Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare, Detention and Juvenile Justice System

Approved By: Ronald E. Richter, Commissioner	**Date Issued:** 11/21/12	**Number of Pages:** 29	**Number of Appendices:** 5
Related Laws: N/A	**Children's Services Divisions/Provider Agency:** Children's Services Divisions of Child Protection; Family Support Services; Family Permanency Services; Youth and Family Justice; and Provider Agency Staff	**Contact Office/Unit:** For additional information on this policy please contact LGBTQ@dfa.state.ny.us	
Supporting Statutes and Regulations: • Foster Care - SSL 372, 373-a, 409-e, 409-f; 18 NYCRR 357.3, 430.12; • Preventive Services - SSL 409-a, 409-e, 409-f, 18 NYCRR 423.7 • CPS - SSL 422(4), (5), (6), (7); 422-a, and 424(4), (5); 18 NYCRR; • Adoption - DRL 114; SSL 373-a; 18 NYCRR 357.3, 421.2 (d), 421.18 • HIV- Public Health Law Article 27; • Domestic Violence - SSL 459-g; 18 NYCRR 452.10	**Supporting Standards:** ACS Foster Care Quality Assurance Standards 2011		
Bulletins & Directives: • OCFS PPM 3442.00 entitled *Lesbian Gay Bisexual and Transgender Youth* dated 3/17/08; • 09-OCFS-INF-06 entitled *Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender, and Questioning Children and Youth in Out-of-Home Placement,* dated 12/30/09.	**Related Policies:** • *Provision of Non-Medicaid Reimbursable Treatment or Services for Youth in Foster Care* – Policy 2010/04 dated 6/7/10 ; • Policy # 2011/02 entitled *Flexibility in Sleeping Arrangement Requirements for Sibling Foster Care Placements;* • *ACS Non-Discrimination – Youth and Families Policy # 2008/05;* • DJJ Operations Order # 06/03 entitled *Resident Personal Property and Grooming Paraphernalia;* DYFJ Directive # 17.1 entitled *Continuity of Care Policy and Procedures* • Children's Services Case Record Management Information Sharing Guidelines Guidance	**Supersedes:** This policy incorporates language from the following documents and hereby renders them obsolete: • Division of Child Protection Policy entitled *Assessing Safety of LGBTQ Children and Youth* dated 5/22/2009; • *Promoting a Safe and Respectable Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare System Policy #2011/05* dated 7/27/2011; and • *Guidelines for Promoting a Safe and Respectable Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved with DYFJ Directive #01-*	

	2009/04; • *Sharing Child Case Record Information between Children's Services, Foster Care and Preventive Provider Agencies* – Guidance 2008/01	*2011* dated 7/27/2011.

Related Forms/Links/Sources:

- **FSS-009- ACS LGBTQ Senior Advisor Form**
- **DYFJ- Resident Request for Ombudsman Services Form**
- http://10.239.3.195:8080/docushare/dsweb/Get/Document-137906/ACS LGBTQ Youth Community Resource Guide - August 2010.pdf
- Caitlin Ryan's Family Acceptance Project
- http://www.wpath.org/publications_standards.cfm
- http://www.endo-society.org/guidelines/final/upload/Endocrine-Treatment-of-Transsexual-Persons.pdf
- Teen SENSE Model Policies and Standards
- GLAAD Media Reference Guide: http://www.glaad.org/reference/lgb; and http://www.glaad.org/reference/transgender

SUMMARY:

Children's Services is committed to providing all youth[1] and families served by Children's Services and our contracted provider agencies a safe, healthy, inclusive, affirming and discrimination-free environment. This includes any child, youth or family member receiving services from Children's Services Protective, Preventive, Foster Care, Juvenile Justice Placement, Detention, or Alternative to Detention (ATD) and Alternative to Placement (ATP) settings, who self-identifies as or is perceived to be lesbian, gay, bisexual, transgender and questioning (LGBTQ). This LGBTQ policy provides best practice guidelines to both Children's Services and provider agency staff on sensitive, respectful and culturally competent practice as well as strategies to address bias and meet the unique needs of youth and their families.

SCOPE:

This Policy applies to all Children's Services staff, as well as provider agency staff responsible for providing services to youth and families within the purview of Children's Services.[2] The provision of services within Children's Services' facilities and programs shall be based on professional standards as found in the New York State Office of Children and Family Services (OCFS) Guidelines for Good Childcare Practices with Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth,[3] and the OCFS policy entitled *Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender, and Questioning Children and Youth in Out-of-Home Placement* (09-OCFS-INF-06, 12/30/09). Additionally, this policy incorporates language from the Division of Child Protection Policy entitled *Assessing Safety of LGBTQ Children and Youth,* 5/22/2009; *Promoting a Safe and Respectable Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare System,* 7/27/2011; and *Guidelines for Promoting a Safe and Respectable Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved with DYFJ Directive 01-2011,* 7/27/11. All three policies are hereby rendered obsolete.

[1] For the purpose of this policy all references to "youth" and/or "children" will apply to youth/children receiving custodial and/or community-based services from Children's Services, including children and youth receiving any and all child protective and preventive services, youth in alternative-to-detention/placement programs, youth in foster care placements, youth in juvenile justice placement, and youth in detention facilities.

[2] All references to staff in this policy include volunteer staff where applicable.

[3] These guidelines are listed in the OCFS PPM 3442.00 entitled *Lesbian Gay Bisexual and Transgender and Questioning Youth,* dated 3/17/08.

Table of Contents

I. General Information About The Term "LGBTQ"

A. Definitions[4]

LGBTQ[5] is an acronym commonly used to refer to lesbian, gay, bisexual, transgender, and questioning individuals. In order to ensure the broadest levels of protection under this policy, LGBTQ youth shall include youth who have self-identified or are perceived by others as LGBTQ. The following is an explanation of each of the terms used to define LGBTQ:

1. Lesbian - refers to a woman who is emotionally, romantically, and/or physically attracted to other women. Some lesbians may prefer to identify as gay to describe themselves or as gay women.

2. Gay - refers to a person who is emotionally, romantically, and/or physically attracted to people of the same gender. Sometimes, it may be used to refer to gay men and boys only. It is preferred over the term "homosexual," which is an outdated term considered derogatory and offensive to many LGBTQ people.

3. Bisexual - refers to a person who is emotionally, romantically, and/or physically attracted to men and women. Bisexual people do not need to have had sexual experiences with both men and women; in fact, they do not need to have had any sexual experience at all to identify as bisexual.

4. Transgender - may be used as an umbrella term to include all persons whose gender identity or gender expression does not correspond with their sex assigned at birth. For purposes of protection from discrimination and harassment, transgender refers to both self-identified transgender individuals and individuals perceived as transgender without regard to whether they qualify for a diagnosis of Gender Identity Disorder.

5. Questioning - refers to a person, often an adolescent, who is exploring or questioning issues of sexual orientation or gender identity or expression in his or her life. Some questioning people will ultimately identify as lesbian, gay, bisexual and/or transgender; others will ultimately self-identify as straight and/or non-transgender.

B. Sexual Orientation vs. Gender Identity

Sexual orientation and gender identity are two different constructs because sexual orientation is separate from gender identity. If someone identifies as

[4] A more comprehensive definition section is included in Attachment A: Glossary of Terms.
[5] For some youth the Q can represent "queer" and at times is used interchangeably with "Questioning."

transgender he/she may also identify his/her sexual orientation as straight, gay, lesbian, or bisexual. Youth may also identify differently on different days, as they continue to develop their identities. It is important for staff to understand that children and adults whose identity is fluid may be exploring their identity and/or may simply be expressing their sexual orientation or gender identity. Please refer to Attachment A for a glossary of other LGBTQ related terms.

II. General Policy

A. Applicability of General Requirements and Guidelines

It is ACS policy that all LGBTQ youth shall be in LGBTQ-affirming homes and LGBTQ-affirming congregate facilities. The following requirements and guidelines apply to all Children's Services and contracted provider agency staff involved in any way with custodial and/or community-based services provided directly by Children's Services staff or under contract with Children's Services, including child protective and preventive services, alternative-to-detention/placement programs, foster care, congregate care, juvenile justice placements, and detention facilities.

B. Non-Discrimination

Children's Services is committed to being respectful of the dignity of all youth and families, and to keeping children and youth (hereinafter referred to as "youth") safe while meeting their unique needs, regardless of their sexual orientation, gender identity and/or gender expression. No Children's Services or provider agency staff shall unlawfully discriminate against other persons in the course of their work. The Children's Services policy entitled *Non-Discrimination -Youth and Families Guidance 2008/05* (6/20/08) prohibits discrimination on the basis of race, ethnicity, creed, color, age, sex, national origin, religion, marital status or partnership, mental or physical disability, gender identity, gender expression, sexual orientation, veteran status, alienage and citizenship status.

C. Coercion and Imposition of Beliefs

1. Under no circumstance is any staff member of Children's Services or its provider agencies to attempt to convince an LGBTQ youth to reject or modify his/her sexual orientation or gender identity. Medical and mental health professional organizations, including the National Association of Social Workers, the American Psychiatric Association, the American Academy of Pediatrics, the American Medical Association, and the American School Counselor Association strongly condemn any attempt to "correct" or change youths' sexual orientation or gender identity through corrective or reparative therapy. Additionally, staff are prohibited from attempting to convince or coerce an LGBTQ youth to disclose or reveal his/her sexual orientation or gender identity only out of

curiosity, or for any other reason not listed as permissible in the section below entitled, *"Disclosure by youth and/or family members"* [see Section II (H)].

2. Children's Services and provider agency staff are prohibited from imposing their personal, organizational and/or religious beliefs on all families, including LGBTQ youth or families. Personal beliefs of Children's Services and provider agency staff shall not under any circumstances impact the way individual needs of youth or families are met.

3. Children's Services and provider agency staff are prohibited from employing, contracting with, or making referrals to, mental health providers and/or other service providers who attempt to change a youth's sexual orientation or gender identity. (Attachment C provides a list of recommended LGBTQ affirming providers).

D. Staff Conduct

1. Children's Services and provider agency staff must model appropriate and affirming behavior at all times. This means that bias, discrimination, bullying or harassment by staff or by youth towards youth and/or families is not tolerated, and immediate action to intervene in any such situations must be taken by staff. Children's Services and provider agency staff are obligated to report staff conduct that violates the Non-Discrimination Policy and/or this policy. If an issue arises, the staff member must confer with his/her supervisor and, if unresolved, contact the Children's Services LGBTQ Senior Advisor. (See section on *Expectations for the ACS LGBTQ Senior Advisor* for additional information).

E. Addressing Incidents

1. Supervisory and management staff must treat all incidents of discrimination and harassment as serious and follow up promptly. In accordance with Children's Services' policy and procedures, alleged violations of this policy by staff or youth will be investigated promptly and, if determined to have occurred, will result in the enforcement of corrective and/or disciplinary action.

F. Guidelines for Staff Interaction with Youth

1. Safety and security, as well as good childcare practices, remain paramount for all youth in care. Children's Services and provider agency staff shall establish and maintain a culture where the dignity of every youth is respected and all youth feel safe. All youth, regardless of gender identity, gender expression, and/or sexual orientation, need to feel safe in their surroundings in order for positive programming and outcomes to occur.

a. Policies must be established and enforced to promote dignity and respect for all youth and families regardless of their gender identity, gender expression, sexual orientation, or family association.

b. All Children's Services and provider agency staff must promote the positive adolescent development of all youth by demonstrating respect for all youth, reinforcing respect for differences among youth, encouraging the development of healthy self-esteem in youth, and helping youth manage the stigma often associated with difference.

c. Staff must not over-emphasize or focus specifically on gender identity, gender expression, and sexual orientation issues with youth.

d. Staff must set a good example and make youth and families aware that any anti-LGBTQ threats of violence, and/or disrespectful, suggestive comments or gestures towards any youth will not be tolerated. Staff also shall not engage in these behaviors.

e. Staff shall be aware that the psychosocial stress associated with explicit and implicit homophobia, heterosexism, and transphobia, and the stigma associated with being LGBTQ youth, may contribute to depression and anxiety, increased suicide risk, substance use, and truancy or dropping out of school.

f. Staff must be familiar with the unique family dynamics that emerge for LGBTQ youth in general, and LGBTQ youth involved with the child welfare and/or juvenile justice systems in particular, and recognize that many LGBTQ youth involved in the juvenile justice system have child welfare histories that precede or have resulted from recognition of sexual orientation and/or gender identity by self and others. All staff must recognize that family responses to youth sexual orientation and/or gender identity may vary widely and interact with other aspects of youth and families' identities including race, class, gender, citizenship, etc.

g. All staff must be aware that many LGBTQ youth, particularly those involved with the child welfare and/or juvenile justice systems, have had experiences of trauma (e.g. violence, sexual abuse, verbal harassment, etc.) related to their sexual orientation and/or gender identity and should receive ongoing clinical training specific to these unique forms of trauma. Staff must also be aware that LGBTQ youth are particularly susceptible to trauma, discrimination and abuse, especially within congregate care facilities. Staff must be able to recognize signs of distress, support disclosure when appropriate, and follow appropriate protocols for reporting.

G. LGBTQ Identities, Language and Terminology

1. All individuals have their own preferences for how they describe themselves, which often evolve over time. All Children's Services and provider agency staff are required to use respectful, inclusive, and gender-neutral language. Examples of such language include, but are not limited to: lesbian, gay, bisexual, transgender, gender non-conforming, sexual orientation, gender identity, "involved with someone," and "partner."

2. Staff are prohibited from using value-laden and outdated terms, including but not limited to: "homo," "homosexual," "sexual preference," "alternative lifestyle," "trannie," "transvestite," and "sex change."

3. Since some terms may be acceptable and/or preferable to one person and offensive to another, staff must reflect/mirror the language and terminology employed by that youth or family member (when appropriate) during one-on-one interaction. Staff must help all youth and family members use language that is respectful to all parties. (For an explanation of LGBTQ-related terms, see the *Glossary of Terms* - Attachment A*)*.

H. Confidentiality

1. LGBTQ youth face great risk of abuse when their sexual orientation and/or gender identity are disclosed to a parent or primary caretaker, particularly when the disclosure occurs without the youth's consent and/or in an inappropriate manner.[6] As such, the following proscriptions concerning confidentiality and disclosure – which govern all information obtained by staff in the course of their work with all youth and families -- must be followed carefully when staff are working with LGBTQ youth.

2. CONNECTIONS has safeguards incorporated into its design to support the confidentiality of the individual and family case record. Federal statutes and numerous sections of the Social Services Law (SSL), the Public Health Law (PHL) and the New York Codes, Rules and Regulations (NYCRR) address the issue of confidentiality.[7]

---

[6] This often includes, but is not limited to, serious physical harm, homelessness, substance abuse and mental health conditions such as depression.

[7] E.g. Foster Care - SSL 372, 373-a, 409-e, 409-f; 18 NYCRR 357.3, 430.12; Preventive Services - SSL 409-a, 409-e, 409-f, 18 NYCRR 423.7; CPS - SSL 422(4), (5), (6), (7); 422-a, and 424(4), (5); 18 NYCRR ; Adoption - DRL 114; SSL 373-a; 18 NYCRR 357.3, 421.2 (d), 421.18; HIV- Public Health Law Article 27-F; 18 NYCRR 421.2 (d), 431.7; Domestic Violence - SSL 459-g; 18 NYCRR 452.10.

3. All staff are required to protect and/or maintain the confidentiality of the families they serve.

4. ACS and provider agency staff shall inform youth during engagement of services and when age-appropriate of the need for their case record information to be shared with other legally authorized individuals, including but not limited to, the courts, school, medical services, agency staff, and all other legally authorized persons. These people/entities may be provided with specific information, pursuant to state and federal laws governing confidentiality, so they may fulfill their responsibilities; adequately provide services; and plan for the health, safety, permanency and well-being of youth and their families.

5. Staff are prohibited from disclosing a youth's sexual orientation or gender identity to other individuals or agencies, without the youth's permission, unless such disclosure is consistent with state or federal law or regulation.[8] Some examples of permissible disclosure include: if the information is necessary to determine safety or if a judge orders the disclosure.

I. Disclosure by Youth and/or Family Members

1. A person may disclose his/her sexual orientation and/or gender identity to staff when, and if, he/she feels ready. Usually, youth and/or family members will disclose in a safe, trusting environment. If a youth or family member discloses that he or she is LGBTQ, staff must speak with him or her about it utilizing appropriate, inclusive and gender-neutral language. Staff must also speak to the youth about circumstances in which the staff member may be required to disclose the LGBTQ status of the youth and whether there may be circumstances where the staff member will ask the youth for permission to disclose his/her sexual orientation and/or gender identity.

2. There are some circumstances when it is appropriate for staff to try affirmatively to provide an opportunity for youth to disclose that they are LGBTQ. Often, this will be raised when discussing the need for residential and/or foster care placement options and medical and/or community supports. This information may also prove relevant to decisions regarding educational services, the PINS and delinquency diversion processes, disposition, reunification and placement. If the staff member is unsure about how best to raise these issues with a youth and/or family member, the staff member must contact for guidance the ACS LGBTQ Senior Advisor. Provider agency staff may also reach out to their supervisors and/or their agency's LGBTQ Point Person (see Section III[L] beginning on page 26 for guidance).

[8] See 05-OCFS-ADM-02 relating to confidentiality of records.

J. Use of Preferred Name

1. All youth may request that Children's Services and provider agency staff use a preferred first name, and the gender with which they identify if applicable, rather than their legal name. All staff are required to comply with such requests; and youth can report noncompliance to the LGBTQ Point Person at the provider agency or directly to the ACS LGBTQ Senior Advisor. Youth must also be referred to by the pronoun that they state reflects their preferred gender identity or expression.

2. When a young person requests the use of a preferred first name and/or preferred gender pronoun, Children's Services and provider agency staff must ask the youth which name (legal name or preferred name) and gender pronouns Children's Services and provider agency staff should use to refer to the youth in conversations with the youth's family, and which name (legal or preferred) and gender pronouns staff should use to refer to the youth in conversations with other service providers (e.g. community-based service providers, Department of Education, or other related agencies, etc.) and the Family Court. Please see the section below entitled, "Documentation," regarding the requirements for documenting these preferences in Connections ("CNNX") or other systems of record.

