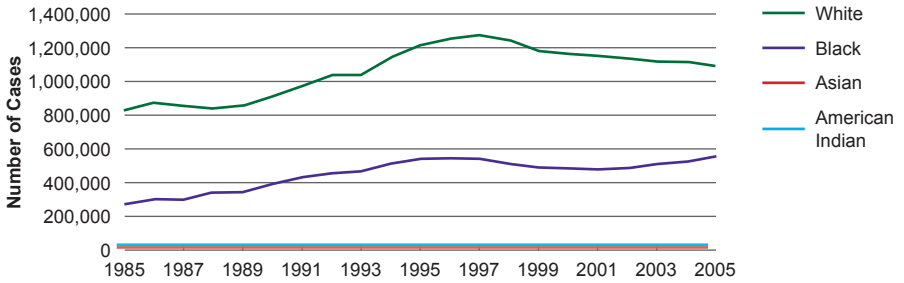
Raoul is 15 years old and gang-affiliated. He has been in and out of the same juvenile facility several times in the past two years for drug-related offenses, and an assault. His current sentence from juvenile court is one year. Shortly after the start of his sentence, Raoul asks if he can speak with someone about HIV/AIDS. He says on the street he used marijuana and alcohol, but no other drugs. He says he is worried about HIV transmission from tattooing: "I heard that you can get AIDS and other diseases from tattoos, especially tattoos in prison. So I want to know if that's true or not. I got my first tattoo the last time I was here [in the juvenile detention facility] from a friend of mine who is an artist." When asked about his family and home life, Raoul says his girlfriend recently told him that she is pregnant.

Issues for the Case Manager

- HIV/AIDS education, including safer sex, tattooing, and other transmission risks
- HIV/AIDS pre-test and post-test counseling resources
- Hepatitis education, Hepatitis A and B vaccination.
- Peer-based programs in the correctional facility
- Family planning education and community-based resources, including prenatal care
- Literacy, language, and basic skills assessment
- Education, school enrollment



Figure 1: Delinquency Caseload by Race

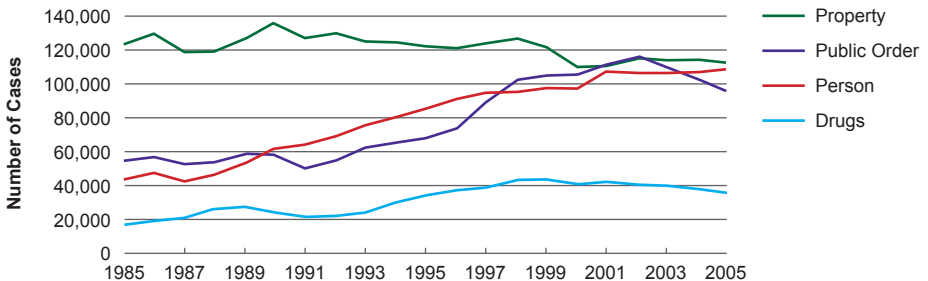


Note: Juveniles of Hispanic ethnicity can be of any race; however, most are included in the White (Caucasian) racial category in this chart.

Source: National Center for Juvenile Justice, 2008.

The number of delinquency cases resulting in detention increased 48% between 1985 and 2005, from 239,900 to 354,100. Juvenile courts in the U.S. saw the largest relative increase in “person offense” cases (144%), followed by “drug offense” cases (110%) and “public order” cases (108%). In contrast, the number of detained “property offense” cases declined 22% during this period. Despite the growth in the overall volume of delinquency cases involving detention, the proportion of cases detained was the same in 2005 as in 1985 (21%) (Figure 2).

Figure 2: Number of Delinquency Cases Involving Detention, 1985–2005



Source: National Center for Juvenile Justice, 2008.

Detention rates were not uniform across racial groups, particularly with regards to drug offense violation cases, which saw African American youth accounting for 31% of all cases between 1985 and 2005, but representing 49% of such cases detained.¹ The number of delinquent cases that were adjudicated and resulted in out-of-home placement increased 30% between 1985 and 2005 (increased 139% for drug offense cases; increased 94% for public order offense cases; increased 89% for person offense cases; and decreased 25% for property offense cases). Out-of-home placement adjudications reached as high as 182,800 cases in 1997 before decreasing 23% by 2005.¹

How Great Is the Risk of HIV/AIDS for Young People?

Young people and adults are all at risk for HIV/AIDS if they have unprotected sex, share needles, or engage in other high-risk behaviors such as having multiple sex partners. Also, alcohol/drug use may lead to high-risk sexual behavior. From the beginning of the HIV/AIDS epidemic in the U.S. through 2007, 18% of all reported HIV infections (not AIDS) occurred in those 24 years of age and younger,² and the impact on young people continues. Of the estimated 56,300 people in the U.S. who became infected with HIV in 2006, 19,200 or 34% were adolescents or young adults 13 to 29 years of age.³ Young people also become sick with advanced HIV disease. The Centers for Disease Control and Prevention (CDC) reported 44,433 cumulative cases of AIDS among people ages 13 to 24 through 2007.⁴

African-American and Hispanic adolescents have been disproportionately affected by the HIV/AIDS epidemic. African Americans and Hispanics between the ages of 13 and 19 accounted for 68% and 19%, respectively, of the reported AIDS cases in this age group in 2007.⁵ And because the average duration from HIV infection to the development of AIDS is ten years, many adults with AIDS were likely infected as adolescents or young adults.⁶

It is estimated that more than half of all HIV-infected adolescents have not been tested and are not aware of being infected.⁷ Among 18 to 24 year old males who have sex with males (MSM) surveyed in five U.S. cities during 2004 to 2005, 14% were infected with HIV, 79% of whom were unaware of their infection.⁸

How Do Most HIV-Positive Young People Get Infected?

According to the CDC research, the majority of HIV/AIDS cases from 2004 through 2007 among adolescent and young adult males were attributed to MSM, while the majority of cases diagnosed among adolescent and young adult females were attributed to high-risk heterosexual contact⁹ (Table 1).

Table 1: Estimated Numbers of HIV/AIDS Cases Among Male and Female Adolescents and Young Adults, by Transmission Category, 2004–2007

Transmission Category	Males				Females			
	13–19 Years		20–24 Years		13–19 Years		20–24 Years	
	n	%	n	%	n	%	n	%
Male-to-Male Sexual Contact	3,171	87	10,226	83				
Injection Drug Use	122	3	558	5	219	11	555	13
Male-to-Male Sexual Contact and Injection Drug Use	130	4	551	4				
High-Risk Heterosexual Contact*	221	6	910	7	1,646	88	3,846	87
Other/Not Identified†	7	< 1	19	<1	7	< 1	16	< 1
Total	3,651		12,264		1,920		4,417	

Note: Data include persons with a diagnosis of HIV infection regardless of their AIDS status at diagnosis. Data from 34 states with confidential name-based reporting since at least 2003.⁹

Source: Adapted from slides 4 and 5: Centers for Disease Control and Prevention (CDC), HIV/AIDS Surveillance in Adolescents and Young Adults (through 2007). Data pertains to the 34 states with long-term, confidential name-based HIV infection reporting.⁹

* Heterosexual contact with a person known to have, or to be at high-risk for, HIV infection.

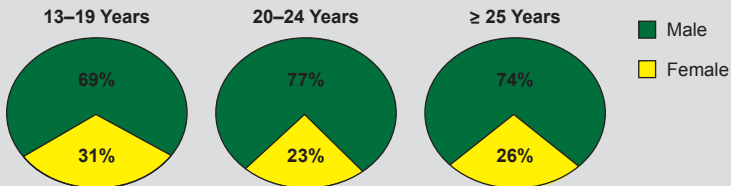
† Includes hemophilia, blood transfusion, perinatal exposure, and risk factor not reported or not identified.



How Does HIV Risk Vary with Age Between Young Men and Young Women?

In terms of age, the proportion of females living with HIV/AIDS in the U.S. is highest in the 13 to 19 age groups. In 2007, females accounted for 31% of adolescents aged 13 to 19 years who were diagnosed with HIV infection, compared with 23% of young adults aged 20 to 24 years, and 26% of adults aged 25 years and older (Figure 3).

Figure 3: Percentage of HIV/AIDS Cases Among Adults and Adolescents, by Sex and Age Group Diagnosed in 2007



Source: Centers for Disease Control and Prevention (CDC), HIV/AIDS Surveillance in Adolescents and Young Adults (through 2007). Data pertains to the 34 states with long-term confidential name-based HIV infection reporting.⁹

Young women are at a greater risk of contracting HIV for several reasons, including:¹⁰

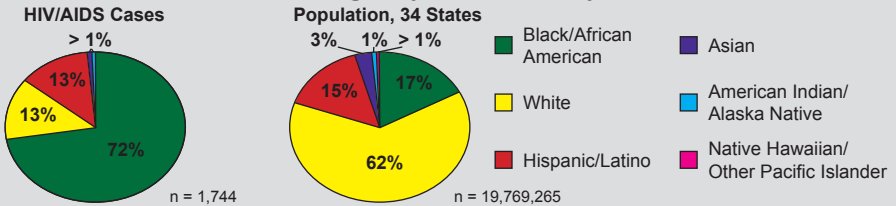
- Biological reasons (e.g., higher rates of gonorrhea and syphilis, which increase risk)
- Lack of awareness of the high-risk behaviors associated with HIV/AIDS
- Not knowing their partners' risk factors (e.g., a history of unprotected sex or injection drug use)
- Feeling less power in relationships
- Having sex with older men who are infected

How Do HIV Risk Factors Vary Based on Race/Ethnicity for Young People?