3. Staff must comply with the youth's requests regarding name and pronoun at all times. Use of the incorrect name or pronoun may pose safety risks to youth who have not disclosed their gender identity to family members, friends, other services providers, and/or the Family Court. If necessary, staff must reiterate the proscriptions regarding confidentiality above when discussing the use of preferred names and/or pronouns with youth.

4. When discussing name and pronoun preference with young people the following questions can be used to assist the dialogue:
   a. Which name would you prefer for me to use when I call your family?
   b. Which gender pronoun should I use for you when I call your family?
   c. When I call your family, would you feel safer if I used your legal name or your preferred name?

5. Staff must periodically check in with young people to see if it is still safe for staff to refer to them by their name and/or pronoun of choice when calling parents/guardians.

K. Documentation

1. When documenting progress notes in Connections (CNNX) or other systems of record, the worker must use the youth's legal name followed by the preferred name (e.g. John a/k/a Jennifer). Staff must also clearly indicate which name is preferred and in which situations, and which name is the legal name. Children's Services and provider agency staff must inform the youth about who will have access to these documents before they are disseminated.

2. Children's Services and provider agency staff must reach out to the assigned Children's Services Family Court Legal Services attorney if records are being produced or subpoenaed by the court and the youth's different names are noted in the records. If the youth is requesting that certain names be kept confidential from the Court, this issue must be raised with the FCLS attorney as soon as the issue arises and before each court date, so that the attorney can determine whether to request that the Court redact the records before they are provided to the other parties (e.g. the parent[s]) involved in the court case.

3. All pertinent documentation under the control of Children's Services and provider agency staff must have both the legal and preferred name of the youth, and clearly indicate which name is preferred and which name is the legal name.

L. LGBTQ-Affirming Literature and Written Materials

1. Children's Services and provider agency staff must make available LGBTQ affirming literature and resources to all youth and families served by the agencies. LGBTQ-affirming literature includes but is not limited to:

   a. written and verbal information regarding respect for, and supports available to, LGBTQ youth,
   b. website list of community resources supports,
   c. other appropriate books and materials,
   d. the youth's rights and responsibilities and the procedures for reporting complaints, and
   e. a copy of this policy where age appropriate shall be given to all youth. Regardless of age-appropriateness or literacy level, the policy must be explained to each youth upon admission to detention, juvenile justice placement, foster care, and congregate care settings. Only staff familiar with the policy and terminology within shall explain the policy to youth.

2. Programs must affirm the identity of each youth by creating supportive environments (e.g. incorporating LGBTQ culturally specific art or social events, such as "LGBTQ Pride" into the general schedule or curriculum). This will indicate that staff and foster parents are knowledgeable of and open to communication on this topic. Educational books and other reading materials for youth interested in learning more about LGBTQ issues must be made available to

youth in foster care and facilities. Materials must be made available in languages other than English, as needed, and as funding is available.[9]

3. Children's Services and provider agencies must display LGBTQ literature and visible signage providing information about the contact information for the ACS LGBTQ Senior Advisor and the provider agency's designated LGBTQ Point Person (see section on *Provider Agency LGBTQ Point Person Expectations)* in common areas that are visible to all staff, youth, and families.

M. Advocacy

1. The Children's Services Office of Advocacy can be used as a resource for LGBTQ youth receiving any services – community-based or custodial – that have questions. Information about the Office of Advocacy may be accessed at http://www.nyc.gov/html/acs/html/advocacy/office_advocacy.shtml or at the Parents and Children's Rights Helpline at (212) 676-9421.

2. The attached *LGBTQ Rights* flyer (Attachment B) can also be used as a supplemental resource for the youth. Additionally, Children's Services has a comprehensive *Community Resource Guide for LGBTQ Youth* which is available electronically (via DocuShare at the following link http://10.239.3.195:8080/docushare/dsweb/Get/Document-137906/ACS LGBTQ Youth Community Resource Guide - August 2010.pdf) and in hard copy (both in document and pocket size). LGBTQ youth and families can also call 311 for further information.

N. Service Referrals

1. All Children's Services and provider agency staff are responsible for referring youth and families for counseling, health, mental health, or other services as needed and appropriate, regardless of a youth's sexual orientation, gender identity, or gender expression. If a youth discloses that he or she is LGBTQ, the youth must be offered the opportunity for counseling and information regarding LGBTQ-appropriate health, and mental health or other services. Referrals to community-based providers who can supplement Children's Services and/or provider agency services, must be made when appropriate.

2. When discharge and transition planning, staff /supervisory staff must refer youth who identify as LGBTQ to community-based providers who have demonstrated that they are culturally competent in working with LGBTQ youth. If a youth who identifies as LGBTQ is referred to a community-based provider which staff

[9] See Executive Order 120 entitled Citywide Policy on Language Access to Ensure the Effective Delivery of City Services dated July 22, 2008.

become aware is not culturally competent in working with LGBTQ youth, staff must inform the youth and provide the youth with other LGBTQ community-based resources to which the youth can turn for assistance. If the youth's gender identity and/or sexual orientation is known to the family or other caretakers to whom the youth is returning/residing, the family must be given this information as well.

3. When making these referrals, staff must recognize that many youth are exploring their sexual orientation, gender identity, and/or gender expression, and that youth may not know all relevant terminology, or may be questioning their own sexual orientation and/or gender identity.

O. Medical and Mental Health Assessments and Services

1. The following requirements and guidelines shall be followed by all clinicians when conducting medical and/or mental health assessments of, providing medical and/or mental health services to, or arranging the provision of medical and/or mental health services to, youth.[10]

   a. Clinicians working with youth must facilitate exploration of any LGBTQ issues by being open, non-judgmental, and empathetic. If the mental health clinicians are not Children's Services or provider agency staff, the Children's Services and/or provider agency staff working with mental health clinicians who are providing services to youth must explore the clinicians' attitudes and opinions towards LGBTQ people to confirm that they can provide services that are open, non-judgmental, and empathetic.

   b. Clinicians must not assume any mental illness/pathology because a youth identifies as LGBTQ or is gender non-conforming. Clinicians must also recognize that all adolescents experience developmental and social challenges during those years; however, LGBTQ youth face additional pressures based on their gender identity or sexual orientation.

   c. Clinicians must be aware that the psychosocial stress associated with explicit and implicit homophobia, heterosexism, and transphobia, and the stigma associated with being LGBTQ youth, may contribute to depression and anxiety, increased suicide risk, substance use, and truancy or dropping out of school.

[10] Per applicable regulations, all youth in foster care, detention, and juvenile justice placement must receive a comprehensive medical and mental health screening upon entry into custodial care, and as needed while in Children's Services' custody, so that individual needs are identified and a treatment response provided. Proscriptions regarding hormone therapy are included below in Section III of this policy.

d. Clinicians must be familiar with the unique family dynamics that emerge for LGBTQ youth in general, and systems involved with LGBTQ youth in particular, and recognize that many LGBTQ youth are in the child welfare and/or juvenile justice systems due to stigma related to their sexual orientation, gender expression, or gender identity.

e. Clinicians must also recognize that many LGBTQ youth are in the child welfare, and/or juvenile justice systems for reasons other than their sexual orientation, gender expression, or gender identity. Clinicians must recognize that family responses to youth's sexual orientation and/or gender identity may vary widely and interact with other aspects of youth and families' identities including race, class, gender, citizenship, etc. Clinicians must therefore employ a comprehensive approach to counseling and facilitate family reconciliation where indicated and possible.

f. Clinicians must be aware that many system-involved LGBTQ youth have had experiences of trauma (e.g. violence, sexual abuse, verbal harassment, etc.) related to their sexual orientation and/or gender identity. Therefore, clinicians must receive ongoing clinical training specific to these unique forms of trauma. Clinicians must also be aware that LGBTQ youth are particularly susceptible to trauma, discrimination and abuse within residential care facilities and must be able to recognize signs of distress, and support disclosure where appropriate, as well as to follow appropriate protocols for reporting.

g. Clinicians must be prepared to help LGBTQ youth explore their feelings about their gender identity and/or sexual orientation along with related issues and questions in a safe and affirming manner. Clinicians shall be familiar with community resources available to LGBTQ youth for the purposes of both collaboration and referral.

h. Clinicians shall be trained and become versed in World Professional Association for Transgender Health's Standards of Care for Gender Identity Disorders (WPATH Standards of Care for the Health of Transsexual Transgender, and Gender Non-conforming People),[11] and the Endocrine Society's Clinical Guidelines on the Endocrine Treatment of Transsexual Persons (2009)[12] and be able to meaningfully integrate counseling and mental health services with medical care that transgender and gender non-conforming youth may be receiving. (Please refer to Attachment C for a list of suggested clinicians within New York that meet these criteria).

---

[11] See http://www.wpath.org/publications_standards.cfm for complete WPATH Standards.

[12] For complete guidelines See http://www.endo-society.org/guidelines/final/upload/Endocrine-Treatment-of-Transsexual-Persons.pdf

i. All clinicians must be made aware that nearly every professional organization within the mental health and medical fields, including the National Association of Social Workers and the American Psychiatric Association, strongly condemn any attempt to "correct" or change youth's sexual orientation or gender identity through corrective or reparative therapy. Attempts to do so are strictly prohibited by this policy (See Section II [B]).

j. Where medically indicated as for all youth, the program clinical staff working with LGBTQ youth must refer the youth to an appropriate specialist.

k. All clinicians must be told by the provider agency either by phone prior to the appointment or when accompanying the youth to the medical or mental health appointment that Children's Services' policy is that youth may only be asked about behaviors, not identities, to appropriately screen and treat for medical conditions. For example, when youth are screened for sexual activity, they shall be asked the sex of sexual partners, rather than whether the young person identifies as LGBTQ. Contracted medical service providers must also provide to their patients appropriate medical information and education for all youth, inclusive of any related to LGBTQ medical and mental health issues.

l. With the exception of emergency medical treatment where following these proscriptions is not possible, all clinicians to which youth are referred shall receive a copy of this policy (one copy, at the first appointment, is sufficient). The provider agency must also confirm with the clinician, prior to the youth receiving clinical services, that the clinician has received professional LGBTQ cultural competency training tailored to the medical profession.[13]

P. Training

1. All Children's Services and provider agency staff and foster parents having direct contact with children and families are required to be trained on the goals and expectations of this policy.[14] Training shall be provided to staff during the staff's initial orientation, and at least once every two (2) years thereafter.

2. The Children's Services' and provider agencies' curriculum shall include but not be limited to:

   a. assessing, identifying, and addressing the specific needs of LGBTQ youth and their families;

[13] As such providers are expected to use contractors that meet the same requirement.
[14] It is expected that all provider agency staff will be trained on the goals and expectations of this policy within one year of the policy issue date.

b. recognizing the difference between their personal values and their professional responsibilities;
c. implementing this ACS LGBTQ Policy and related policies;[15]
d. developing the skills needed to assist families in negotiating the difficulties that may emerge when an adolescent self-identifies as LGBTQ;
e. demonstrating sensitivity when addressing this issue with parents, and helping parents to sustain a positive and healthy relationship with their child; and
f. for supervisory staff, monitoring the implementation of this policy and related services.

3. Training may be provided in a classroom setting, or using various technology resources (e.g. e-learning, webinars, or teleconference).

4. LGBTQ training curriculums must be vetted by ACS. Curriculums shall be sent to LGBTQ@dfa.state.ny.us for approval. In collaboration with the James Satterwhite Academy, provider agencies, and the LGBTQ advocacy and provider community, Children's Services may be available to assist in the provision of training concerning LGBTQ cultural competency, and working with LGBTQ youth and families.

III. Requirements and Guidelines for Specific Divisions and/or Program Areas

A. Applicability of Special Requirements and Guidelines

While the general requirements and guidelines above apply to all Children's Services and provider programs, there are additional requirements and guidelines that are unique to specific Children's Services and provider program areas. The following provides expectations of all Children's Services and provider agency staff within the stated program areas.

B. Children's Services Division of Child Protection ("DCP") Staff Conducting Child Protective Investigations

1. Safety and Risk Assessments

a. When assessing the safety and risk of an LGBTQ youth, Children's Services staff within DCP[16] must, in addition to looking for other safety factors, assess whether a parent's attitude about the child's actual or perceived sexual

[15] This ACS Policy *on Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families involved in the Child Welfare, Detention, and Juvenile Justice System; ACS Non-Discrimination Policy,* and *ACS Non-Medicaid Reimbursable Policy.*

[16] Although this refers only to Child Protective Services staff within the Division of Child Protection, safety assessments of this nature, and the proscriptions and requirements contained within this policy with respect to such assessments,

orientation and/or gender identity is contributing to the parent's behavior, and in turn, whether the parent's behavior impacts the child's safety or places the child at risk.

b. Children may experience maltreatment on the basis of a caretaker's *perception* of the child as being LGBTQ, regardless how the child identifies. Occasionally, youth who are not LGBTQ are perceived by others to be LGBTQ and abused and/or neglected as a result. This may even be true for very young children and toddlers who behave in gender atypical ways (e.g. boys who play with dolls or girls who play with trucks) but are too young to identify as LGBTQ.

2. Interviewing an LGBTQ Youth

   a. Often, LGBTQ youth experience hostility and rejection in their home (or other places where their families might not be able to protect them) based upon their actual or perceived sexual orientation and/or gender identity. This hostile atmosphere might not be apparent to the Child Protective Specialist (CPS), so appropriate measures must be taken to speak privately with the youth during child protective investigations. The CPS should use sensitive and inclusive language that signals to the young person that he/she will be treated with respect and dignity, regardless of how he/she identifies.

3. Interviewing the Parent/Caretaker of an LGBTQ Youth

   a. As noted above, LGBTQ youth face great risk of abuse when their sexual orientation and/or gender identity are disclosed to a parent or primary caretaker, particularly when the disclosure occurs without the youth's consent and/or in an inappropriate manner. CPS interviews with parents may include a discussion of the child's actual or perceived sexual orientation/gender identity only when the youth has already identified openly as LGBTQ to the parents (or other primary caretaker) and the alleged abuse/and or maltreatment are directly related to the child's perceived or actual sexual orientation, gender expression, or gender identity. In this instance:

      i. The CPS must focus the investigation on eliciting from the parents their attitudes and beliefs about LGBTQ people.
      ii. The CPS may not divulge to the parents any personal details the youth may have told the CPS about his or her sexual orientation or gender identity, without the express consent of the youth.
      iii. If the parent displays negative attitudes about LGBTQ people, even when deeply rooted in religious beliefs and cultural values, and the alleged abuse

---

also apply to mandated reporter staff throughout Children's Services when they are conducting safety and risk assessments.

and/or maltreatment are related to the youth's perceived or actual sexual orientation, gender expression, or gender identity, the CPS must determine whether those attitudes are impacting the youth's immediate safety, as well as whether those attitudes may put the youth at risk for future physical or emotional harm.

4. Completing the Safety Assessment of an LGBTQ Youth in CONNECTIONS (CNNX)

   a. The parent/caretaker's attitude about the child's actual or perceived sexual orientation and/or gender identity, as well as the behaviors that stem from that attitude, must be carefully considered when identifying safety factors in cases involving LGBTQ youth. When documenting the youth's safety assessment in CNNX, the CPS must select the applicable safety factors. For example:

      i. If a parent will only allow the child to remain in the home if the child is "straight": Safety Factor 7 (Parent/Caretaker is unable and/or unwilling to meet the children 's needs for food, clothing, shelter, medical or mental health care and/or control child's behavior) must be chosen;

      ii. If a parent is verbally abusive to the child, ostracizes the child, ridicules, or belittles the child: Safety Factor 10 (Parent(s)/Caretaker(s) view, describe or act toward the child(ren) in predominantly negative terms and/or have extremely unrealistic expectations of the child(ren)) must be chosen;

      iii. If a parent will not allow the child to dress in a manner in accordance with his/her gender identity: Safety Factor 10 (Parent(s)/Caretaker(s) view, describe or act toward the child(ren)in predominantly negative terms and/or have extremely unrealistic expectations of the child(ren)) must be chosen; and

      iv. If the child is afraid to remain in the household out of fear that the parent may harm the child, or allow the child to be harmed: Safety Factor 14 (Child(ren) expresses or exhibits fear of being in the home due to current behaviors of Parent(s)/Caretaker(s) or other persons living in or frequenting the household) must be chosen.

   b. As with any other safety assessment, the assessment must focus on the behaviors the caretaker is displaying that impact the safety of the child and/or place the child at risk of physical and/or emotional harm. Neither a child or youth's actual or perceived sexual orientation and/or gender identity, nor the parent's cultural and/or religious beliefs, excuses a parent's or caretaker's abusive or neglectful behavior.

c. Safety planning for LGBTQ youth must include interventions that will cause the youth to be both physically and emotionally safe.

C. Preventive Services[17]

1. When Children's Services and provider agency preventive services staff come in contact with youth and families that identify as LGBTQ, the following guidelines shall be followed:

   a. Staff involved with preventive services shall help stabilize and create safety for LGBTQ youth in their homes to prevent out-of-home placement for LGBTQ youth whenever possible. This work shall include providing LGBTQ specific community resources to youth and families for support (e.g. a copy of the ACS LGBTQ Community Resource Guide.)[18]

   b. Staff shall carefully consider the parent/caretaker's attitude towards the child's actual or perceived sexual orientation, gender identity, and other related behaviors throughout the life of the case when identifying possible safety factors in a family receiving, or being recommended for, preventive services. This shall be done on an ongoing basis by engaging parents/caretakers and informing them that family rejection is a strong predictor of negative health outcomes (e.g. mental health, substance abuse and sexual risk). It is also essential to emphasize that a continued relationship with some level of acceptance and understanding is critical to the health of the child.[19]

2. If a case is referred to preventive services because of an LGBTQ-specific issue and the determination of the preventive provider agency, at intake or at any time throughout the life of the case, is that this is not a case that can be appropriately serviced by the agency because the agency lacks sufficient expertise in LGBTQ issues, the preventive provider shall communicate this to the ACS LGBTQ Senior Advisor via the LGBTQ Senior Advisor Request Form (Form FSS-009) (see section on Advocacy and Incident Reporting Procedures for Youth for additional information).[20] These requests must be sent to LGBTQ@dfa.state.ny.us.