Low socioeconomic status, urban living, substance abuse, and limited access to health care are some of the risk factors that disproportionately affect minorities, particularly African Americans.¹¹ Their increased exposure to these factors has led to the disproportionate impact of the HIV/AIDS epidemic on African American adolescents. In 2007, 17% of adolescents 13 to 19 years of age were African American, yet 72% of HIV/AIDS diagnoses in this age group were in African American adolescents

(Figure 4).⁹ In fact, African American and Hispanic males 15 to 19 years old in 2006 were 21 and 6 times more likely, respectively, to be living with HIV/AIDS than Caucasian males (a rate of 141.7 and 39.8 versus 6.7 per 100,000 population, respectively).¹² African American and Hispanic females 15 to 19 years old in 2006 were 17 and 5 times more likely to be living with HIV/AIDS than Caucasian females (a rate of 129.5 and 40.2 versus 7.5 per 100,000 population).¹²

Figure 4: Percentage of HIV/AIDS Cases by Population Among Adolescents 13-19 Years of Age, By Race/Ethnicity



Source: Centers for Disease Control and Prevention (CDC), HIV/AIDS Surveillance in Adolescents and Young Adults (through 2007). Data pertains to the 34 states with long-term confidential name-based HIV infection reporting.⁹

How Do Rates for Other STDs Vary Based on Race/Ethnicity for Young People?

Adolescents and young adults aged 15 to 24 years have high rates of the most common STDs. Persons in this age group have been estimated to acquire nearly half of all newly occurring STDs, although they represent only 25% of the sexually active population.¹² Reasons for the increased rates are the same as for HIV infection noted above.

STDs also disproportionately affect African Americans. For African Americans males 15 to 19 years old in 2006, the rates for gonorrhea and chlamydia were 1,468 and 2,195 per 100,000 population respectively. These rates were 38 and 14 times higher than for Caucasian males.¹² For African American females 15 to 19 years old in 2006, the rates for gonorrhea and chlamydia were 2,830, and 8,858 per 100,000 population respectively. These rates were 14 and 6 times higher than for Caucasian females.¹² The syphilis rates for African Americans were 25 (males) and 21 (females) times higher than for Caucasian males and females, however, syphilis occurs less frequently—15 and 11 per 100,000 population for African American males and females respectively.¹² The rates of these three STDs for Hispanic males and females were 2 to 4 times higher than for Caucasian males and females.¹²

Prevention Considerations

What Is the Role of Sexual Behaviors Among Youth in the Juvenile Justice System?

Nationally, youth in the juvenile justice system have higher rates of STDs than their peers in the community.¹³ They are more likely than their high school peers to report an early age of first sexual intercourse, having multiple sex partners, and inconsistent condom use.¹⁴ In a study of Chicago juvenile detainees, 62% of males and 43% of females 10 to 13 years old ever had vaginal sex.¹⁵ In the general population, 8% of males and 6% of females younger than 14 years of age ever had vaginal sex.¹² Older age juveniles in the justice system continued with a higher rate of sexual activity than comparable ages in the general population (Table 2).

Table 2: Youths in the Juvenile System and the General Population Who Ever Had Vaginal Sex

	Age Group		
	10–13	14–15	16–18
Males—Juvenile System†	62%	86%	98%
Males—General Population**	8%	26%	66%
Females—Juvenile System†	43%	66%	79%
Females—General Population**	6%	28%	71%

* Percentages are for those under 14, 16, and 19 years of age.

† Teplin, L.A. et al. (2003). *American Journal of Public Health*, 93(6), 906–912.

‡ CDC Surveillance Summaries, July 17, 2009. *MMWR*, 58 (No. SS-6).

Youth in the juvenile system also report a greater frequency of multiple partners. While 17% of males and 14% of females aged 15 to 19 in the general population reported having more than three partners in their lifetime,¹² in the juvenile system 31% (males) and 7% (females) in the age group 10 to 13 reported having more than three partners in the three months prior to the interview.¹⁵ The Chicago juveniles were re-interviewed 3 to 4.5 years later and more than two-thirds of the youth were found to have persisted in engaging in 10 or more risk behaviors that included having unprotected sex, having sex while drunk or “high,” and with multiple sex partners.¹⁶

What Is the Role of Substance Use Among Youth in the Juvenile Justice System?

Five cities participating in a national drug use survey in 2002 found that 60% of male juveniles and 46% of female juveniles tested positive for drugs at the time of their arrest.¹⁷ A study of juvenile detainees in Chicago found that even among the youngest girls, ages 10 to 13, most reported using marijuana and alcohol.¹⁵ Injection drug use poses the highest direct HIV/AIDS risk, but other drug and alcohol use can also increase HIV/AIDS risk because it can impair judgment and make a person take unnecessary risks.

Why Is Tattooing a Risk Factor for HIV/AIDS?

HIV is spread when the blood or body fluids of an HIV-positive person enter the body of another person, either through a break in the skin or through a mucous membrane. Therefore, tattooing and body piercing, as performed in institutions with makeshift and unsterilized devices, also presents a risk for HIV infection.¹⁸ Tattooing punctures the skin, and is therefore a way to spread HIV, Hepatitis B (HBV) and C (HCV). These viruses can live on a tattoo needle or tip, in the ink, in the shaft/tube that holds the ink, in the cotton or towels used to blot tattoos, and on the gloves the tattoo artist wears. It is not possible to adequately sterilize all these components in the prison setting, so the only safe tattoo is one that is done with all new, previously unused materials.¹⁹



Treatment Considerations

What Are the Symptoms of HIV/AIDS and How Does It Progress?

Some of the most common symptoms experienced soon after becoming infected with HIV (by 40% to 90% of persons) include fever, rash, tiredness, headache, achy muscles and joints, swollen lymph nodes, and sore throat.²⁰

These symptoms tend to occur within one to four weeks after infection.

As these resemble the symptoms of common illnesses such as the flu, HIV infection is not often diagnosed at this stage.²¹ Two studies have noted that if symptoms include fever combined with a rash,²² or fever combined with a rash and achy muscles,²³ the odds increase that a suspected case is due to a recent HIV infection. This symptomatic period usually lasts four weeks, until the immune system is able to reduce the initial high HIV viral load. The HIV-infected individual then generally enters a long chronic and asymptomatic phase that may generally last 5 to 10 years.

The CDC describes some of the symptoms that may be associated with advanced HIV infection as follows: rapid weight loss; dry cough; recurring fever or profuse night sweats; profound and unexplained fatigue; swollen lymph glands in the armpits, groin, or neck; diarrhea that lasts for more than a week; white spots or unusual blemishes on the tongue, mouth or throat; pneumonia; red, brown, pink, or purplish blotches on or under the skin or inside the mouth, nose, or eyelids; memory loss, depression, and other neurologic disorders.²⁴ As with the initial, primary HIV infection, these symptoms may be caused by other illnesses and only HIV testing can accurately determine HIV infection.

Each part of the often used term—HIV/AIDS—represents different stages of infection. During the chronic phase, the infected person is considered to be HIV-positive (HIV+). The onset of AIDS is defined as when CD4 T-cell counts reach 200 (CD4 T-cells are immune-system cells targeted by HIV) or when a person incurs an AIDS-associated illness. Without antiretroviral therapy, the HIV viral load increases, CD4 T-cell level continues to decrease and the patient dies of opportunist diseases allowed by the weakened immune system.



What HIV/AIDS Prevention Considerations Apply Specifically to Youths?

It has been shown that adolescents prefer to receive information about how to prevent HIV infection from their health care providers rather than from their parents, teachers, or friends.²⁵ However, fewer than half of clinicians provide such guidance.²⁶ Health care providers' recommendations have also been shown to influence an adolescent's decision to be tested for HIV (58% of adolescents who have a health care provider cited their provider's recommendation as their reason for testing).²⁷

How Does Confidentiality of HIV/AIDS-Related Information Apply to Juveniles?

Ensuring that HIV test results are confidential can be one of the most important ways to encourage people to be tested for HIV. Unfortunately, confidentiality of HIV/AIDS-related information can be difficult to maintain in many institutions.

In institutions that serve juveniles, this issue can be further complicated by the fact that parents and guardians often have full access to children's medical records.

Generally, a minor cannot consent to treatment. Rather, the parent, guardian, or another authorized person (known as in *loco parentis*) must consent, and may access the minor's health information. As previously stated, a minor is defined, in

many states, as an individual under the age of 18. Case managers should be aware of confidentiality and disclosure policies in the correctional facilities they serve, including the federal Health Insurance Portability and Accountability Act (HIPAA) privacy regulations and state-by-state variations in their supporting legislation.

Two important roles that F/CBOs can fill are: 1) to encourage juveniles to accept testing for HIV and other STDs, and 2) to make sure to acquire the requisite consent so medical providers within the institutions are authorized to transfer patient records to providers in the community.



How Do Relatively Short-Term Sentences Affect HIV/AIDS Services for Institutionalized Youth?