---

[17] This applies to all Preventive ACS and provider agency staff that provide services to youth and families who self-identify as or are perceived to be lesbian, gay, bisexual, transgender and questioning (LGBTQ). This includes all preventive services procured by Children's Services, including but not limited to, the Juvenile Justice Initiative and Family Assessment Program within the Division of Youth and Family Justice.

[18] Provider agency staff can access this document via DocuShare at http://10.239.3.195:8080/docushare/dsweb/Get/Document- 137906/ACS LGBTQ Youth Community Resource Guide - August 2010.pdf

[19] See Caitlin Ryan's Family Acceptance Project.

[20] For additional information on LGBTQ Senior Advisor, see section on *ACS LGBTQ Senior Advisor*.

3. As in all preventive cases, when eliciting information from a child's parent or other caretaker, a worker must take the necessary steps and actions to verify that a child is not left in neglectful circumstances. Once the conversation has occurred, the preventive staff shall make strong efforts to interview the youth, apart from the parents/caretakers, because youth are in the best position to determine whether they feel comfortable in their home. If a preventive worker has reasonable cause to suspect that a child is an abused or maltreated child, the worker must make a report to the Statewide Central Register of Child Abuse and Maltreatment, consistent with his/her mandated reporting responsibility.

4. The preventive provider agency will report each and every incident of LGBTQ-related bias, harassment and/or abuse to the ACS LGBTQ Senior Advisor via form FSS 009 and the ACS LGBTQ Senior Advisor will keep track of incidents and how they are handled.

D. General Responsibilities for LGBTQ Youth in Foster Care, Congregate Care, Detention and Juvenile Justice Placement Settings

1. When a youth who identifies as LGBTQ enters foster care, congregate care, detention and/or juvenile justice placement settings (hereinafter referred to as "Children's Services custodial care"), staff must make diligent efforts to place the youth in an LGBTQ affirming home or facility, and shall ensure that other needs of the youth are recognized and met.[21]

2. Staff shall also ensure that the families and facilities that are providing an LGBTQ affirming home/environment for youth are given the support needed to provide optimal care for LGBTQ youth.

3. All youth shall be held to the same standards of age-appropriate behavior. Standards regarding romantic and sexual behavior shall be applied evenhandedly, regardless of sexual orientation or gender identity. Staff must maintain boundaries for safe and appropriate behavior with all residents. Staff must not respond in a more punitive or more lenient manner to any inappropriate behavior related to dating or sex that is not permitted in Children's Services custodial care. The same consequences apply to all youth, including LGBTQ youth, who violate these rules.

4. All youth must be included in all activities for which they are eligible and show a positive interest. Encouraging or discouraging participation in activities on the basis of the sexual orientation and/or gender identity of the youth is prohibited.

[21] An LGBTQ- affirming home or congregate care setting is one with foster parents and/or staff who welcome LGBTQ youth, treat them with respect and dignity, and diligently work to meet their unique needs.

E. Mental Health Services in Congregate Care Settings, including Congregate Care Foster Care Settings, Juvenile Justice Placement, and Detention

1. In addition to the general guidelines for mental health assessments and services outlined in Section II(N) Children's Services and provider agency staff in congregate care settings must provide psycho-educational awareness-raising sessions for the entire youth population in the residential settings. These sessions shall engage youth in a meaningful dialogue about the concepts of homophobia and transphobia, and the importance of increasing tolerance and respect. These sessions must be facilitated by a qualified professional with expertise in working with LGBTQ youth.

2. Psycho-educational sessions for the youth in congregate care settings must include group and individual opportunities, as appropriate to the behavior model used by the program, to discuss any sexual orientation or gender identity questions or feelings that may arise as a result of having youth in the Children's Services custodial care setting who may be perceived as "different."

F. Hormone Therapy

1. All youth in Children's Services custodial care receive an initial health screening, which includes identification of existing medications being taken by the youth. During the course of that initial screening, if the youth reports that he/she was prescribed hormones by a licensed medical provider in the community, this medication shall be continued upon medical assessment and approval while the youth is in care. If hormone therapy is discontinued for a youth, the youth shall continue to be monitored by medical and behavioral health staff in order to treat any symptoms that may occur as a result.

2. If it is learned that hormone therapy is being obtained by a youth on the street or without a prescription, the youth must be immediately referred to LGBTQ clinically and culturally competent medical and mental health providers for an evaluation. Staff must ensure that all necessary treatment continues if determined necessary by the medical and mental health clinicians.

3. If a **youth in foster care or juvenile justice placement** makes a request to begin hormone therapy while in Children's Services' custodial care, he/she must be promptly referred to a LGBTQ culturally competent medical and mental health provider for an evaluation. The medical provider, in consultation with the youth's case planner, must initiate a request for financial support and treatment

through the Children's Services Non-Medicaid Reimbursable (NMR) Policy.[22] A determination will be made through the process described in the NMR policy regarding the initiation of hormone therapy based on the determination of the Deputy Commissioner, with recommendations from the Children's Services Health Review Committee, and the accepted standards of care in the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Non-conforming People. [23]

4. If any **youth in detention** makes a request to begin hormone treatment, the contracted medical provider(s), in consultation with Children's Services, will make a determination regarding the initiation of hormone therapy or other medical treatments related to gender identity based on accepted standards of care (see WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Non-conforming People).[24]

5. For all youth under the age of 18 in Children's Services custodial care, appropriate consent from the youth's parent/legal guardian must be first sought and obtained as required by law and/or ACS policy.[25]

6. When youth in foster care and/or juvenile justice placement are also in detention, the rules regarding youth in detention, above, stand. All youth in detention are treated the same with regard to hormone therapy, regardless of any other custodial status.

G. Medical Care Specific to LGBTQ Youth Other Than Continuity of Care Hormone Therapy for Youth In Detention

Where the initiation of other medical care specific to LGBTQ youth is at issue (e.g. medically necessary transition-related surgeries), DYFJ's Deputy Commissioner or his/her designee may review the request and decide whether initiating the recommended treatment while the youth is still in DYFJ custody is appropriate and feasible. If DYFJ's Deputy Commissioner determines that the medical treatment cannot be initiated while the youth is in DYFJ's custody, the youth's medical provider in his/her community or medical department at OCFS, or other discharge agency must be informed, upon the youth's request.

---

[22] Provision of Non-Medicaid Reimbursable Treatment or Services for Youth in Foster Care – Policy 20101/04 dated 6/7/10 (page6).

[23] See http://www.wpath.org/publications_standards.cfm for complete WPATH Standards. See also the Endocrine Society's Clinical Guidelines on the Endocrine Treatment of Transsexual Persons (2009) at http://www.endo-society.org/guidelines/final/upload/endocrine-treatment-of-transsexualpersons.Pdf

[24] In accordance with DYFJ Directive # 17.1 entitled *Continuity of Care Policy and Procedures.*

[25] See ACS Procedure 102/Bulletin No. 99-1 (amended), Guidelines for Providing Medical Consents for Children in Foster Care. Note: As of November 2012, this Procedure/Bulletin is being revised and will be released as a policy under the same title.

H. Medical Care Other Than Hormone Therapy for Youth in Foster Care or Juvenile Justice Placement

If a youth in foster care or juvenile justice placement makes a request for gender affirming medical care while in Children's Services' care and custody, he/she must be promptly referred to an LGBTQ culturally competent medical and mental health provider for an evaluation. If the medical care is non-Medicaid reimbursable, the youth's case planner, after consultation with the youth's medical provider, must initiate a request for treatment and financial support through the Children's Services Non-Medicaid Reimbursable (NMR) Policy.[26] A determination will be made through the process described in the NMR policy regarding the initiation of gender affirming medical care based on the determination of the Deputy Commissioner, with recommendations from the Children's Services Health Review Committee and the accepted standards of care in the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Non-conforming People. [27]

I. Bedrooms

1. Generally, it is most appropriate to house transgender youth in Children's Services custodial care based on their gender identity (i.e. their internal, personal sense of being a young man or a young woman or a boy or a girl)[28]. In considering the appropriate placement for a known transgender youth, individual sleeping quarters must be considered if available.

2. Foster boarding homes
   a. In foster boarding homes, separate bedrooms are required for children of the opposite sex over seven years of age. Children of the opposite sex in residential facilities must be placed in separate bedrooms at the age of five or older. In cases where it is necessary to keep siblings or half siblings placed together in the same foster home, children are permitted to share the same bedroom providing this sleeping arrangement is consistent with the health, safety, and welfare of each of the siblings or half-siblings.[29]

   b. For cases where a transgender youth is residing in a foster boarding home, the agency is expected to make sleeping arrangement decisions on an individualized basis. Decisions on bedrooms for transgender youth in foster boarding homes must be based on the youth's individualized needs and must prioritize the youth's emotional and physical safety. The agency staff must

[26] Provision of Non-Medicaid Reimbursable Treatment or Services for Youth in Foster Care 0 Policy #2010/04, dated 6/7/10 (page 6).
[27] See also the Endocrine Society's Clinical Guidelines on the Endocrine Treatment of Transsexual Persons (2009).
[28] Horizon (718) 401-2499; Crossroads (718) 240-3862; and NSD (718) 597-3431.
[29] See Children's Services Policy # 2011/02 entitled *Flexibility in Sleeping Arrangement Requirements for Sibling Foster Care Placements.*

take into account the youth's perception of where he or she will be most secure, as well as any recommendations by the youth's health care provider. It is critical to include the transgender youth in the decision making process.

3. Congregate Care Settings - Foster Care, Juvenile Detention, and Juvenile Justice Placement

   a. For cases where a transgender youth is residing in a residential facility, Children's Services shall make every effort so that LGBTQ youth are housed in a facility that can provide individual sleeping quarters (one-person bedroom) to allow for privacy. Transgender youth must not automatically be housed according to their gender assigned at birth. As in foster care settings, the agency shall make housing decisions for transgender youth based on the youth's individualized needs and that prioritize the youth's emotional and physical safety. The agency staff shall take into account the youth's perception of where he/she will be most secure, as well as any recommendations by the youth's medical and/or mental health care provider, if any.

   b. When a youth in detention or a juvenile justice placement is not housed according to his/her identified gender, authorization must be provided by the appropriate Associate Commissioner or his/her designee and documented in the youth's record.

J. Bathroom Facilities

Bathroom facilities shall take into account the safety and privacy needs of transgender and gender non-conforming youth. All youth shall be allowed to use individual stalls, within commonly accepted time limits, and be allowed to shower privately. Transgender youth shall not be required to shower or undress in front of other youth.

I. Hair and Other Personal Grooming

Grooming rules and restrictions, including rules regarding hair, make-up, and shaving, shall be the same for all youth in Children's Services custodial care regardless of LGBTQ status. A youth shall not be prevented from using, or disciplined for using, a form of personal grooming because it does not match gender norms. Transgender and gender non-conforming youth shall be permitted to use approved forms of personal grooming consistent with their gender identity.

J. Clothing

Youth in Children's Services custodial care shall be permitted to wear clothing consistent with their gender identity. Youth will be made aware that they are always able to wear undergarments and/or other clothing of their identified gender. When Children's Services and provider agencies are providing clothing for youth, staff shall make reasonable efforts to ensure that gender appropriate undergarments are available. As with all youth, outer attire should be congruent with the occasion. In keeping with safety and security concerns, youth in detention and juvenile justice placement facilities may, but are not required to, shave their faces and bodies as permitted by Children's Services Procedure.[30]

K. Discharge and Permanency Planning

1. It is critical to work with youths' families throughout their stay in Children's Services custodial care to enhance reunification or other discharge efforts. During discharge and permanency planning, staff shall be mindful that a youth may not want to disclose LGBTQ status to his/her family/discharge resource. If this was not a precipitant of the youth's removal from the home, and he or she wishes to keep his/her LGBTQ status private, during discharge planning, staff shall not disclose the youth's LGBTQ status to the family and/or discharge resource.[31]

2. Children's Services and provider agency staff working with LGBTQ youth in Children's Services custodial care must identify and become familiar with community resources to support LGBTQ youth. When appropriate, staff must assist families of LGBTQ youth in identifying supportive resources in their area that are culturally competent in LGBTQ issues in order to help create a seamless transition to permanency with adequate support systems in place.

L. Provider Agency LGBTQ Point Person Expectations

1. Foster care and juvenile justice placement provider agencies are required to designate an LGBTQ Point Person. Each designated Point Person is required to receive LGBTQ cultural competency training, attend all ACS LGBTQ Action Group meetings, maintain a record of all LGBTQ-related issues that arise within his or her agency (including, but not limited to reports of harassment or bias and any unmet need for an LGBTQ-affirming foster home or juvenile justice placement), and coordinate trainings within the provider agency to ensure that all staff working directly with youth receive cultural competency training related to LGBTQ youth and families. A Point Person Network will be created by Children's Services, and maintained by the ACS LGBTQ Senior Advisor. In order to increase the effectiveness of the Point Person Network, all youth in foster care,

[30] DJJ Operations Order # 06/03entitled *Resident Personal Property and Grooming Paraphernalia*
[31] Please refer to *Confidentiality* section for further information.

congregate care, and/or juvenile justice placement with a provider agency must be notified of the existence and role of the LGBTQ Point Person and must be provided with the means by which to access the Point Person in order to report issues, complaints or concerns.

2. The agency Point Person will report all incidents reported to him/her to the ACS LGBTQ Senior Advisor. To report LGBTQ youth and family-related concerns, Point Persons shall complete (for foster care) the attached *ACS LGBTQ Senior Advisor Request* (Form FSS 009*)* (See Attachment D) and forward it to the ACS LGBTQ Senior Advisor at LGBTQ@dfa.state.ny.us. The ACS LGBTQ Senior Advisor will keep track of incidents and how they are handled.[32]

M. Advocacy and Incident Reporting Procedures for Youth in Children's Services Custodial Care

1. Foster Care and Juvenile Justice Placements

   a. The Foster Care Point Person Network is available for youth in foster care and juvenile justice placements to express and resolve concerns regarding the care and treatment of LGBTQ youth in those settings, and their families. The Foster Care Point Person Network is convened by Children's Services LGBTQ Senior Advisor and the Division of Family Permanency Services periodically to discuss issues related to the implementation of the LGBTQ policy, best practices in working with LGBTQ youth and families, and other issues related to LGBTQ policy and programs. Each agency is required have a designated LGBTQ Point Person who can be accessed as a resource to assist when an issue requiring case consultation arises and/or be utilized as a reporter to the Children's Services LGBTQ Senior Advisor. The LGBTQ Point Person must keep track of all reportable bias, harassment, and bullying issues of LGBTQ youth and families, and model appropriate and affirming behavior at all times. If the Point Person receives a grievance related to harassment or discrimination on the basis of actual or perceived gender identity, gender expression or sexual orientation, the LGBTQ Point Person must notify his/her supervisor for help in resolving the issue.

   b. All legal-related inquiries must first be brought to the attention of the assigned FCLS attorney. The FCLS attorney will then notify the ACS LGBTQ Senior Advisor and the attorney for the child.

   c. The provider shall report each and every incident of LGBTQ-related bias, harassment, and/or abuse to the ACS LGBTQ Senior Advisor via form FSS 009,

[32] A user-friendly version of this form is accessible on DocuShare.

and the ACS LGBTQ Senior Advisor will keep track of incidents and how they are handled.

2. Detention Facilities

   a. The Resident Advocacy Program and Ombudsperson shall be available for youth in detention to express and resolve concerns regarding their care and treatment. If Ombudspersons receive a grievance related to harassment or discrimination on the basis of actual or perceived gender identity, gender expression, or sexual orientation, the Ombudsperson shall notify an Associate Commissioner of Detention immediately. The Associate Commissioner notified must ensure the grievance is addressed appropriately. The Resident Advocacy Program and Ombudspersons shall protect the confidentiality of youth who make grievances related to harassment or discrimination on the basis of actual or perceived gender identity, gender expression, or sexual orientation and should take appropriate measures to prevent retaliation.

   b. Youth in detention must be advised upon admission that they may contact the appropriate Ombudsperson to report issues, complaints, or concerns about any issue, including those related to LGBTQ youth and families.[33]

IV. ACS LGBTQ Senior Advisor

A. Overarching Responsibilities

The ACS LGBTQ Senior Advisor is responsible for assessing LGBTQ needs within the child welfare system. The Senior Advisor develops and maintains relationships with community-based LGBTQ programs to improve access to services for youth involved with protective, preventive and foster care services. He/she also develops training curricula for child welfare staff and works with other areas of Children's Services so that policies and programs address the LGBTQ-specific needs of children and families.

B. Monitoring Responsibilities

1. The ACS LGBTQ Senior Advisor shall track and monitor the following:

   a. all incident reports received (FSS 009, *LGBTQ Senior Advisor Request Form)*;
   b. provider agencies to determine compliance with the LGBTQ expectations, and provide technical assistance where needed;[34]

[33] Horizon - (718) 401-2499; Crossroads - (818) 240-3862; and NSD - (718) 597-3431

[34] Provider agencies are responsible for gathering tracking information and submitting it to the ACS LGBTQ Senior Advisor

c. the redesigned Point Person Network; and
d. the integration of LGBTQ policies into practice.

2. The ACS LGBTQ Senior Advisor will collaborate with other program areas that provide oversight of Children's Services' staff and contracted providers to hold all pertinent staff accountable for their performance with respect to this policy.

For additional information on training resources as well as on this policy please contact the ACS LGBTQ Senior Advisor at LGBTQ@dfa.state.ny.us.

---

for an assessment of their progress.

Attachment A: GLOSSARY OF TERMS

Anatomical sex: An individual's sex, male or female, based on the appearance of his/her sexual organs.

Biological sex: An individual's sex, male or female, based on his/her sex chromosomes.

Birth sex: The sex, male or female, that is noted on an individual's birth certificate issued at birth.

Bisexual: refers to a person who is emotionally, romantically, and/or physically attracted to both men and women. Bisexual people do not need to have had sexual experiences with both men and women; in fact, they do not need to have had any sexual experience at all to identify as bisexual.

Gay: refers to a person who is emotionally, romantically, and/or physically attracted to people of the same gender. Sometimes, it may be used to refer to gay men and boys only. It is preferred over the term "homosexual," which is an outdated term and is considered derogatory and offensive to many LGBTQ people.

Gender: The set of meanings assigned by a culture or society to someone's perceived biological sex. Gender is not static and can shift over time. Gender has at least three parts:

a) **Gender Identity**: An individual's internal view of his/her gender; one's own innermost sense of being male or female. This will often influence name and pronoun preference for an individual.

b) **Physical Markers**: Aspects of the human body that are considered to determine sex and/or gender for a given culture or society, including genitalia, chromosomes, hormones, secondary sex characteristics, and internal reproductive organs.

c) **Role/Expression**: Aspects of behavior and outward presentation that may (intentionally or unintentionally) communicate gender to others in a given culture of society, including clothing, body language, hairstyles, socialization, relationships, career choices, interests, and presence in gendered spaces (e.g. restrooms, places of worship, etc.). Refers to the manner in which a person expresses his or her gender through clothing, appearance, behavior, speech, etc. A person's gender expression may vary from the norms traditionally associated with his or her biological sex. Gender expression is a separate concept from sexual orientation and gender identity.

Gender Identity Disorder or GID: A diagnosable medical condition where an individual has a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the opposite sex, as well as a persistent discomfort about one's assigned birth sex or sense of inappropriateness in the gender role of that sex. In addition, the individual must

be evidencing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender non-conforming: Having or being perceived to have gender characteristics and/or behaviors that do not conform to traditional or societal expectations. Gender non-conforming people may or may not identify as LGBT.

Gender roles: Social and cultural beliefs about appropriate male or female behavior, which children usually internalize between ages 3 and 7.

Genderqueer: A term of self-identification for people who do not identify with the binary terms that have traditionally described gender identity (for instance, male or female only). Also see *gender non-conforming*, *queer*, and *transgender*.

Heterosexism: The assumption that all people are or should be heterosexual. Heterosexism excludes the needs, concerns, and life experiences of lesbian, gay, bisexual, and transgender people, while it gives advantages to heterosexual people. It is often a subtle form of oppression which reinforces realities of silence and invisibility.

Heterosexuality: A sexual orientation in which a person feels physically and emotionally attracted to people of the "opposite" sex; "straight" is a synonym.

Homophobia: The irrational hatred and fear of homosexuals or homosexuality. Homophobia includes prejudice, discrimination, harassment, and acts of violence brought on by fear and hatred. It occurs on personal, institutional, and societal levels.

Internalized homophobia: The fear and self-hate of one's own homosexuality that occurs for many individuals who have learned negative ideas about homosexuality throughout childhood. One form of internalized oppression is the acceptance of the myths and stereotypes applied to the oppressed group.

Lesbian: refers to a woman who is emotionally, romantically, and/or physically attracted to other women. Some lesbians may prefer to identify as gay when describing themselves, or as gay women.

LGBTQ: an acronym commonly used to refer to lesbian, gay, bisexual, transgender, and questioning individuals.

Preferred Gender Pronouns (PGP): are the ways people refer to themselves and how they prefer to be referred to in terms of gender. The most commonly used PGPs include:

- She – her – hers
    - Example: "She forgot her wallet. She thinks that she left it in her car."
- He – him – his

- Example: "He had a lot more energy, once his fever went away."
  Some people do not identify as either male or female and accordingly prefer gender neutral pronouns:
- Zie or Ze – hir – hirs
  - Example: "Zie opened hir door to find a package waiting."

Some people who do not identify as either male or female may also use their name or "they" as a PGP.

Queer: A historically derogatory term for LGBTQ people. The term has been widely reclaimed, especially by younger LGBTQ people, as a positive social and political identity. It is sometimes used as an inclusive, or umbrella, term for all LGBTQ people; more recently, queer has become common as a term of self-identification for people who do not identify with the restrictive and binary terms that have traditionally described sexual orientation (for instance lesbian, gay, or bisexual only). Some LGBTQ community members still find queer an offensive or problematic term. Also see *Genderqueer*.

Questioning: refers to a person, often an adolescent, who is exploring or questioning issues of sexual orientation or gender identity or expression in his or her life. Some questioning people will ultimately identify as lesbian, gay, bisexual, and/or transgender; others will self-identify as straight and/or non-transgender.

Sexual orientation: refers to a person's emotional, romantic, and physical attraction to persons of the same and/or different gender.

Straight: A person (or adjective to describe a person) whose primary emotional, romantic, and physical orientation is toward people of the opposite gender.

Transgender: may be used as an umbrella term to include all persons whose gender identity or gender expression do not match society's expectations of how an individual should behave in relation to his or her gender. This term can include transsexual, genderqueer, cross-dresser, and other people whose gender expression varies from traditional gender norms. For purposes of protection from discrimination and harassment, transgender refers to both self-identified transgender individuals and individuals perceived as transgender without regard to whether they qualify for a diagnosis of *Gender Identity Disorder* (see above).

Transgender men and boys: are young people who were assigned the sex of female at birth and who now identify as male. Similarly, the term FTM, or female-to-male, refers to those who now identify as boys or men. Also see *transsexual*.

Transgender women and girls: are young people who were assigned the sex of male at birth and who now identify as female. Similarly, the term MTF, or male-to-female, refers to those who now identify as girls or women. Also see *transsexual*.

Transition: An individualized process by which a transgender person starts living as the gender she or he identifies as. There are three general aspects to transitioning: social (i.e. selection of a new name, a request that people use the correct pronoun), medical (i.e. possibly hormones, surgery, etc.), and legal (i.e. gender marker and legal name change, etc.). A transgender individual may transition in any combination, or none, of these aspects.

Transphobia: A reaction of fear, loathing, and discriminatory treatment of people whose identity or gender presentation (or perceived gender or gender identity) does not "match," in the societally accepted way, the sex they were assigned at birth.

Transsexual: A term for someone who transitions from one physical sex to another in order to bring his/her body more in line with their innate sense of their gender identity. It includes those who were born male but whose gender identity is female, and those who were born female but whose gender identity is male, as well as people who may not clearly identify as either male or female. Transsexual people have the same range of gender identities and gender expression as non-transsexual people. Many transsexual people refer to themselves as transgender.

Definitions for this glossary have been adapted from the following resources:

Breaking the Silence, National Center for Lesbian Rights

Hidden Injustice: Lesbian, Gay, Bisexual, and Transgender Youth in Juvenile Courts, The Equity Project

LGBTQIA Glossary, University of California, Davis, Lesbian Gay Bisexual Transgender Resource Center *Trans Action Guide*, Gay Lesbian Straight Educational Network

Attachment B: LGBTQ RIGHTS FLYER

(Taken from the NYC Anti-Violence Project, - LGBTQ Youth Violence Initiative "A Guide for NYC LGBTQ Public School Students" and "Staying Safe – LGBTQ Youth and the NYPD".)

LGBTQ youth in foster care and the juvenile justice system have rights:

- To feel safe
- To be free from discrimination because they are LGBTQ
- To have people accept them for who they are
- To have adults stick up for them

LGBTQ youth and school

All NYC public schools should:

- Treat all students, including LGBTQ students, equally
- Apply all policies to LGBTQ students in the same way as applied to other students
- Not single out LGBTQ students for abuse
- Not discriminate based on sex (including your school's responsibility for stopping sexual harassment)
- Address anti-gay/anti-trans harassment (schools can be held legally accountable for ignoring harassment, abuse or discrimination)
- Post complaint procedures
- Handle all complaints fairly treat Gay-Straight Alliance (GSAs) like any other student club

So:

- Come out when you are ready and be proud of who you are
- Report any abuse including homophobic or transphobic comments, graffiti, etc.
- Form a GSA in your school
- Take a date to the prom (Your school can't require that only girl-boy couples can go to school dances)

LGBTQ youth and the NYPD

General Tips:

- If you have identification such as a driver's license, non-driver or school ID, always carry it
- If you are stopped by the police, be honest about your age because minors get special legal protections when dealing with the police
- Try to stay calm and be respectful
- Do not run, even if you did not do anything wrong
- Keep your hands where they can be seen
- Even if you are innocent, don't touch or resist the officer
- If you leave your school during school hours, try to carry a note, your schedule, or some other proof that you are not skipping school

A Police Officer:

- May stop you and ask questions if they think you are skipping school or are a runaway
- Can also question anyone they reasonably believe is committing a crime, has committed, or is about to commit a crime
- Might ask your name, age, and where you are going (It is your legal right not to answer any of these questions)

If a police officer reasonably suspects that you are carrying a weapon, he or she may pat your clothes down to look for the weapon. If a police officer acts inappropriately (for example by making sexual remarks, touching you in a sexual way, or does more than a basic pat down) tell your lawyer or someone you can trust.

Attachment C:
LIST OF LGBTQ AFFIRMING CLINICIANS ALL NYC BOROUGHS[35]
(Recommended by LGBTQ Advocates)

LGBTQ HEALTH CARE PROVIDERS

Adolescent AIDS Program/Risk Evaluation Program
Children's Hospital at Montefiore Medical Center
Gay and Lesbian Adolescent Health Resource Center (GLAHRC)
111 East 210th St.
Bronx, NY 10467
(718) 882-0232 x. 223
www.adolescentaids.org
M-F, 1:30pm-5pm
STD/HIV testing, treatment, and referrals for comprehensive medical and mental health services for LGBT youth ages 13-24.

Bronx Community Pride Center, Health Link Line
975 Kelly Street, Suite 202
Bronx, NY 10459
718-292-4368
www.bronxpride.org
9am-9pm everyday
Free hotline that offers referrals to LGBT-friendly doctors and other medical, legal, and social service providers. Providers with expertise in transgender health are included.

Community Healthcare Network – Transgender Program
Bronx Health Center
975 Westchester Ave.
Bronx, NY 10459
(718) 320-4466 (Program Coordinator: Renato)
M, Tu, Th, F – 9am-5pm; W – 10am-6pm
Support Groups – M- 2-4pm (Spanish), W – 2-4pm (English)
www.chnnyc.org/services/transgender-program/
Offers healthcare services to all transgender people of all ages, including primary healthcare, preventive health services, weekly workshops, support group meetings, mental health counseling, and HIV counseling and testing. Hormone therapy for individuals 18+.

The Door
Adolescent Health Center
555 Broome St.
New York, NY 10013
(212) 941-9090 x. 3221 or x. 3222
www.door.org

[35] Provider Agencies should verify if the clinician is a Medicaid participant prior to sending youth for services.

Offers physical examinations, general health care and education, dermatology, nutritional counseling, sexual and reproductive health care, and routine dental services to all young people ages 12-21, as well as counseling services geared toward LGBTQ youth.

H.E.A.T. (Health and Education Alternatives for Teens)
SUNY Downstate Medical & Kings County Hospital Center
760 Parkside Ave (Room 308)
Brooklyn, NY 11226
(718) 467-4446 (for appointments – Richard Weinstein)
www.heatprogram.org
M-F 9am-5pm
Free medical and mental health services, counseling, and HIV/STD testing and support for LGBTQ youth, including hormone therapy for transgender youth ages 13-24.

H.O.T.T. (Health Outreach to Teens)
Callen-Lorde Community Health Center
356 W. 18th St. (between 8th and 9th Aves.)
New York, NY 10011
(212) 271-7212, (212) 271-7200
www.callen-lorde.org/services/hott.html
M, Tu, Th – 10am-8pm; W – 10am-12pm, 1:30pm-8pm (no new patients); F – 10am-4pm; Sat. 10pm-1am
Free or low cost medical and mental health care/counseling, including physical exams, gynecological exams, and STD/HIV treatment and testing to LGBTQ and homeless youth ages 13-24. Hormone therapy available for youth ages 18-24.

The Jim Collins Foundation
P.O. Box 1002
North Branford, CT 06471
(203) 376-8089
www.jimcollinsfoundation.org
Awards grants for transgender people ages 18+ in need of gender-confirming surgery to live a healthy life but without the ability to pay for it.

The Mount Sinai Adolescent Health Center
312 E. 94th St.
New York, NY 10128
(212) 423-3000
http://www.mssm.edu/research/centers/adolescent-health-center
Medical and mental health care for adolescents 10-22 years old.

Positive Health Project
301 W. 37th St. (near 8th Ave)
New York, NY 10018
(212) 465-8304 Ext.
www.positivehealthproject.org
M-F – 10am-5pm

Provides healthcare services to transgender people ages 18+, including basic medical care, psychotherapy and counseling, psychiatric referrals, acupuncture, Syringe Exchange Program, and support groups.

South Bronx Health Center for Children & Families
Montefiore Medical Center
871 Prospect Avenue
Bronx, NY 10459
(718) 991-0605 x. 264 (Maria Umpierre)
M-Th – 9am-7:30pm; F – 1pm-6pm
Provides medical care and services to transgender youth, including feminizing or masculinizing hormone therapy. There is no minimum age requirement.

Streetwork Project
Harlem Drop-In Center
209 W. 125th St.
New York, NY 10027
(212) 695-2220
Hours of Operation: Monday Through Sunday (9:00 am - 9:00 pm) Lower East Side Drop-In
33 Essex St.
New York, NY 10002
(646) 602-6404
Hours of Operation: Monday, Tuesday, Thursday, Friday 2:00PM - 7:00PM www.safehorizon.org
Provides services to LGBTQ homeless youth up to age 24, including free medical and psychiatric services, counseling, syringe exchange, HIV prevention, and wellness activities including acupuncture, yoga, and nutritional counseling.
HIV-RELATED CARE

Alianza Dominicana
530 W. 166th St.
New York, NY 10032
(212) 740-1960
http://www.alianzaonline.org/main/
M and F – 9am-5pm, Tu, W, Th – 9am-8pm
HIV/STD testing, substance abuse prevention, and counseling services and programs for LGBT youth ages 16-24.

Bellevue Adolescent T.O.P.S. (Teen Outreach Prevention Services)
462 1st Ave., corner of 27th St.
New York, NY 10016
(212) 562-6333
M-F 9am-5pm by appointment only
Support, confidential HIV testing, pre/post test counseling, complete medical evaluation/care, and clinical treatment for youth. Clinic has a liaison with Green Chimneys Children's Services.

Community Health Action of Staten Island
25 Victory Blvd
Staten Island, NY 10301

(718) 808-1389
www.chasiny.org
M-F – 9am-5pm
HIV education, outreach, and health programs for LGBTQ youth.

Gay Men's Health Crisis (GMHC)
224 West 29th Street
New York, NY 10011
(212) 367-1100 or (212) 367-1000
www.gmhc.org
HIV/AIDS prevention, testing, and services for youth of all ages and free syringe access for individuals 18+.

Hispanic AIDS Forum
Manhattan:
213 W. 35th St. (12th floor)
New York, NY 10001
(212) 868-6230
xmorgan@hafnyc.org
Bronx:
967 Kelly St.
Bronx, NY 10459
(718) 328-4188
www.hafnyc.org
E-mail – info@hafnyc.org
HIV/AIDS organization for the Latino community. HIV testing and prevention programs for youth under 24, offering training and leadership services, workshops, counseling, support groups, and special events. Includes counseling and support for transgender women.

Harlem United Community AIDS Center, Inc.
306 Lenox Ave.
New York, NY 10027
(212) 803-2850
info@harlemunited.org
http://www.harlemunited.org
Serves people living with HIV/AIDS. Medical/ dental care, mental health services, expensive therapies, alternative medicine. Also provides array of services in prevention, education, supportive housing, HIV testing. See website for info/locations.

AIDS Treatment Data Network/ Housing Works
611 Broadway Room 613
New York NY
10012 United States
(800) 734-7104; (212) 260-8868
http://www.housingworks.org/heal/medical-and-dental-care
HW provides case management, treatment and access information, advocacy and counseling, education, and referral services for people with HIV, chronic hepatitis, and other diseases.

Safe Space and Spacemobile
Queens:
89-74 16nd St. (2nd floor)
Jamaica, NY 11432
(718) 526-2400
www.safespacenyc.org
In addition to drop-in centers below, the Spacemobile travels around the city providing health services.

FOR FURTHER REFERRALS

Center CARE and Y.E.S. (Youth Enrichment Services)
at the LGBT Community Center
208 W. 13th Street
New York, NY 10011
(212) 620-7310
www.gaycenter.org
Provides confidential assessments and referrals to a network of LGBT-affirmative or identified counselors, therapists, psychiatrists, community organizations and agencies, and other resources.

Gay Men of African Descent
103 East 125St. Suite 7E
New York NY
10035 United States
(212) 828-1697
www.gmad.org

Ali Forney Center
527 West 22nd St., 1st Floor
New York NY
10011 United States
(212) 222-3427
http://www.aliforneycenter.org/
AFC is the nation's largest and most comprehensive organization dedicated to homeless LGBT youth. Our goal is to provide homeless LGBT youths, aged 16-24, with the support and services they need to escape the streets and begin to live healthy and independent lives.

FSS-009
Rev. 11/12

NYC Administration for Children's Services

Attachment D:
ACS LGBTQ Incident/Inquiry Form

Please complete appropriate information. You do not need to have all information indicated for request to be processed.

Type of Request: ___ Resources ___ Placement ___ Harassment ___Other

Incident/Inquiry Occurrence: ___ Internal ___External

Client/Family Date: _____

Youth Name:	DOB:
Case Name:	Case #:

Source of Referral

Name:	Agency:
Relation to youth:	Telephone #:

Agency Contact Information

Contract Agency:	Site/Location:
Agency Worker:	Telephone #:
Supervisor:	Telephone #:
Director:	Telephone #:

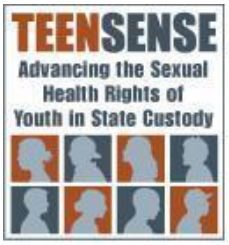
ACS Contact Information

Borough:	Site/Location:
Worker:	Telephone #:
Supervisor:	Telephone #:
Manager:	Telephone #:

Legal Information

FCLS Attorney:	Telephone #:

Narrative Description of Presenting Concern and Requested Service:



MODEL POLICY
SEXUAL HEALTH CARE FOR YOUTH IN STATE CUSTODY

In order to appropriately address the sexual health care needs of youth in the state's care, it shall be the policy of **[this agency/jurisdiction]** to guarantee that youth in its **[custody/care]** receive the following health services:

- Health screenings that address both their physical and mental health, including examinations that include their sexual histories and instances of abuse;
- Universal offers of testing for sexually-transmitted infections (STIs), including HIV, that include proper pre-test and follow-up counseling even if the tests are negative;
- Written information, counseling, and treatment related to pregnancy, STIs including HIV, and sexual abuse;
- Written information and regular counseling on the routes, risks, and prevention of STI and HIV transmission, including but not limited to correct use of condoms to prevent pregnancy and disease.
- Ongoing care and discharge planning related to sexual and reproductive health.