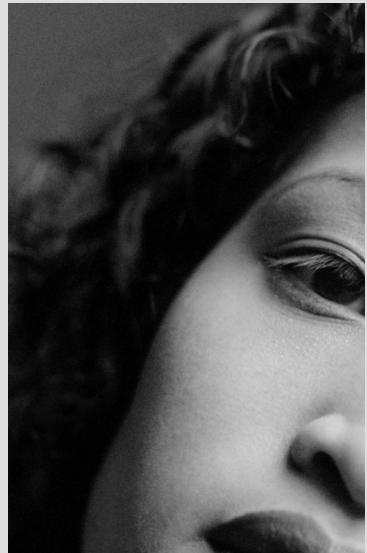
Because juveniles often have shorter periods of institutionalization than adults, it is important for health and social services staff working with juveniles to have close links with community-based agencies. For example, it may not be possible to complete a full hepatitis vaccination series for an HIV-positive institutionalized youth; but a case manager should be able to document the current vaccination status and take steps to ensure that the series is completed after release at a community-based clinic. High turnover in juvenile facilities may also call for accelerated protocols for counseling and education services. HIV/AIDS corrections workers should use both single session and multi-session protocols in order to provide services to short-term and longer-term juvenile prisoners. (See NMAC booklet, *“Hitting the Bricks: Successful Reentry*

Case Study: Tina

Tina is 16 years old and has been arrested for prostitution. She says she always uses protection during sex, and in fact there were several condoms in her pockets when she was arrested. She states that she does not use drugs, but the intake counselor notices that her lips are cracked and burned, and suspects that Tina may recently have been smoking crack cocaine. Tina says that her boyfriend told her not to get tested for HIV in the jail because it could result in her case being treated as a felony. She says her boyfriend is 34 years old and that he treats her well.

Issues for the Case Manager

- Detoxification, medical monitoring
- HIV/AIDS basic education and risk assessment
- Peer-based programs in the correctional facility
- HIV/AIDS counseling and testing resources, including community-based anonymous or confidential services
- Substance abuse treatment resources
- Family/relationship counseling resources
- Hepatitis education: Hepatitis A and B vaccination
- Literacy, language, and basic skills assessment.
- Education, school enrollment



of *Offenders Living with HIV/AIDS*” for additional information on transitioning care from an institution to the community.)

Why Are High STD Rates Relevant to HIV/AIDS Risk?

High STD rates are relevant to HIV/AIDS risk for three reasons:

1. Unprotected sex that results in the transmission of an STD can also result in HIV transmission.
2. STDs can cause genital lesions that can increase a person’s susceptibility to HIV infection. In addition, STDs increase the number of CD4 T-cells in a female’s cervical secretions. Increased CD4 T-cells in vaginal secretions can increase a female’s susceptibility to HIV infection.
3. If a person is coinfecting with HIV and an STD, that can result in more “shedding” of HIV. That means the coinfecting person is more likely to infect another person if he or she engages in high-risk behavior, like unprotected sex.²⁸

What About Hepatitis C (HCV) and Institutionalized Youth?

The prevalence of HCV in institutionalized youth is higher than among the non-institutionalized population. It is estimated that 1.8% of the general U.S. population has been infected with HCV, and that 2 to 3.5% of institutionalized juveniles have been infected.²⁹ The estimated prevalence of HCV infection is higher among institutionalized young females (3 to 7%) than institutionalized young males (2 to 3%).²⁹ Sharing needles or works for intravenous drug use is the main HCV risk factor for institutionalized young people.²⁹

Other activities that can potentially transmit HCV include sharing tattooing equipment, unprotected sex, or any other activity that results in blood-to-blood contact. There is no vaccine to prevent infection with HCV. The CDC has produced comprehensive recommendations on addressing hepatitis A, B, and C among institutionalized juveniles.²⁹ See the Resources section at the end of this booklet for information on how to obtain a free copy of these recommendations.”(see also NMAC booklet *Hepatitis and HIV in Prisons*)

What About Hepatitis B (HBV) Vaccination for Incarcerated Youth?

There is a vaccine to prevent infection with HBV and it is safe for people who are living with HIV/AIDS. The CDC recommends that

all juveniles who receive a medical evaluation in a correctional facility be administered the HBV vaccine.²⁹ According to the CDC, the HBV vaccine should be started for juveniles who have never been vaccinated, regardless of their length of stay in the institution, and the vaccine series should be completed for juveniles who started but did not complete the full vaccination series. In general, the CDC recommends that correctional facilities maintain vaccination records for all prisoners. Case managers should ensure that immunization records are transferred when a prisoner is released, and that incomplete vaccination series are completed in the community after release.

What About Hepatitis A (HAV) Vaccination for Institutionalized Youth?

There is a vaccine to prevent infection with HAV. It is also safe for people who are living with HIV/AIDS. HAV can be dangerous for people who are also infected with HCV. The CDC recommends that all juveniles who live in states where HAV is prevalent be vaccinated against HAV.²⁹ The CDC also recommends that an HAV vaccination be considered for institutionalized juveniles in all other states.

Who Pays for Hepatitis Vaccines for Incarcerated Youth?

The federal Vaccines for Children (VFC) program pays for HAV and HBV vaccine for persons up to age 18 who qualify for the program. By enrolling in VFC, adult or juvenile correctional facilities may be able to obtain free hepatitis vaccines for juvenile prisoners. See the Resources section at the end of this booklet for contact information for the VFC program.