All medical care services shall be conducted in a confidential, culturally competent, and inclusive manner. Youth who are pregnant, gender non-conforming, or lesbian, gay, bisexual, transgender, questioning, or intersex (LGBTQI) shall not be treated differently or receive a lesser standard of care, and shall be offered services consistent with their gender identity and sexual orientation.

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

This work is made possible
by generous donations from:

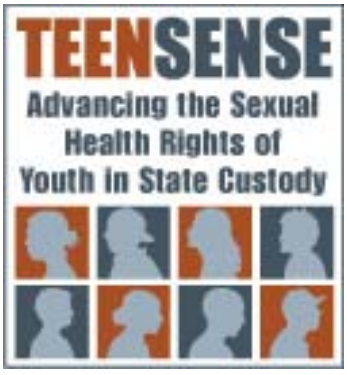
These Standards Have Been Endorsed By:

Administration for Children's Services, New York City
African American Office of Gay Concerns
AIDS Alliance for Children, Youth and Families
BreakOUT!, New Orleans, LA
HiTOPS, New Jersey
Hetrick-Martin Institute
Hyacinth AIDS Foundation
Juvenile Justice Project of Louisiana
National Center for Lesbian Rights
National Coalition of Anti-Violence Programs (NCAVP)
National Organization of Women, New Jersey
National Alliance of State and Territorial AIDS Directors (NASTAD)
Planned Parenthood of Greater Northern New Jersey
SUNY Downstate Medical Center: HEAT Program, Brooklyn, NY
SUNY Downstate Medical Center: FACES Network, Brooklyn, NY
True Colors, Inc. Sexual Minority Youth Services of CT
University of Medicine and Dentistry of New Jersey: Paulette Stanford, MD, Division of Adolescent and Youth Adult Medicine
University of Medicine and Dentistry of New Jersey: JumP

THE CENTER FOR HIV LAW & POLICY

TEENSENSE

MODEL SEXUAL HEALTH CARE STANDARDS



The Center for HIV Law and Policy • 65 Broadway, Suite 832 • New York, New York 10006
212-430-6733 phone • 212-430-6734 fax • info@hivlawandpolicy.org • www.hivlawandpolicy.org

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.

To contact us:
Email us at info@hivlawandpolicy.org.

Or write to:
The Center for HIV Law and Policy
65 Broadway, Suite 832
New York, NY 10006
212.430.6733
212.430.6734 fax

ACKNOWLEDGEMENTS

The Center for HIV Law and Policy thanks Kaityi Duffy, Kate Chaltain, Mark Guest, and Kat Dunnigan for research and drafting of an early version of this publication. This document reflects all of their input. We also thank Gulielema Leonard Fager for her review and edits. Dr. Jeffrey Birnbaum was also a fantastic resource and contributed significantly to the final content of these standards. We thank Dr. Robert Johnson, MD, FAAP, The Sharon and Joseph Muscarelle Endowed Dean, Professor of Pediatrics, Director of Adolescent and Young Adult Medicine, New Jersey Medical School for a final review of the standards. Finally, we thank the youth of the New Jersey Training School for Boys of Monroe Township, New Jersey, and the Female Secure Care and Intake Facility of Bordentown, New Jersey, for their honesty and insight, and the staff of the respective facilities for their hospitality.

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

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.

.

THE CENTER FOR HIV LAW & POLICY

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.

TEENSENSE
Advancing the Sexual Health Rights of Youth in State Custody

TABLE OF CONTENTS

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.

---

[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:

---

[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.

[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.

---

[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]

[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

---

[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.

---

[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?

---

[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

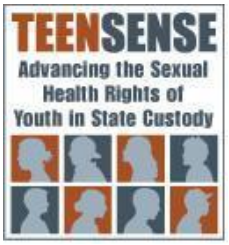
A youth may refuse specific health evaluations and treatments in accordance with the laws of the jurisdiction.[101]

---

[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.



MODEL POLICY
SEXUAL HEALTH EDUCATION FOR YOUTH IN STATE CUSTODY

In order to appropriately address the sexual health needs of youth in the state's care, it shall be the policy of **[this agency/jurisdiction]** to guarantee that youth in its **[custody/care]** receive the following services in order to meet the sexual health knowledge needs of lesbian, gay, bisexual, transgender, questioning, or intersex (LGBTQI) and heterosexual youth in out-of-home custody.

Sexual Health Education services and curricula shall include:

- At least basic information on sexually-transmitted infections (STIs) and HIV transmission in addition to a list of community resources related to pregnancy, STI prevention, sexual violence, and LGBTQI discrimination – regardless of whether a youth is in custody for 24 hours or for over two months;
- Information and discussion on the nature and forms of sexual abuse, harassment, and abuse on the basis of gender identity or sexual orientation, and reporting procedures and protections for young people who are the victims of abuse or harassment;
- Access to information on topics including contraception, reproductive choice, anatomy, and drug use/harm reduction skills that increases in proportion to a youth's time in out-of-home custody;
- Classroom environments and teachers that demonstrate non-judgmental, inclusive attitudes and that create a comfortable space for youth of any gender identity and sexual orientation to learn about all points on the spectrum of gender and sexuality, adopt safer sex practices, and develop levels of understanding and skills that increase sexual health into adulthood while reducing the incidence and tolerance of sexual abuse.

Teen SENSE

Model Sexual Health Education Standards for Youth in State Custody

THE CENTER FOR HIV LAW & POLICY

TEENSENSE
Advancing the Sexual Health Rights of Youth in State Custody

This work is made possible
by generous donations from:

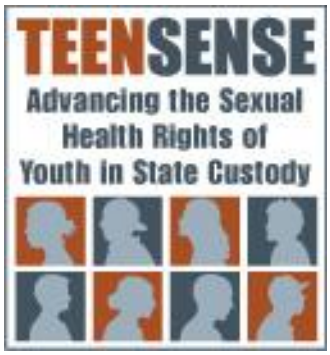
These Standards Have Been Endorsed By:

Administration for Children's Services, New York City
African American Office of Gay Concerns
AIDS Alliance for Children, Youth and Families
BreakOUT!, New Orleans, LA
HiTOPS, New Jersey
Hetrick-Martin Institute
Hyacinth AIDS Foundation
Juvenile Justice Project of Louisiana
National Center for Lesbian Rights
National Coalition of Anti-Violence Programs (NCAVP)
National Organization of Women, New Jersey
National Alliance of State and Territorial AIDS Directors (NASTAD)
Planned Parenthood of Greater Northern New Jersey
SUNY Downstate Medical Center: HEAT Program, Brooklyn, NY
SUNY Downstate Medical Center: FACES Network, Brooklyn, NY
True Colors, Inc. Sexual Minority Youth Services of CT
University of Medicine and Dentistry of New Jersey: Paulette Stanford, MD, Division of Adolescent and Youth Adult Medicine
University of Medicine and Dentistry of New Jersey: JumP

THE CENTER FOR HIV LAW & POLICY

TEENSENSE

MODEL SEXUAL HEALTH EDUCATION STANDARDS



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.

To contact us:
Email us at info@hivlawandpolicy.org.

Or write to:
The Center for HIV Law and Policy
65 Broadway, Suite 832
New York, NY 10006
212.430.6733
212.430.6734 fax

Acknowledgements

The Center for HIV Law and Policy thanks Kate Chaltain, Mark Guest, and Kat Dunnigan for research and drafting of an early version of this publication, and Nancy Caamaño, Elizabeth Casparian, Kaiyti Duffy, Melissa Keyes-Digioia, Robert Johnson, M.D., Jody Marksamer, Fatima Meadows, Guido Sanchez, Kimberly Page-Shafer, Stephen Pitt, Michelle Staples-Horne, Stephanie Witt, Gulielma Leonard Fager, and Gary Paul Wright for their helpful comments and collaboration. This document reflects all of their input. We would also like to thank the youth of the New Jersey Training School for Boys of Monroe Township, New Jersey, and the Female Secure Care and Intake Facility of Bordentown, New Jersey, for their honesty and insight, and the staff of the respective facilities for their hospitality.

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.

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 a overwhelmingly are from communities most affected by HIV: low-income youth, Black and Latino youth; gay, bisexual, transgender, and questioning youth (LGBTQ),; and survivors of violence and other abuse. Empowering these populations to protect their rights and their health is 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.

MODEL SEXUAL HEALTH EDUCATION STANDARDS

Executive Summary

The Teen SENSE Model Sexual Health Education Standards are designed to reflect the minimum requirements of curricula that meet the sexual health knowledge needs of LGBTQ and heterosexual youth in out-of-home custody. The Model Sexual Health Education Standards include:

- content goals (divided according to the time a youth spends at a state facility),
- instructional characteristics (standards to which classroom environments and practices should adhere),
- and instructor characteristics (which set forth competencies that teachers of sexual health education should possess).

Under these standards, youth in state custody should receive at least basic information on STI and HIV transmission in addition to a list of community resources related to pregnancy, STI prevention, sexual violence, and LGBTQ discrimination – regardless of whether a youth is in custody for 24 hours or for over two months. As a youth's time in state custody increases, so should his or her access to information on topics including contraception, reproductive choice, anatomy, and drug use/harm reduction skills. Classroom environments and teachers themselves should demonstrate non-judgmental, inclusive attitudes that create a comfortable space for youth of any sexual orientation and gender identity to learn about all points on the spectrum of sexual orientation, adopt safer sex practices, and develop levels of understanding and skills that increase sexual health into adulthood while reducing the incidence and tolerance of sexual abuse.

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.

Table of Contents

Introduction

What are the Model Sexual Health Education Standards?

These Model Sexual Health Education 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 sexuality education for youth in state custody into one document. The Standards are not a curriculum; rather, they reflect minimum requirements that curricula should meet in order to appropriately address the sexuality education needs of youth in the state's care. These model standards are intended for use by facility directors, advocates, medical professionals, and direct service providers who have access to state youth facilities and outside facilitators or curriculum writers.

The Model Sexual Health Education Standards are divided into three sections reflecting three interrelated and equally important components of a sexuality education curriculum: (1) Content Goals; (2) Instructional Characteristics; and (3) Instructor Characteristics.

> **The Content Goals** are meant to guide the selection of the curriculum's content by providing the minimum goals that a curriculum should be designed to achieve. The goals are broken down by the amount of time that a young person is in custody. This is to take into account the varying levels of education that can be provided over different courses of time. While these Content Goals do not create a curriculum, any curriculum used must be tailored to achieve these minimum goals.
>
> **The Instructional Characteristics** provide minimum standards for a curriculum's classroom environment and practices. They also demonstrate principles and standards to which a curriculum must adhere to. Curricula that do not reflect the Characteristics must be modified or abandoned in favor of conforming to the standards. Instructors also must ensure that their methods and attitudes reflect these standards.
>
> **The Instructor Characteristics** set forth requirements that instructors must possess to be able to teach sexuality education, including knowledge of the content, attitude, and ability to implement the standards.

The Model Sexual Health Education Standards apply to all youth in state custody, from foster care facilities to detention facilities to foster care home placements. The standards should be understood to be minimum requirements that will vary in application and applicability based on the precise circumstances of the youth in state 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 Education Standards are one component of CHLP's Teen SENSE initiative. Teen SENSE has also published Model Sexual Health Care Standards 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 care. 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.

How were the Standards created?

The core of the document is based on materials from the Sexuality Information and Education Center for the United States (SIECUS), *Guidelines for Comprehensive Sexuality Education, K-12* (3rd Ed. 2004); Douglas Kirby, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases* (Healthy Teen Network 2007); and various materials published by Physicians for Reproductive Choice and Health, the Equity Project, EngenderHealth, the American Academy of Pediatrics, ANSWER, and Planned Parenthood's Center for Family Life and Education of Greater Northern New Jersey . We supplemented these materials with recommendations, principles and position statements from a wide range of expert sources, including the Society for Adolescent Medicine, the American Academy of Pediatrics, Physicians for Reproductive Choice and Health, ETR Associates, Cicatelli Associates, HiTops, and Planned Parenthood's Center for Family Life and Greater Education of Northern New Jersey. The Standards are intended to clearly frame the information and provide a framework for an approach, best practices and policies, and standards of care that comprise comprehensive sexual health and HIV prevention education.

Part One: Content Goals

Part One provides the minimum goals that the content of the curriculum should be designed to achieve. They are organized according to the maximum amount of time that a youth spends in the state's care. Part Two: Instructional Characteristics provides additional information on the curriculum elements and development and should be read in conjunction with this section. Part Three: Instructor Characteristics sets forth the minimum requirements sexual health education instructors providing instruction to youth should possess.

I. For Youth in Custody Up to 24 Hours

Youth must be provided with written material that provides information regarding:
- HIV and sexually transmitted infections ("STIs").
- How to prevent STI transmission and unwanted pregnancy through correct, consistent condom use, and use of water-based lubricants.

Youth also must be provided information cards that they can keep with them while in custody. The cards should contain community resources for STI testing and treatment, HIV testing and treatment, pregnancy testing and options counseling, sexual health care, sexual violence support services, and support for LGBTQ teens.

II. For Youth in Custody 2-7 Days

Youth must be provided with all resources discussed in Section I.

Youth must be provided with preliminary one-on-one counseling onsite in addition to sexual health care services (including voluntary, written and informed consent for HIV, STI, and pregnancy testing) and referrals for continuing care and counseling. Counseling should be inclusive and should not make assumptions about youth's sexual orientation or gender identity.

Preliminary counseling should include:

- Discussion of HIV and STIs, how they are transmitted, and how transmission can be prevented with the correct and consistent use of condoms, dental dams, and other prophylactic measures.
- The importance of testing and treatment for HIV and STIs.
- Counseling on pregnancy prevention using condoms and contraception.
- Counseling on sexual assault and abuse, with referral to appropriate medical and mental health resources. Special care should be taken to counsel youth on what constitutes sexual abuse; the right to be free of sexual harassment, abuse and assault within state care; and complete information on how to report staff or foster family predation.
- Ample time for questions and answers with the youth.

III. For Youth in Custody 8-30 Days

Youth must be provided with all resources discussed in Sections I and II.

Youth should be provided education and training sufficient to achieve proficiency in the following minimum content areas:

A. Sexually Transmitted Infections

- Youth should be able to identify the prevalence and cause of STIs and health problems that may be caused by untreated STIs, including infertility.[1]
- Youth should understand the major symptoms of STIs and that symptoms may be hidden, absent, or unnoticed.
    - Youth should understand that STIs can be transmitted even if a person does not show symptoms of having an STI.
    - Youth should know that there is no way to determine that another person does or does not have an STI other than being tested by a medical professional.
- Youth should be able to identify how STIs are transmitted in both different-sex and same-sex sexual practices and transmission through methods other than sexual contact, such as unsterilized needles and from mother-to-child during pregnancy, birth, and breastfeeding.
    - Youth should be able to identify and debunk myths about STI transmission.
    - Youth should understand the different transmission routes and risks for different STIs.
- Youth should be able to understand and explain that a person can have more than one STI at a time, can get an STI more than once, and that anyone (regardless of age or sexual orientation) can get an STI if he or she has sexual contact with an infected person.
- Youth should be able to understand and explain that STIs can increase the chance of HIV transmission.
- Youth should be able to identify how STIs can affect females and males differently.
- Youth should be able to identify methods of preventing exposure to and transmission of STIs and how different types of sexual contact pose different levels of risk.
    - Youth should have access to male and female condoms in the context of a sexual health care program that includes instruction on all types of condom use for youth of all genders/gender identity and sexual orientation, and that reinforces the benefits of condom use for all sexually-active people.
    - Youth should be able to identify methods of prevention and explain how such methods work, including avoiding sexual activity that poses a risk of disease transmission, proper use of latex condoms and lubricants, dental dams, and latex barriers. Youth should be able to identify and debunk myths about STI transmission and prevention.
- Youth should be able to understand the importance of discussing concerns about STIs with their sexual partner.
- Youth should be able to identify how they can be tested for STIs and understand state laws protecting their ability to receive confidential STI testing.
- Youth should be able to identify the steps to take if they suspect they have an STI.
    - This includes: to stop having sexual intercourse until they are tested and treated by a physician, to promptly go to a healthcare provider for testing and treatment, and to refer sexual partners to a healthcare provider as well.

[1] While not all states classify HIV as an STI, HIV is grouped with STIs in this document for classification purposes.

- Instructors should emphasize that it is never too late to be tested for an STI or to take steps to treat an STI, regardless of when an STI is suspected or diagnosed,
- Youth should be able to understand the need for STI testing if they have been sexually active or sexually assaulted.
- Youth should be able to identify which STIs can be cured, how they are cured, and which STIs can be treated, and the benefits of treatment.
  - Those STIs caused by bacteria, such as gonorrhea, chlamydia, or syphilis can be cured with prescription medication. Others, such as Herpes, can be life-long health conditions.
- Youth should understand that all individuals are deserving of respect and love, and that individuals with STIs are equally able to live satisfying lives. An STI is not a sign that someone has "been bad" or is a bad person.

B. HIV/AIDS

- Youth should understand the nature of HIV and AIDS are and the distinction between them.
  - Youth should also know how HIV affects the body, that it currently is considered a manageable chronic disease, and that HIV can remain asymptomatic for years.
- Youth should be able to identify the bodily fluids that HIV is found in high enough concentrations to lead to possible transmission to another person (primarily blood and semen) and to distinguish these bodily fluids from those in which HIV is not found at all or not found in high enough concentrations to transmit HIV to another person (*e.g.*, saliva, urine, feces, sweat, and tears).
- Youth should be able to identify the ways that HIV is transmitted, the actual transmission risk associated with different types of sexual intimacy, and to identify and debunk myths about HIV transmission. Youth should be able to identify risk factors for HIV, specifically unprotected vaginal and anal sex.
- Youth should be able to identify HIV prevention methods for all sexual practices and to identify and debunk myths about prevention. This should include:
  - The ability to explain the proper use of condoms, lubricant, dental dams, and latex barriers during vaginal, oral, and anal sex.
  - The ability to explain how abstinence, sex with condoms, and sexual contact other than vaginal or anal sex can prevent HIV transmission.
  - The ability to understand how being on effective medical treatment greatly reduces the risk that a person with HIV will pass on the virus to another.
  - The ability to explain how the proper use of clean, sterile needles as opposed to reusing needles can prevent exposure to and transmission of HIV.
- Youth should understand the HIV testing process, state laws that protect their right to obtain a test without parental consent, state laws protecting their right to informed consent and counseling, and the ability to obtain access to treatment.
- Youth should be able to explain the concept of a "window period" following infection during which a person may still test negative though he/she may be HIV positive.
- Youth should understand the importance of testing if they have engaged in receptive anal or vaginal sexual activity, been sexually assaulted, or shared drug injection equipment..
- Youth should understand that at present there is no cure for HIV or AIDS, but recognize that treatment is available, that it can improve the health and prolong the life of people living with HIV, and reduce the risk that a person with HIV will pass the virus on to someone else.
  - Youth should understand that those undergoing treatment and who work to stay healthy can live for a very long time.

- Youth should be able to identify and discuss the harms of discrimination against people living with HIV.
- Youth should be informed of support groups for people living with HIV/AIDS and their loved ones.

C. Pregnancy

- Youth should be able to identify how pregnancy occurs and understand that pregnancy can happen anytime a female has unprotected vaginal intercourse with a male.
  - They should be able to identify and debunk myths about pregnancy prevention.
- Youth should understand the importance of prenatal care and should be informed of applicable state laws that may allow them to access pregnancy tests, prenatal care, and abortion services without parental consent or notification.

D. Prevention Skills

- Youth should be engaged in a frank discussion of their right to bodily autonomy in all situations.
  - They should know about their legal rights to refuse or consent to medical care, and their absolute right to be free from unwanted sexual contact in relationships, including from family members, other youth, and staff at detention or foster care facilities.
- As part of this conversation, youth should discuss the right to refuse any contact, including sexual, and should discuss and explain the importance of respecting another person's refusal and having your own refusal respected.
- In terms of relationships, youth should understand the concepts of negotiation, compromise, the issues that cannot be compromised, and how this concept applies to sexual practices and limits.
  - Youth should understand the importance of effective negotiation and how power inequalities in a relationship can have a significant effect on the health and safety of the individuals in the relationship and can affect negotiating power between the parties.
  - Harm reduction in negotiating safer sex should be discussed in detail, with priority given to concrete advice on less dangerous activities and negotiating condom use.

E. Sexual Orientation

- Youth should understand that:
  - Sexual orientation refers to a person's physical and/or romantic attraction to an individual of the same and/or different gender,
  - Sexual orientation falls across a spectrum, and that one's understanding and identification of his/her sexual orientation may change over the course of his/her lifetime.
  - Youth should understand that sexual orientation is only one aspect of who a person is.
  - Youth should also understand that gay and lesbian romantic relationships are just as fulfilling as heterosexual relationships, and that LGBTQ people form families and have children.
- Youth should understand that LGBTQ and heterosexual people come from all countries, cultures, races, ethnicities, socio-economic backgrounds, and religions.
- Youth should understand that scientific theories have concluded that sexual orientation cannot be changed by therapy or medicine.
- Youth should be able to identify discrimination against, rejection, and harassment of LGBTQ youth by peers, family, schools, and others and the effects that such behavior can have on LGBTQ youth.

  - Such effects include making LGBTQ youth afraid to identify as LGBTQ and increasing the risk of depression, dropping out of school, homelessness, and substance abuse among LGBTQ youth.
- Youth should understand that people of all sexual orientations deserve respect and have the right to express their sexual orientation and identity. Youth should be able to discuss strategies for reporting harassment of themselves or others based on sexual orientation.
- Youth should be able to identify and discuss the concepts of heterosexism, internalized homophobia, and how such phobias can contribute to LGBTQ adolescent isolation.
- Youth should understand the concept of coming out and why coming out can be important to an individual.
- Youth should be able to identify the additional challenges and threats LGBTQ youth of color may face due to both racism and homophobia.
- Youth should understand how intolerance and discrimination against LGBTQ youth can lead to increased mental health difficulties, such as depression, risk of suicide, and increased substance abuse among LGBTQ youth.
- Youth should understand that the majority of LGBTQ youth lead normal, productive lives and develop resilient adaptations to social biases and mistreatment.

F. Gender Roles & Gender Identity

- Youth must be able to define gender roles, gender identification, and gender stereotypes.
  - Youth should understand that gender identification may include male, female, or other (e.g. intersex, cross-gender, etc.) identification.
  - Gender expression may not necessarily match gender identity.
  - Youth should also understand that the way a person expresses his or her gender does not necessarily have anything to do with whether that person is heterosexual, gay, lesbian, or bisexual.
- Youth should understand and be able to recognize and describe the following definitions and concepts:
  - Transgender: "Transgender" describes people whose internal sense of gender (gender identity) doesn't match what society expects of them based on their biological sex. Transgender is also used as a general term to describe many different identities that exist such as "transsexual," "drag king," "drag queen," "crossdresser," "genderqueer," "shapeshifter," bigendered," and "androgyne." Transgender people are often described as: Male-to-female (M-to-F), or Female-to-male (F-to-M), or by the gender they currently identify with ("male identified" or "female identified").
  - Transsexuals: described people who have had, are in process of, or are planning sex-reassignment surgery. They may also use hormonal means to change parts of the body to match their own understanding of gender without having a complete genital sex-reassignment surgery.
  - Androgynes: describes androgynous presentation. Androgyne behavior combines both genders or is gender-neutral.
- Youth should be able to understand the concept of gender identity as something that may change over the course of an individual's lifetime, and that transgender people report experiencing conflict over gender assignment throughout childhood and adolescence.
- Youth should understand that gender identity is just one part of who a person is and discuss the need to respect people of all gender identities.

  - Youth should be able to identify gender discrimination, harassment, and violence, discuss the harms of discriminating against someone because of their gender identity, the impact that it has on individuals, and the need to report discrimination to a trusted adult, school official, or law enforcement authority.
- Youth should be aware that there is some federal, state, and local legal protection from discrimination based on gender identity, and youth should be aware of the laws in the city and state in which they reside.

G. Sexual Violence, Abuse, and Harassment

- Youth should be able to define the following concepts, recognize them in the various forms and circumstances in which they occur, discuss their consequences:
  - Sexual abuse
  - Sexual harassment/harassment based on perceived sexual orientation or gender identity
  - Sexual assault
  - Domestic violence
  - Sexual coercion
  - Rape
- Youth should understand how a person who has been the victim of any of the acts listed above can report such acts to the appropriate authorities and can benefit from support and counseling.
  - Youth should know that all acts of sexual abuse, violence, and harassment, including verbal harassment and abuse, are against the law, and that they have legal recourse.
  - Youth should know that sexual abuse is never appropriate or acceptable in any setting (including foster care homes, detention facilities, school, etc.).
  - Youth should also know that there are many different people that they can report such abuse to (*i.e.*: doctors, police, teachers, school counselors, etc.).
  - Youth should know both the moral and legal reasons why they should never be perpetrators of sexual violence, abuse, or harassment. They should know that they are still legally responsible for their behavior even if such behavior occurs while in state detention facilities.
  - Youth should know how to report abuse while in a detention facility, including abuse perpetrated by other youth.
  - Youth should be assured that they will be protected from violence, abuse or retaliation in the event that they report sexual abuse by a staff member or other youth, regardless of whether they are themselves the targets of such abuse. Youth should be informed of how those who report abuse will be protected from subsequent harm related to such reports.
- Youth should be able to identify what steps to take if they have been the victims of sexual assault, the benefits of seeking medical and mental health care if they have been the victim of sexual assault, and how they can seek this type of care after a sexual assault.

H. Facility & Community Resources

- Instructors should provide youth with community resources and contact information for additional information on all issues discussed.
  - This should also include resources for further inquiry into topics regarding sexuality, sexual health, violence, relationships, discrimination, and LGBTQ issues and questions.

IV. For Youth in Custody 1-2 Months

Youth must be provided with all resources discussed in Sections I, II, and III.

Youth should be provided education and training sufficient to achieve proficiency in the following additional minimum content areas:

A. Specific STIs:

- Youth receive education and information with regard to the following STIs:
  - Chlamydia
  - Gonorrhea
  - Syphilis
  - Human Papillomavirus (HPV)
  - Genital Herpes
  - Hepatitis B
- This information and education must be sufficient to provide youth with an understanding of the following information and concepts for each STI:
  - Prevalence among demographics relevant to the specific youth (*e.g.*, youth, youth in the state or region)
  - Whether it is caused by bacteria or virus
  - Symptoms and whether the STI can be asymptomatic
  - Complications that can result from infection
  - How STIs can be transmitted and transmission myths
  - How transmission can be prevented through abstinence; use of condoms, dental dams, or latex barriers during specific sexual practices; use of clean needles; and through any other applicable methods
  - How youth should be offered testing for STIs, the importance of testing, and information should be provided summarizing state laws that allow youth to be tested without parental consent or notification of results
  - The cures, treatment, or vaccines available for STIs and the importance of treatment to avoid future complications

B. Risk Continuum for Pregnancy, STIs, and HIV

- Youth should be able to identify the risk of HIV transmission, HPV, herpes, and other STIs in the sexual practices listed below. Instructors should emphasize the distinctions between the categories and discuss what each category means in terms of statistical risk. If "typical use" or "actual use" statistics are used with regard to condom use, "perfect use" statistics should also be mentioned.
- Even in cases where someone is exposed to HIV through sex or a needle, a 28-day course of anti-retroviral drugs, known as post-exposure prophylaxis (n-PEP) appears effective in preventing infection.
- In using the Risk Continuum, instructors should be sure to emphasize youth's opportunities to protect themselves rather than use fear-based tactics. Terms such as "insertive" and "receptive" should be explained to youth.

Risk Continuum:

- Little or No Risk:
  - Abstinence; hugging, massage; masturbation; fantasy; phone sex; dry kissing; cyber sex; unshared sex toys; and having sex with a monogamous and uninfected partner
  - Sexual stimulation of another using one's hands; giving a man oral sex without putting the head of his penis in one's mouth; giving or receiving oral sex with a condom, dental dam, or plastic wrap; receiving oral sex without a barrier; sharing sex toys with cleaning or use of a new condom; and tongue kissing
  - Insertive or receptive vaginal sex with a condom and insertive anal sex with a condom
- Possible Risk:
  - Receptive anal sex with a condom
  - Receptive anal or vaginal sex with someone who is HIV-positive but is on effective medication and has an undetectable viral load.
- Known Risk:
  - When discussing risk, instructors should make it clear that individual risk is affected by many factors, e.g., whether one or both partners has had an STI, whether a person with HIV is on effective treatment and has no detectable viral load, and so on.
    - Giving oral sex without a condom, dental dam, or plastic wrap (noting that it is safer if there is no ejaculation in the mouth and there is no known risk for women who have sex with women)
    - Sharing sex toys without cleaning or use of new condom
    - Insertive anal sex without a condom and insertive vaginal sex without a condom
    - Receptive anal sex without a condom and receptive vaginal sex without a condom

C. Contraception

- Youth should understand what contraception is, that it can help prevent pregnancy, and that some, but not all, also reduce the risk of certain STIs.
- Youth should be able to weigh the risks and advantages of contraception methods and understand that a responsible and knowledgeable adult (such as a physician) can help them select a method of contraception.
- Youth should be familiar with how contraception can be integrated into a relationship.
  - They should be able to discuss the differing views on contraception depending on religion, cultural values, and personal values.
- Youth should be able to identify the following contraception methods and know that they are available "over the counter," without a visit to a health care provider:
  - Male condoms
  - Female condoms
  - Spermicides in their different forms
- Youth should be able to identify their effectiveness for pregnancy prevention, STI and HIV prevention, and other advantages and disadvantages.
- Youth should understand how birth control pills and other commonly used forms of hormonal contraception work and that they are available by prescription from a health care provider.
  - They should understand that most cities have sexual health clinics, such as Planned Parenthood, where young people can get counseling, sexual health exams, and prescriptions for birth control at reduced prices.

- They should be able to identify their effectiveness or ineffectiveness for pregnancy prevention, STI and HIV prevention, and other advantages and disadvantages.
- Youth must be provided with information on health care providers they can visit within the facility and outside the facility to obtain contraception.

- Youth should understand how emergency contraception (EC) works and that a visit to a health care provider is required to obtain such contraception until they are 17 years old.
  - They should be able to identify EC's effectiveness for pregnancy prevention, STI and HIV prevention, and other advantages and disadvantages. Youth must be provided with information on health care providers they can visit within the facility and outside the facility to obtain EC. Youth should understand the distinction between EC and the abortion pill, and that EC will not end a pregnancy.
- Youth should understand the concept of delaying sex (i.e. sexual abstinence) and how it can prevent unwanted pregnancy, STIs, and HIV.
  - They should understand and be able to discuss the benefits and challenges of abstinence, how people can give and receive sexual pleasure without intercourse, and how to have a romantic relationship and express feelings without intercourse.
  - Youth should understand the concept of sexual limits and the importance of discussing such sexual limits with their partners.

V. For Youth in Custody Over 2 Months

Youth must be provided with all training and resources discussed in Sections I, II, III, and IV.

Youth should be provided education and training sufficient to achieve proficiency in the following additional minimum content areas:

A. Anatomy & Development:

- Youth should be able to identify and understand the functions of the following anatomy: the nipples, urethra, urethral opening; buttocks, anus, penis, testicles, scrotum, sperm, seminal fluid, uterus, cervix, ovaries, fallopian tubes, and ovum.
- Youth should understand how the reproductive systems work, including the process of male sperm production, erection, and ejaculation, and the female process of ovulation and menstruation.
- Youth should understand that sex is not binary, that not all bodies follow this pattern, and that all bodies are deserving of respect.
  - Youth should understand what it means to be an intersex individual. [2]

[2] "'Intersex' is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male. For example, a person might be born with external female genitalia but the internal anatomy of the person has male genitalia. Or a person may be born with genitals that seem to be in-between the usual male and female types—for example, a girl may be born lacking a vaginal opening, or a boy may be born a scrotum that is divided so that it has formed more like labia. Or a person may be born with mosaic genetics, so that some of her cells have XX chromosomes and some of them have XY." Intersex Society of America, *What is Intersex?* (2010), available at http://www.isna.org/faq/what_is_intersex (last visited September 29, 2011).

B. Sexuality & Healthy Relationships

- Youth should be able to understand the concept of sexuality as the expression of human sexual feeling, and a natural, healthy part of being human.
    - Youth should be able to discuss the concept of sexuality as including how a person feels about his or her body, whether a person feels masculine or feminine or somewhere in between, the way a person dresses, the way a person moves, how a person speaks, the way a person acts and feels about other people, and who the person is attracted to and falls in love with. This list is meant to be inclusive, not exclusive. Youth should be able to address other aspects of sexuality that are not listed above.
    - Youth should understand that sexuality is multifaceted and has biological, social, psychological, spiritual, ethical, and cultural dimensions.
    - Youth should understand that most people, regardless of biological sex, gender, age, ability, and culture are sexual beings, though sexual expression is not necessarily a significant part of some people's lives.
    - Youth should be able to identify how sexuality can be more rewarding and positive when expressed in a non-exploitive way.
    - Youth should understand that sexuality is experienced in a variety of ways at different stages and points in people's lives. And that everyone has their own way of expressing their sexuality to others and every person has their own way of feeling or experiencing it for themselves.
- Sexuality, Society, and Culture:
    - Sexuality & Society: Youth should be able to discuss the messages society gives them about how they are supposed to act, date, and sexually behave; how these messages can often conflict with messages from their family and community; how these messages may differ depending on their gender and age; and how these messages contribute to peer pressure. Youth should understand the diversity of views on sexuality and the importance of making independent decisions. Youth should practice the ability to critically evaluate messages from different sources and establish guidelines for their own behavior.
    - Sexuality & the Media: Youth should be able to discuss and describe the profound effect media has on sexual information, values, and behavior; ways in which the media's portrayal of sexuality is realistic and unrealistic; and the messages they have received from television, movies, music videos, and on the internet and whether these messages are accurate. Youth should be able to identify stereotypes reflected in the media and how these stereotypes can negatively affect them and their opinion about certain groups of people, including LGBTQ individuals, and gender roles.
    - Sexuality & Religion: Youth should be able to discuss and describe how various religions' views about sexuality affect people's sexual attitudes, behaviors, and sexual decision-making and the conflict that can occur between peoples' values and religious beliefs in the context of sexuality. Youth should understand how gender roles and beliefs about sexual orientation have historically been affected by religion and how, although LGBTQ people have historically been excluded from many religious congregations, a growing number of congregations now openly welcome members of the LGBTQ community. Youth should be encouraged to discuss ways that religion has affected their feelings about sexuality or the feelings of someone they know.
    - Sexuality and the Law: Youth should be familiar with the U.S. laws governing sexual and reproductive rights. This particularly pertains to the following:

- The Supreme Court has ruled that, to a certain extent, people have the right to make personal decisions concerning sexuality and reproductive health matters, such as abortion, contraception, sterilization, and engaging in same-sex sexual relationships.
- State laws govern the age of consent for sexual behaviors.
- Some states and cities have passed laws banning discrimination on the basis of sexual orientation. Youth should be familiar with relevant laws in their city or state.
- The Supreme Court recently ruled that state laws restricting certain types of sexual behavior between consenting adults are unconstitutional. Consenting adults, regardless of gender or sexual identity, cannot be prosecuted for engaging in a sexual relationship.
- Courts across the United States are currently debating legal issues concerning same-sex marriage.
- Public nuisance behavior, such as exhibitionism and voyeurism, are illegal in most states.
- Prostitution is illegal in all states except for Nevada.
- Child pornography – a visual depiction of a minor engaging in sexually explicit conduct – is illegal in all states.
- Some federal and state laws protect individuals from harassment in jobs, schools, and state institutions if the harassment is based on the individual's sex, their identified or perceived sexual orientation, or gender identity.