Are There Special Issues for Female Young Offenders That Should Be Addressed in HIV/AIDS Services?

Male and female institutionalized juveniles often come from a background of family violence and victimization. In general, the reaction of young people to this violence differs by gender. Reactions by adolescent females, for example, include running away, prostitution, teenage pregnancy, petty theft, shoplifting and gang involvement.³⁰ In addition, eating disorders can be a frequent problem for adolescent females. As noted above, adolescent females are more at risk for HIV infection than older women. The National Institute of Corrections,³¹ the National Institute of Justice,³² and other researchers³³ and model programs³⁴ have found that an important characteristic of quality correctional programs for women is that they address participants' self-sufficiency, self-esteem and empowerment.³⁵

Case Manager's Checklist on HIV/AIDS and Incarcerated Youth

For young people who are HIV-positive, detention can present an opportunity to link up with HIV/AIDS services and learn about their diagnosis. Institutionalized youth who are not HIV-positive can take advantage of HIV/AIDS services to learn about HIV/AIDS and to develop skills and knowledge to protect themselves from the virus while they are institutionalized, and once they go home after release.

HIV/AIDS case managers working with institutionalized youth should have a broad understanding of HIV/AIDS and local resources in order to answer questions posed by clients and to anticipate and meet client needs. Case managers should:

Know the Basics About HIV/AIDS (see the NMAC publication *HIV/AIDS Fundamentals: What You Need to Know*)

- What is HIV/AIDS?
- How is it transmitted?
- What risk behaviors can put a juvenile at risk for HIV/AIDS?
- How can youth modify their behavior to keep themselves from getting infected with HIV?
- What are the basics of HIV/AIDS testing and treatment?



Know the Basics About HIV/AIDS Testing

- Can juveniles be tested for HIV/AIDS in the correctional facility?
- What type of HIV tests (oral or blood) are available?
- How long does it take to get results?
- Is there pre- and post-test HIV/AIDS counseling with a certified counselor?
- Does the facility require consent from a parent or guardian for an HIV test?
- Can the test be taken anonymously?
- If the HIV test is not anonymous, will the results be kept confidential?
- To whom can/will a juvenile's HIV test results be disclosed?
- Does a positive HIV test result have unwanted consequences for juveniles (i.e., segregation, reduced access to jobs or programs, loss of confidentiality)?

Know the HIV/AIDS Resources in the Institution

- What HIV/AIDS education is provided to institutionalized youth?
- What HIV/AIDS education is provided to staff?
- Is there peer-based HIV/AIDS education or support programs available to institutionalized youths?
- What written HIV/AIDS materials are available for institutionalized youths?
- Are written materials translated into appropriate languages?
- What are the arrangements in the correctional facility for providing medical care to institutionalized youth living with HIV/AIDS?
- Is there an HIV/AIDS specialist physician available to treat HIV-positive youth?
- Does the HIV/AIDS specialist have experience in treating adolescents?

Know Related Resources in the Institution

- What substance abuse treatment programs are available for juveniles who want to stop using drugs and/or alcohol?
- What harm reduction programs are available for juveniles who are still using drugs and/or alcohol?
- What vaccinations are available to institutionalized youth and can they be tested for STDs and hepatitis infection?
- What education and vocational training resources are available to institutionalized youth?
- What other training and skills-building resources are available to institutionalized youth?

Know Related Resources in the Community

- Are you familiar with the many local community-based resources that your clients may need to access after release? These may include:
 - Housing
 - Education
 - Special Education
 - Medical Care
 - Food
 - Clothing
 - Substance Abuse Treatment
 - Mental Health Services
 - Vaccination Services

Conclusion

Institutionalized youth have much to gain from quality HIV/AIDS services. Because of drug use and high-risk behavior, this population is at high risk of contracting HIV/AIDS in the community. Time in institutions offers an opportunity for HIV/AIDS service providers to reach at-risk youth and help them develop the skills, knowledge and confidence to protect themselves and others from HIV/AIDS. Time in institutions also offers an opportunity for HIV/AIDS service providers to provide education and treatment to young people already living with HIV/AIDS.

Resources

General HIV/AIDS Resources, including Communities of Color

- National Minority AIDS Council website: www.nmac.org; phone: (202) 483-NMAC
- Centers for Disease Control and Prevention (CDC) <http://www.cdc.gov/hiv/>
- AIDS.gov website: www.aids.gov
- AIDSinfo. (HHS). <http://aidsinfo.nih.gov/> Health information specialists provide customized, confidential answers to questions about HIV/AIDS clinical trials and treatment. Spanish-speaking health information specialists are available.
Call: 1-800-448-0440, Monday to Friday from 12:00 p.m. to 5:00 p.m. (Eastern Time). Real time, online assistance, Monday to Friday 12:00 p.m. to 4:00 p.m. (Eastern Time), is also available at their website: <http://aidsinfo.nih.gov/LiveHelp/>
- National Prevention and Information Network (NPIN) <http://www.cdcnpin.org/>
- The Body: The Complete HIV/AIDS Resource website: www.thebody.com