C. Pregnancy & Pregnancy Options

- Youth should be familiar with their legal and civil rights regarding pregnancy as a minor.
  - They should be familiar with the state and federal laws that allow them to receive confidential medical care and, to the extent true in their jurisdiction, make decisions regarding the continuation or termination of their pregnancy.
- Males should be aware of their rights, and their legal responsibilities relating to pregnancy.
- All youth should be made aware of specific services available to them, and, depending on the laws and regulations in their jurisdiction, the right to obtain care without the consent of their parents or foster parents.
  - Prenatal Care: Youth should be familiar with what prenatal care entails and why it is important.
    - Specifically, youth should be familiar with the benefits of exercise, healthful foods, visits to a healthcare provider and testing and treatment for STIs and HIV, and the potential harms of alcohol, tobacco, drugs, and STIs and HIV. Women who are pregnant or considering becoming pregnant should take care of their reproductive health and seek prenatal care.
  - Pregnancy Options: Youth should be able to identify all options available to a woman who has an unwanted pregnancy. These options include parenting, adoption, foster care, and abortion.
    - Youth should be familiar with how adoption works according to state law. They should be provided the names and contact information of adoption resources.
    - Abortion:
      - Youth should understand what an abortion is, that it is performed by a healthcare provider, and that it is generally very safe and rarely interferes with a woman's ability to become pregnant or give birth in the future. Youth should be able to identify facts and myths about abortion safety.
      - Youth should be able to distinguish between surgical and medical abortion and to distinguish abortion from emergency contraception.

- Youth should be familiar with constitutional and state law protections of a woman's right to have an abortion and a minor's right to have an abortion.
  - If state law requires parental notification or consent with a bypass mechanism, youth should be familiar with these requirements and the bypass mechanism. Youth should be familiar with their own state's abortion limitations based on the length of the pregnancy, as well as exceptions to these restrictions. Youth should also be familiar with laws protecting their confidentiality in obtaining an abortion.
- Youth should be familiar with possible state legal protections preventing others—including parents and partners—from forcing a woman or minor to have an abortion against her will.
- Youth should be familiar their rights regarding abortion access and payment while in custody. This is a complex set of legal rights that vary greatly according to state law, and youth should be made familiar with the laws in their state.

D. Contraception

- Youth should be able to identify the contraception methods listed below. They should know that the contraception methods are available by prescription from a health care provider. Youth should also be able to identify their effectiveness for pregnancy prevention, STI and HIV prevention, and other advantages and disadvantages. If phrases such as "perfect use" and "typical use" are used in discussion, they should be explained to the youth so that they are not potentially misleading.
  - Condoms
  - Birth Control Pills
  - Birth Control Injections
  - Birth Control Patch
  - Birth Control Ring
  - Intrauterine Contraceptives (IUC)
  - Implants (Implanon)
  - Emergency Contraception
    - This form of contraception can be used up to 120 hours (5 days) after unprotected sex. It is more commonly referred to as the Morning After Pill or Plan B.

E. Reproductive Coercion

- Youth should be engaged in a thorough discussion of reproductive coercion.
  - They should understand that no person may force another person to become pregnant or stay pregnant against their own will.
  - Youth should understand that any pressure to become pregnant, whether through verbal threats, physical aggression, or birth-control sabotage, is a violation of their rights.

F. Communication Skills

- Youth should be able to explain and apply the components of effective communication and to explain the importance of effective communication and being an advocate for their own needs.
- Youth should be able to identify different communication styles, and to distinguish effective and ineffective communication tactics.
- Youth should understand how to apply effective communication skills in various circumstances including sexual relationships, friendships, and with health care providers.

G. Drug Use/Harm Reduction Skills

- Youth should be able to identify that drugs and alcohol can significantly influence one's behavior and decision-making skills. The effects of drugs and alcohol can lead to unintended, negative consequences.
- Youth should be able to identify factors that cause individuals to use drugs and alcohol.
- Youth should be able to identify and apply ways to make responsible decisions about drug and alcohol use.
- Youth should be able to discuss ways to reduce their risk behaviors if they are using drugs and alcohol. Particular discussion should surround the use of intravenous drugs, and the need to use clean needles. Youth should be provided with information about where to acquire clean needles.
- Youth should also be able to identify facility or community resources if they chose to stop using drugs or alcohol and they would like help getting clean.

H. Paternity, Child Support, and Coping as a Young Parent

- Paternity, Public Assistance, and Child Support:
  - Youth should be able to identify what paternity is, how it can be established, and the benefits and rights a father, mother, and child may gain when paternity is established.
  - Youth should be able to identify the legal responsibilities of parents and the resources available to young parents to learn the skills needed to support their children.
  - Youth should be able to describe the impact that establishing paternity can have in terms of public assistance, such as welfare, and for child support and visitation. Youth should be able to distinguish the differences between child support and visitation rights.
- Coping as a Young Parent:
  - Youth should be able to describe the importance of parents having a positive relationship both with their child and the person caring for their child, and best practices for achieving this.
  - For parents who are youth in detention, they should be able to identify the importance of telling children where they are when they are in state custody. Subsequently, they should have information on how to deal with children's reactions to their detention. In preparation for release, they must have information regarding how to prepare to be reunited with their children and their responsibilities for their children.
  - Youth should be able to identify positive and negative parenting behaviors, including the importance of being respectful to the other person caring for their child, listening to their child, creating a written parenting plan, not criticizing the other parent or caretaker to the child, and not fighting with the other parent or caretaker in front of the child.
  - Youth should be able to discuss anger management strategies, and the difficulties and rewards of breaking the potential cycle of violence within their families. They should be given clear resources for parenting help and strategies within their community.

Part Two: Instructional Characteristics

Part One outlined the minimum goals that the curriculum's content should be tailored to achieve. Part Two provides guidance on how to select and implement a curriculum that ensures this content is presented effectively. Part Two also identifies goals that should be achieved in the curriculum and should be addressed by the instructors. Effective teaching requires not only the right curriculum content, but also a safe, inclusive environment. The teaching methods used should also help youth understand and apply new information as well as change attitudes and behavior. This section outlines elements that will help prepare and execute an effective curriculum.

I. Curriculum Characteristics

The curriculum should:

- Convey the information set forth in Part One in a comprehensive and scientifically accurate manner.
- The curriculum should focus on the following goals: preventing STIs, HIV, and unwanted pregnancy; decreasing sexual abuse while increasing the reporting and detection of such abuse; promoting an accurate understanding of the nature and importance of sexual orientation and gender identity; and providing a supportive, healthy, and inclusive environment for LGBTQ youth.
- Focus clearly on the goals:
    - The majority of lessons, activities, and facts should support achieving the goals.
    - The curriculum should clearly and accurately inform young people about STIs, HIV, becoming pregnant (or impregnating another), sexual abuse, and issues surrounding sexuality and sexual orientation.
    - The curriculum should clearly and accurately inform young people about the health, psychological, and long-term consequences of STIs, HIV, unintended pregnancy, sexual abuse, and discrimination based on one's sexual orientation or gender identity.
    - The curriculum should include activities that motivate young people to protect themselves from STIs, HIV, and unintended pregnancy. It should also include information about identifying and reporting sexual abuse.
- Focus on specific behaviors to achieve goals:
    - Examples of specific behaviors that lead directly to achieving goals include, but are not limited to: abstinence, condom use, dental dams, STI testing and treatment, HIV testing and treatment, access to contraception, understanding one's anatomy and being able to identify healthy versus unsafe and physically harmful relationships, and building and demonstrating respect for persons of all sexual orientations.
- The curriculum must address, in tangible ways, the actual experiences of the youth in state care. The curriculum must recognize that the risk-taking done on a daily basis by these youth, while often alarming, can make sense in the context of their real and perceived choices. The youth need practical resources on how to manage existing conditions and the repercussions of sexual assault, homelessness, sex work, drug use and pregnancy.
- Instructors must address violence and harassment perpetrated by youth and adults against LGBTQ youth.

  - Educators should – in a non-accusatory manner – discuss why a range of behaviors, from teasing to outright assault, is detrimental. Instructors should also discourage youth from taking a "sidelines" attitude when witnessing harassment and violence.
- Programs must not ignore issues of sexism, racism, and homophobia as they relate to sexual violence.
  - Effective sexual assault prevention programs must address broader issues of societal contempt for women, people of color, and LGBTQ people.
  - Sexual assault of men should also be addressed, and it should not be assumed that men could never experience assault themselves.
  - Young people should also be educated as bystanders in recognizing sexual assault and intervening in a safe manner.
- Instructors must have trauma training, and should be hyper aware of the effect of their lessons on the participating youth. The curriculum and instructors should assume that most, if not all, of the risk behaviors and risk traits exist within their classroom or instructional setting. HIV and STI infection, a history of sexual assault, LGBTQ persons, and pregnancy are all likely to be present in the group of youth.
  - Every effort should be made to make lessons informative and non-judgmental, and no youth should ever be singled out to share his/her personal experience unless that information is readily volunteered by the youth.

II. Teaching Characteristics

A. Environment

- The curriculum should create a safe social environment for youth to participate. If the social environment does not feel safe to participants, they are much less likely to actively engage, express their views, ask questions, or internalize the important messages of the curriculum. The following steps should be taken to ensure a safe social environment:
  - The institution should have policies providing for confidentiality during sexuality education instruction. These confidentiality policies would apply to any and all staff present as well as youth.
  - Staff should be well-versed in confidentiality policies and should face penalties for violation of confidentiality. The rules of confidentiality among youth and staff, as well as a clear explanation of what information must be legally reported, should be explained to all youth and staff at the beginning of instruction and when any new youth or staff member is present.
  - Spend sufficient time at the beginning for introductions, icebreakers if necessary, and establishing group ground rules (e.g. one person talks at a time, no put-downs, what is said in the room stays in the room, etc.).
  - Provide adequate opportunities for all youth to participate.
  - Encourage facilitators to praise youth and provide positive reinforcement where appropriate.

B. Instruction Methods

- Employ instructionally-sound teaching methods that actively involve the participants and help participants personalize the information.
  - Examples: Short lectures, class discussion, small group work, brainstorming sessions, role plays, videos, stories, live skits, simulations of risks and practicing strategies to avoid risk, competitive games, forced-choice activities, surveys of attitudes and intentions, problem solving activities, and condom demonstrations.

- Employ activities, instructional methods, and behavioral messages that are appropriate to the youth's culture, developmental age, and sexual experience.
- Cover topics in a logical sequence.

C. Curricula and Instructors Should Adhere to the Following Principles:[3]

- Young people need and deserve respect.
  - This includes an appreciation for the difficulty and confusion of adolescence and of the many factors that have contributed to the problems that youth – particularly youth in state custody – face.
  - Youth are deserving of respect and should be treated in a respectful manner and tone.
- Youth need to be accepted.
  - Instructors must listen to and hear what young people have to say, even if the instructor disagrees with what is being said.
  - In general, it is more effective to explore the possible pitfalls of youth attitudes than for an instructor to tell them what youth ought to believe and do.
- Youth learn as much, if not more, from each other as from adults.
  - Often, if instructors let youth talk, allow them to respond to each other's questions and comments and ask for their advice, youth feel empowered and take responsibility for their own learning.
  - It is much more powerful for a peer to challenge another youth's attitude than for an adult to do so.
- Open, honest, scientifically correct information and communication about sexuality is essential.
  - For most of their lives these youth have gotten the message that sex is hidden, mysterious, and something that should not be discussed in a serious and honest manner. Limiting what youth can talk about and using vague language perpetuates this secrecy and mystery.
- A positive approach to sexuality education is the best approach.
  - Both the risks and pleasures of sex should be acknowledged in a balanced way. Sex should be associated both with things grave and serious and with things open, playful, and humorous.
  - Offer a model of what it is to be sexually healthy rather than focusing on what is sexually unhealthy.
- Young people have a fundamental right to sexuality education.
  - Young people have a right to know about their own bodies, how they function, and about the sexual changes that are occurring to them now and will continue throughout their lifetimes. They have a right to have their questions answered.
- Youth who have explored their own values and attitudes and have accurate information are in the best position to make healthy decisions about their sexual lives.
- All sexual orientations and gender identities must be acknowledged.
  - Some youth are, or think they may be lesbian, gay, bisexual, or transgender. It is important to create an environment that recognizes the needs of these often isolated and invisible youth.
  - Teaching frankly about sexual orientation and gender identities benefits all youth because it allays fears about same-sex feelings or gender identity that many of them experience.

[3] Planned Parenthood of Greater N. N.J., *Principles of Sexuality Education* (2001) (adapted from Steve Brown & Bill Taverner, *Streetwise to Sex-Wise: Sexuality Education for High Risk Youth*) (on file with CHLP; available for cost at http://www.plannedparenthood.org/greater-northern-nj/book-details-30042.htm (last visited September 30,2011).

Part Three: Instructor Characteristics

Set forth below are the minimum requirements that sexual health education instructors providing instruction for youth in custody should possess. Instructors are encouraged to exceed these minimum requirements, and to receive continuing education beyond what is set forth below to ensure that their knowledge is up-to-date and relevant.

I. Knowledge of Content

Instructors must have completed relevant undergraduate, graduate, or professional development coursework that has provided them significant training in the following topics:

- Adolescent development
- Basic sexuality education
- Anatomy and reproduction, including:
    - General sexual health
    - STIs and HIV/AIDS, including testing, transmission, symptoms, treatment, and all prevention methods.
    - Pregnancy and contraception
    - Puberty
    - Sexual response
    - LGBTQ health issues
- Gender identity
- Sexual assault, including training on recognizing the facts and risks of sexual assault; staff predation; and the provision of aid to those who have been sexually assaulted recently or in the past.

II. Attitudes & Values:

Instructors must have completed relevant undergraduate, graduate, or professional development coursework and significant training in the following:

- Homophobia reduction, including
    - Inclusive language
    - Challenges facing LGBTQ youth, including the difficulties in coming out
    - Gender stereotyping reduction
- Group facilitation and activity-based learning

Instructors must have completed a Sexual Attitude Reassessment seminar.

Instructors should demonstrate personal qualities of effective teachers, including, but not limited to:

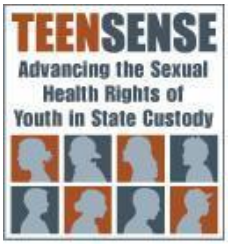
- Willingness and enthusiasm for teaching this subject area.
- Belief that sexual adjustment is an important aspect of total personality adjustment.
- Comfort with one's own sexuality, sexuality in general, and topics to be covered.
- Clarity on one's own personal code of ethics and values.
- Open-minded and non-judgmental attitude with respect to values, attitudes, beliefs, and behaviors that may differ from the instructor's own.

- Respect for different cultural and religious values and beliefs.
- Ability to relate effectively to youth, with honesty, warmth, and sensitivity.
- Willingness to learn and enthusiasm, rather than hostility, to new information and teaching methodologies.

III. Methods

Instructors must demonstrate familiarity with, and the ability to design and implement lesson plans that achieve the content goals in, Part One and use the methods described in Part Two. This includes having skills regarding:

- Using appropriate communication and teaching techniques, such as role playing, brainstorming, large and small group processing, and cooperative learning.
- Creating an effective, functional learning environment that develops and enhances youth's motivation to learn



MODEL POLICY
TRAINING FOR YOUTH FACILITY STAFF: ENSURING COMPETENCE THAT INCLUDES THE RIGHTS AND NEEDS OF LGBTQ YOUTH

It shall be the policy of **[this agency/jurisdiction]** to provide relevant training to all staff of foster care, detention, and other government operated and regulated youth facilities that equips the staff to understand and protect the health and well-being of all youth, regardless of the youth's gender identity or sexual orientation.

Staff at every level of child welfare, juvenile justice, and other youth agencies – including but not limited to medical and social service providers, security personnel, and staff of educational, food service, and athletic programs – shall be trained on the rights of all youth to health, sexual and reproductive services, autonomy, safety, and freedom from all forms of discrimination and harassment. Staff training shall also reflect the need for universal staff competence in communicating with and advising all youth.

At the conclusion of training staff shall be able to:

- Identify the effects of stigma or discrimination on lesbian, gay, bisexual, transgender, or questioning (LGBTQ) or HIV-positive youth's health;
- Understand their responsibilities to provide comprehensive physical and mental health services to all youth in a respectful manner;
- Maintain confidentiality and an atmosphere of safety and acceptance;
- Ensure access to services and social events consistent with LGBTQ youth's interests and communities with which they identify;
- Abide by the relevant laws and agency policies established to support all youth; and
- Explain procedures for reporting and responding to youth and staff complaints about conduct that is in conflict with these policies.

Teen SENSE

Model Staff Training Standards

Focusing on the Needs of LGBTQ Youth in State Custody

THE CENTER FOR HIV LAW & POLICY

TEENSENSE
Advancing the Sexual Health Rights of Youth in State Custody

This work is made possible
by generous donations from:

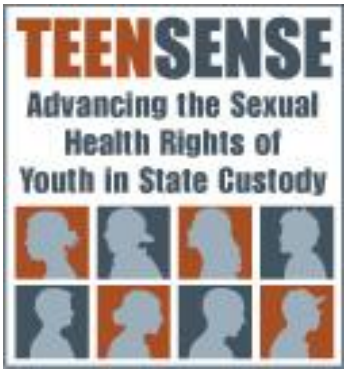
These Standards Have Been Endorsed By:

Administration for Children's Services, New York City
African American Office of Gay Concerns
AIDS Alliance for Children, Youth and Families
BreakOUT!, New Orleans, LA
HiTOPS, New Jersey
Hetrick-Martin Institute
Hyacinth AIDS Foundation
Juvenile Justice Project of Louisiana
National Center for Lesbian Rights
National Coalition of Anti-Violence Programs (NCAVP)
National Organization of Women, New Jersey
National Alliance of State and Territorial AIDS Directors (NASTAD)
Planned Parenthood of Greater Northern New Jersey
SUNY Downstate Medical Center: HEAT Program, Brooklyn, NY
SUNY Downstate Medical Center: FACES Network, Brooklyn, NY
True Colors, Inc. Sexual Minority Youth Services of CT
University of Medicine and Dentistry of New Jersey: Paulette Stanford, MD, Division of Adolescent and Youth Adult Medicine
University of Medicine and Dentistry of New Jersey: JumP

THE CENTER FOR HIV LAW & POLICY

TEENSENSE

MODEL STAFF TRAINING STANDARDS:
Focusing on the needs of LGBTQ Youth



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.

To contact us:
Email us at info@hivlawandpolicy.org.