HIV/AIDS Resources Relevant to Children and HIV/AIDS

- Vaccines for Children Program (Centers for Disease Control and Prevention): <http://www.cdc.gov/vaccines/programs/vfc/default.htm> or contact the National Immunization Hotline at (800) 232-2522
- Adolescent Health Resources (American Medical Association): <http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/adolescent-health.shtml>
- Children and HIV (New Mexico AIDS Education and Training Center); Also available in Spanish: <http://www.aidsinonet.org/factsheets/view/612>
- HIV and AIDS (Nemours Foundation): http://kidshealth.org/kid/health_problems/infection/hiv.html

- HIV Infection in Infants and Children (National Institute of Allergy and Infectious Diseases): <http://www3.niaid.nih.gov/topics/HIVAIDS/Understanding/Population+Specific+Information/children.htm>

HIV/AIDS Resources Relevant to Teenagers

- D'cisions: Drugs + HIV, Learn the Link (National Institute on Drug Abuse): <http://hiv.drugabuse.gov/english/message/webisodes.html>
- HIV and AIDS (Nemours Foundation): http://kidshealth.org/teen/sexual_health/stds/std_hiv.html
- HIV Infection in Adolescents and Young Adults in the U.S. (National Institute of Allergy and Infectious Diseases): <http://www3.niaid.nih.gov/topics/HIVAIDS/Understanding/Population+Specific+Information/hivadolescent.htm>
- How Do People Get AIDS? (Nemours Foundation); Also available in Spanish: http://kidshealth.org/teen/sexual_health/stds/AIDS.html

Additional resources can be found in the NMAC booklets: *Hitting the Bricks: Successful Reentry of Offenders Living with HIV/AIDS*, *HIV/AIDS Fundamentals: What You Need to Know*, and *Mental Health and Substance Abuse Among Offenders with HIV/AIDS*.

References

1. National Center for Juvenile Justice. (2008). *Juvenile Court Statistics 2005*. Authors: C. Puzzanchera and M. Sickmund.
2. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2009). HIV/AIDS surveillance—General epidemiology (through 2007). Retrieved June 6, 2009, from <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/general/index.htm>.
3. Hall H. I., Song, R., Rhodes, P., Prejean, J., An, Q., Lee, L. M., et al. (2008). Estimation of HIV Incidence in the United States. *Journal of the American Medical Association*, 300(5), 520–529.
4. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2009). *HIV/AIDS Surveillance Report, 2007*. Retrieved June 8, 2009, from <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>.
5. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. HIV/AIDS Surveillance in Adolescents and Young Adults (through 2007). (2009). Retrieved June 8, 2009, from <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/adolescents/index.htm>.
6. Department of Health and Human Services, NIAID Fact Sheet. HIV Infection in Adolescents and Young Adults. Retrieved July 19, 2009, from www.niaid.nih.gov/factsheets/hivadolescent.htm.
7. Rotheram-Borus, M. J., & Futterman, D. (2000). Promoting Early Detection of Human Immunodeficiency Virus Infection Among Adolescents. *Archives of Pediatrics & Adolescent Medicine*, 154(5), 435–439.
8. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2005). HIV Prevalence, Unrecognized Infection, and HIV Testing Among Men Who Have Sex With Men—Five U.S. cities, June 2004–April 2005. *Morbidity and Mortality Weekly Report*, 54, 597–601.
9. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. HIV/AIDS Surveillance in Adolescents and Young Adults (through 2007). Retrieved July 19, 2009, from <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/adolescents/index.htm>.
10. U.S. Department of Health and Human Services. Women & HIV/AIDS. Retrieved May 14, 2009, from <http://www.womenshealth.gov/hiv/women-at-risk/>.
11. Romero, E. G., Teplin, L. A., McClelland, G. M., Abram, K. M., Welty, L. J., & Washburn, J. J. (2007). A Longitudinal Study of the Prevalence, Development, and Persistence of HIV/Sexually Transmitted Infection Risk Behaviors in Delinquent Youth: Implications for Health Care in the Community. *Pediatrics*, 119, e1126–e1141.
12. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2009). Sexual and Reproductive Health of Persons Aged 10–24 Years—United States, 2002–2007. *Morbidity and Mortality Weekly Report*, 58(6), 1–58.

13. National Institute of Justice. (1996). HIV/AIDS and STDs in Juvenile Facilities. Washington, DC: National Institute of Justice.
14. Broussard, D., Leichter, J. S., Evans, A., Kee, R., Vallury, V., & McFarlane, M. M. (2002). Screening Adolescents in a Juvenile Detention Center for Gonorrhea and Chlamydia: Prevalence and Reinfection Rates. *The Prison Journal*, 82(1), 8–18.
15. Teplin, L. A., Mericle, A. A., McClelland, G. M., & Abram, K. M. (2003). HIV and AIDS Risk Behaviors in Juvenile Detainees: Implications for Public Health Policy. *American Journal of Public Health*, 93(6), 906–912.
16. Romero, E. G., Teplin, L. A., McClelland, G. M., Abram, K. M., Welty, L. J., & Washburn, J. J. (2007). A Longitudinal Study of the Prevalence, Development, and Persistence of HIV/Sexually Transmitted Infection Risk Behaviors in Delinquent Youth: Implications for Health Care in the Community. *Pediatrics*, 119, e1126–e1141.
17. Office of National Drug Control Policy. (2003). Juveniles and drugs.
18. Kantor, E. (2006). HIV Transmission and Prevention in Prisons. Retrieved June 9, 2009, from <http://hivinsite.ucsf.edu>.
19. W. Danks. (2003). Tattooing & You: The Safeguards Within Prison. Toronto: Prisoners HIV/AIDS Support Action Network.
20. Vanhems, P., Dassa, C., Lambert, J., Cooper, Perrin, L., Vizzard, J., et al. (1999). Comprehensive Classification of Symptoms and Signs Reported Among 218 Patients with Acute HIV-1 Infection. *Journal of Acquired Immune Deficiency Syndrome*, 21(2), 99–106.
21. Schacker T., Collier, A.C., Hughes, J., Shea, T., & Corey, L. (1996). Clinical and Epidemiologic Features of Primary HIV Infection. *Annals of Internal Medicine*, 125(4), 257–264.
22. Hecht, F. M., Busch, M. P., Rawal, B., Webb, M., Rosenberg, E., Swanson, M., et al. (2002). Use of Laboratory Tests and Clinical Symptoms for Identification of Primary HIV Infection. *AIDS*, 16(8), 1119–1129.
23. Daar, E. S., Little, S., Pitt, J., Santangelo, J., Ho, P., Harawa, N., et al. (2001). Diagnosis of Primary HIV-1 Infection. *Annals of Internal Medicine*, 134(1), 25–29.
24. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. How Can I Tell if I'm Infected with HIV? What Are the Symptoms? (2007). Retrieved June 9, 2009, from <http://www.cdc.gov/hiv/resources/qa/qa5.htm>.
25. Rawitscher, L. A., Saitz, R., & Friedman, L.S. (1995). Adolescents' Preferences Regarding Human Immunodeficiency Virus (HIV)—Related Physician Counseling and HIV Testing. *Pediatrics*, 96, 52–58.
26. Rand, C. M., Auinger, P., Klein, J. D., & Weitzman, M. (2005). Preventive Counseling at Adolescent Ambulatory Visits. *Journal of Adolescent Health*, 37(2), 87–93.
27. Murphy, D. A., Mitchell, R., Vermund, S. H., & Futterman, D. (2002). Factors Associated with HIV Testing Among HIV-Positive and HIV-Negative High-Risk Adolescents: The REACH Study. *Pediatrics*, 110(3), e36.
28. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (1998). Prevention and Treatment of Sexually Transmitted Diseases as an HIV Prevention Strategy. *The Body: The Complete HIV/AIDS Resource*.

29. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2003). Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings. *Morbidity and Mortality Weekly Report*, 52(RR01), 1–33.
30. Owen, B., & Bloom, B. (1997). Profiling the Needs of Young Female Offenders: A Protocol and Pilot Study. (1997). Retrieved June 9, 2009, from www.ncjrs.org/pdffiles1/nij/grants/179988.pdf
31. Bloom, B., Owen, B., & Covington, S. (2003). *Gender Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders*. Washington, DC: National Institute of Corrections.
32. Morash, M., Bynum, T. S., & Koons, B. A. (1998). *Women offenders: Programming Needs and Promising Approaches*. Retrieved June 9, 2009, from http://www.hawaii.edu/hivandaids/Women_Offenders_Programming_Needs_and_Promising_Approaches.pdf
33. AIDS Alliance for Children, Youth, and Families. (2003). *Serving Women in the Corrections System through Ryan White CARE Act Programs*. Washington, D.C.: AIDS Alliance for Children, Youth, and Families.
34. Boudin, K., Carrero, I., Clark, J., Flournoy, V., Loftin, K., Martindale, S., et al. (1999). ACE: A Peer Education and Counseling Program Meets the Needs of Incarcerated Women with HIV/AIDS Issues. *Journal of the Association of Nurses in AIDS Care*, 10(6), 90–98.
35. Zaplin, R. T. (Ed.). (2007). *Female Offenders: Critical Perspectives and Effective Interventions*, (2nd ed.). Sudbury, MA: Jones & Bartlett Publishers.



1931 13th Street, NW • Washington, DC 20009
202.483.NMAC (6622) • www.nmac.org

This publication was supported by cooperative agreement 5U65PS323703 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.