Or write to:
The Center for HIV Law and Policy
65 Broadway, Suite 832
New York, NY 10006
212.430.6733
212.430.6734 fax

Acknowledgements

The Center for HIV Law and Policy thanks Paula Toynton, Jody Marksamer, Melissa Keyes-Digioia, Stephen Pitts, Gulielma Leonard Fager, and Nancy Camaaño for their helpful comments and collaboration. This document reflects all of their input. We also thank the youth of the New Jersey Training School for Boys of Monroe Township, New Jersey, and the Female Secure Care and Intake Facility of Bordentown, New Jersey, for their honesty and insight, and the staff of the respective facilities for their hospitality.

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 Foundation.

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 great risk of HIV and other STIs, they are overwhelmingly 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 for the 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.

MODEL STAFF TRAINING STANDARDS:
Focusing on the needs of LGBTQ Youth

Executive Summary

The Teen SENSE Model Staff Training Standards are designed to ensure that all staff of foster care, detention, and other government operated and regulated youth facilities are equipped to understand and protect the health and well-being of all youth, regardless of sexual orientation or gender identity. These standards should serve as a guide for staff at every level of child welfare and juvenile justice agencies, from medical service providers to security personnel, who should be trained on the rights of all youth to freedom from all forms of discrimination, and to health, sexual and reproductive autonomy, and safety. The standards also reflect the need for universal staff competence in communicating with and advising all youth.

Under the Model Staff Training Standards, staff's responsibilities include: being able to identify the effects of stigma or discrimination on LGBTQ or HIV-positive youth's health; understanding their responsibilities to provide comprehensive physical and mental health services to all youth in a respectful manner; maintaining confidentiality and an atmosphere of safety and acceptance; ensuring access to services and social events consistent with LGBTQ youth's interests and communities with which they identify; and abiding by the relevant laws and agency policies established to support all youth.

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 Foundation.

Table of Contents

Introduction

What are the Model Staff Training Standards?

These Model Staff Training 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 youth sexual health care into one set of interrelated standards. The Staff Training Standards are intended to help facility directors and trainers ensure that training curricula for staff at juvenile detention and foster care facilities include the minimum amount of information that will allow staff to adequately understand and respond to the needs of all youth in their custody, including lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth.

Unlike the Teen SENSE Model Sexual Health Care and Model Sexual Health Education Standards, which address the needs of both heterosexual and LGBTQ youth, the Model Staff Training Standards are focused on the particular needs of LBGTQ youth. LGBTQ youth are disproportionately represented in state foster care and detention facilities and often face harassment, physical and emotional abuse, and are ostracized by other youth and the adults charged with their care. The Model Staff Training Standards address the general lack of understanding about sexual orientation and gender identity, and the need for youth facility staff to be culturally competent in LGBTQ issues to prevent abuse and harassment.

The Teen SENSE Standards emphasize that comprehensive sexual health care must be integrated throughout a youth's stay while in the custody of the state. Youth in state custody, including LGBTQ youth, are more likely to engage in behaviors that put them at risk of acquiring HIV and other STIs. A variety of factors likely contribute to this increased vulnerability, including a past history of sexual abuse and physical trauma, limited access to health care, and little or no sexuality education.[1] Transgender youth in foster care and state detention facilities typically have unique health needs, especially if they have been receiving hormone therapy. Access to sexual health care is a fundamental part of the essential health care to which youth in state custody have a right under state, federal and international law. In turn, sexual health safety requires that all staff at every level of a state foster care or detention facility understand and respect the needs of these young people and how they, as staff, can help to address those needs.

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 care. 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.

[1] See Linda A. Teplin et al., *HIV and AIDS Risk Behaviors in Juvenile Detainees: Implications for Public Health Policy*, 93 Am. J. Pub. Health 906, 910 (2003); American Academy of Pediatrics, Committee on Adolescence, *Health Care for Children and Adolescents in the Juvenile Correctional Care System*, 107 Pediatrics 799 (2001).

How were the Standards created?

The core of the document is based on materials from the National Commission on Correctional Health Care, *Standards for Health Services in Juvenile Detention & Confinement Facilities*, Standard Y-C-09 (2004); Physicians for Reproductive Choice & Health ("PRCH"), Adolescent Reproductive Education Health Program ("ARHEP"), *Gay, Lesbian, BiSexual, Transgendered & Questioning Adolescents*, Power Point Presentation (2006); Child Welfare League of America, *Best Practice Guidelines for Serving LGBTQ Youth in Out-of-Home Care* (2006); and the National Center for Lesbian Rights, *The Legal Rights of Young People in State Custody* (2006). These Standards are not a curriculum, but rather reflect minimum requirements that curricula should reflect in order to appropriately meet the needs of youth in the state's care.

Standards for Staff Training

I. Goal

To ensure that training curricula designed for staff at state foster care and youth detention facilities meet basic standards regarding the health and well-being of all youth in state custody, regardless of sexual orientation or gender identity.

II. Target Audience

Staff *at every level* of child welfare and juvenile justice agencies, including all administrative staff, medical and mental health providers, direct care staff, social workers, contractors, security personnel, and any other employees or volunteers who may have contact with youth in custody.

III. Core Components of Comprehensive Staff Training Programs

1. Training Protocol Standards

Training sessions will:

- Be provided to all members of target audience at initial orientation and at designated intervals thereafter to reinforce concepts.
- Take into account the professional roles, professional and life experience, education, and learning styles of participants.
- Use principles and practices of adult learning and active training to create effective training programs.

2. Training Outcome Standards

These standards are designed to help trainers develop staff training curricula that address the many general and sexual health care needs of youth, particularly LGBTQ youth, in state custody. In order for staff training to be effective, training programs for juvenile justice and child welfare staff should help participants become able to:

- Protect the rights of all youth, including LGBTQ and HIV-positive youth, in state custody.
- Describe the correlation between the effects of stigma based on sexual orientation or gender identity and the reasons why some youth may be in custody.
- Explain the meaning and immutability of sexual orientation, gender identity, and gender expression as an inalienable part of individual and human identity and self-worth.
- Explain the detrimental effects that homophobia and transphobia have on health outcomes for LGBTQ youth.
- Implement agency policies and practices that support healthy, safe, age-appropriate exploration and expression of sexual/gender identity for all youth.

- Provide for the privacy and confidentiality of all youth, including LGBTQ and HIV-positive youth.
- Provide for the safety of all youth, including LGBTQ and HIV-positive youth.
- Apply rules regarding sexuality and sexual or gender-related behavior equally to all youth.
- Engage respectfully with LGBTQ youth's gender identity and expression.
- Ensure that LGBTQ youth have knowledge of and access to services and/or social events consistent with their interests and geared toward the community with which they identify.
- Use appropriate and respectful terms to identify youth of all sexual orientations and gender identities.
- Make referrals and provide resources as necessary for sexual health care and treatment.
- Appreciate and understand the need for these competencies and make an investment in the process.
- Ensure that the specific health care needs of transgender youth are met.

IV. Content Areas

In order to meet educational objectives, trainings should cover the following content areas at a minimum:

- Law and policy;
- Diversity/cultural awareness/vocabulary;
- Identity/sexuality/gender formation;
- Effects of homophobia/transphobia/heterosexism;
- Importance of appropriate sexual health education;
- Understanding, identifying, preventing, and reporting sexual abuse by staff or other youth.

V. Educational Objectives[2]

1. Protect the rights of all youth, including LGBTQ and HIV-positive youth, in state custody.

Youth are particularly vulnerable to rights abuses, either because they do not fully understand their own rights, or because they feel – or actually are – powerless to assert them. This is especially true for youth in state custody. Staff must understand, respect, and protect the rights of youth in their care.

To demonstrate competency, participants will be able to:

- Understand their legal and ethical responsibilities to treat all youth, including LGBTQ and HIV-positive youth, fairly and with respect.
- Identify the state, federal, and international rights of youth in state custody.[3]

[2] See National Center for Lesbian Rights, *LGBTQ Youth in the Juvenile Justice System* (2006) and *The Legal Rights of LGBTQ Youth in the Child Welfare System* (2006), available at http://www.nclrights.org/site/PageServer?pagename=issue_youth_docsDownloads#fcjj (last visited Sept. 16, 2011).

- Articulate application of state laws and policies prohibiting discrimination based on sexual orientation and gender identity to youth in state custody.
- List at least three ways professionals can protect the rights of all youth in custody.

2. Describe the correlation between the effects of stigma based on sexual orientation or gender identity and the reasons why some youth may be in custody.

Youth who identify as LGBTQ are more likely than other youth to become homeless. LGBTQ youth also are more likely to be harassed and ostracized at school, leading to truancy. These factors make LGBTQ youth more likely to end up in foster care or engage in conduct that may lead to their detention.

To demonstrate competency, participants will be able to:

- Indicate understanding of the societal, familial, and developmental challenges confronting LGBTQ youth in and out of custody and the relevance of these issues in meeting the individualized needs of LGBTQ youth in custody.
- Indicate understanding of social alienation experienced by some LGBTQ youth and especially youth who fall loosely into an "at risk" category.
- List three reasons why LGBTQ youth are at risk for (1) child welfare system involvement, (2) dropping out of school, (3) homelessness, and (4) serving time in juvenile detention facilities.

Please refer to the Appendix for more information on sexuality, sexual orientation, and gender roles, and identity.

3. Explain the detrimental effects that homophobia and transphobia have on health outcomes for LGBTQ youth.

As a result of stigma, fear, and a history of mistreatment, LGBTQ youth are less likely to be engaged in regular health care, which leads to poor health outcomes.

To demonstrate competency, participants will be able to:

- Indicate understanding of difficulties and prejudices facing LGBTQ youth in and out of custody.
- Articulate the negative effects trauma and stigma have on adolescent development.
- List at least three negative health outcomes that LGBTQ youth who have been rejected by their families are at greater risk of experiencing compared to LGBTQ youth who have not faced family rejection.
- List three factors that may improve health outcomes for LGBTQ youth.
- Demonstrate understanding of the facts of, and reasons why, LGBTQ youth in custody are at greater risk of sexual abuse and other violence.

---

[3] See The Center for HIV Law and Policy, *Juvenile Injustice: The Unfulfilled Rights of Youth in State Custody to Comprehensive Sexual Health Care* (2010), available at http://www.hivlawandpolicy.org/resources/view/565 (last visited Sept. 16, 2011).

4. Implement agency policies and practices that support healthy adolescent development of gender identity and sexuality.

Once policies are adopted by the policy makers within the agency authorized to oversee state foster and detention facilities, staff within the facility must understand how to implement the policies. In order to accomplish this, staff must develop sensitivity to LGBTQ youth. Staff must not only support, but also encourage, LGBTQ youth to embrace their own sexual/gender identity.

To demonstrate competency, participants will be able to:

- Indicate a sensitivity to and understanding of age-appropriate adolescent sexuality and gender expression.
- Articulate to youth the agency's rules indicating what conduct is not allowed in state facilities with respect to the treatment of other youth on the basis of sexual orientation.
- Identify at least three ways in which the agency supports youth in appropriate expression of sexuality and/or gender identity.
- Differentiate between instances of non-consensual sexual abuse and consensual sexual activity between youth.
- Articulate to youth the forms of sexual abuse, how to identify abuse, and how to report it safely.
- Demonstrate an understanding of agency policies and practices regarding sexual orientation and gender expression.
- Indicate an understanding of youth developmental stages, including the ways in which trauma and stigma experienced by some youth can interfere with these development stages.
- Provide ongoing, interactive, and youth-appropriate programs on sexuality and gender
- Provide a safe environment for youth to ask questions and gather information.
- Identify the reporting procedures for infractions of agency policies and the ways to which infractions are responded.

5. Provide for the privacy and confidentiality of all youth, including LGBTQ and HIV-positive youth.

Youth in state custody are less likely to seek needed services if they are concerned that their privacy will be violated. To encourage youth to access services, staff must maintain confidentiality and understand why it is imperative to do so. This is also important for LGBTQ youth who may feel or be vulnerable to violence if their sexual/gender identity is disclosed to others within the facility.

To demonstrate competency, participants will be able to:

- Offer private and confidential counseling, meetings, and medical interventions (including medication distribution) to all youth.
- Maintain confidential records for all youth and know who has access to these records.

- Articulate the relevance of state and local confidentiality laws to their work with LGBTQ youth.
- Discuss with youth their rights to privacy and confidentiality.
- Identify procedures for ensuring the confidentiality of all youth's health status and conditions, particularly HIV/AIDS.

6. Provide for the safety of all youth, including LGBTQ and HIV-positive youth.

As a result of dynamics within a state detention or foster care facility, some youth may be vulnerable to harassment or violence. Because these youth are in the care of the state, the state has an obligation to provide for their safety and protect them from harm. Staff must understand which conduct is inappropriate, how to address inappropriate or potentially abusive staff interactions with youth, when to intervene, and how to address the situation without punishing the person who was the subject of the harassment or violence.

To demonstrate competency, participants will be able to:

- Provide all youth with safety and protection as required by law.
- List sub-populations of youth who may be additionally vulnerable to sexual or physical assault in state facilities.
- Demonstrate awareness of what constitutes emotional abuse that is sometimes directed particularly at LGBTQ youth.
- Identify at least two strategies that can be used to respond to situations in which one youth is verbally harassing or threatening another youth because of sexual orientation and/or gender identity.
- Describe how professionals can provide safety to LGBTQ and HIV-positive youth in custody without resorting to isolating the youth, which is in violation of the youth's rights.
- Identify ways to detect and eliminate an individual youth's risk of sexual abuse or assault.
- Respond to all complaints of physical and sexual abuse (including abuse allegedly perpetuated by professionals) in a timely and appropriate manner.
- Differentiate between instances of non-consensual sexual abuse and consensual sexual activity between youth.

7. Engage respectfully with LGBTQ youth's gender identity and expression.

Staff who are uncomfortable with expressions of gender that are outside what is considered to be the norm are more likely to treat youth with varying gender identities in a way that is not supportive or respectful. For example, calling youth by derogatory names (including "fag" or "faggot" or referring to something as "gay" in a derogatory manner) is unacceptable behavior. Unequal or disrespectful treatment, whether intentional or inadvertent, can never be tolerated.

To demonstrate competency, participants will be able to:

- Indicate a sensitivity and understanding of how all youth express their gender.
- Provide a safe environment for youth who have a non-conforming gender identity.
- Encourage youth to respect the gender identity of transgender and gender non-conforming youth.

- Use a transgender youth's preferred name and pronoun when referring to that youth.
- Explain the difference between sexual orientation and gender identity.
- List at least three things staff can do to show respect for a youth's gender identity.

8. Ensure that LGBTQ youth have knowledge of and access to services and/or social events consistent with their interests and geared toward the community with which they identify.

LGBTQ youth often face isolation and depression due to society's response to their sexual and gender identity. Youth should have access to and knowledge of supportive communities and service providers for counseling and related resources.

To demonstrate competency, participants will be able to:

- Familiarize themselves with LGBTQ issues and the basic counseling skills needed to offer resources to in-custody youth with questions or concerns.
- Identify community-based healthcare programs, including mental health care, that are competent to work with LGBTQ youth and available to youth with whom participants interact.
- Identify at least one accessible local supportive service agency or organization for LGBTQ or HIV-positive youth.

9. Use appropriate and respectful terms to identify youth of all sexual orientations and gender identities.

Using terms that validate a youth's sexual or gender identity demonstrates an understanding and sensitivity toward the issues youth struggle with and will likely lead to better outcomes for those youth because they feel respected.

To demonstrate competency, participants will be able to:

- Indicate knowledge of LGBTQ terminology and definitions.
- Demonstrate the ability to use LGBTQ terminology and definitions in their work with young people.

10. Make referrals and provide resources as necessary for care and treatment.

LGBTQ youth, particularly transgender youth and HIV-positive youth, may have particular health care needs. As a result, these youth must have access to medical care in a timely matter. All information surrounding the visit, including reason for the visit and diagnosis, must remain confidential.

To demonstrate competency, participants will be able to:

- Provide timely and ongoing medical care and treatment, including counseling and mental health care, unique to transgender youth.

- Ensure the availability of private and confidential counseling, meetings, and medical interventions (including medication distribution) to all youth.
- Identify procedures to maintain the confidentiality of records for youth.
- List at least three examples of when referrals should be made to a supportive service agency or network for LGBTQ identified or HIV-positive youth.
- Identify at least one supportive service agency or network for LGBTQ identified or HIV-positive youth.

11. Meet the specific health care needs of transgender youth

Transgender youth have unique health care needs that often go unmet due to institutional ignorance, fear, stigma, or discrimination. By law, however, state facilities are obligated to provide medically appropriate and culturally sensitive health care to all youth, including transgender youth, who are in their custody. Specifically, when a state takes custody of a juvenile, it has an obligation to ensure the health and safety of juveniles in its care.[4]

To demonstrate competency, participants will be able to:

- Understand legal responsibilities to provide appropriate medical and mental health care to all youth, including transgender youth.
- Understand state, local or facility rules or policies for the housing of transgender youth, and recognize why some youth's gender presentation may diverge from that of the majority at the facility.
- Demonstrate the ability to identify competent medical and mental health professionals who can evaluate and provide treatments to transgender youth in state custody.
- Understand the importance of implementing the treatment recommendations made by a medical professional with expertise in providing care to transgender youth.
- Identify at least three steps professionals should take to ensure that transgender youth in custody are receiving the medical treatments they need from supportive providers with expertise in this area.

12. Appreciate and understand the need for these competencies and make an investment in the process.

[4] See, e.g., *Youngberg v. Romeo,* 457 U.S. 307 (1982), where the Supreme Court held that those who are in state custody but have not been convicted of a crime are entitled to an even more protective standard of care than those convicted of a crime. Although the Supreme Court has not explicitly applied *Youngberg* to minors in custody, the reasoning of *Youngberg* applies at least equally to these minors, of whom the state assumes custody through civil proceedings. This more protective standard applies even to those in juvenile detention facilities because, when a minor commits an act that constitutes a crime if committed by an adult, the minor is adjudicated delinquent in a civil action rather than convicted of a crime (See *DeShaney v. Winnebago County Dep't of Social Servs.*, 489 U.S. 189, 209 n.9 (1989)). Because juvenile institutions are legally deemed "noncriminal and nonpenal" in nature, "juveniles . . . who have not been convicted of crimes, have a due process interest . . . which entitles them to closer scrutiny of their conditions of confinement than that accorded convicted criminals." *A.J. v. Kierst*, 56 F.3d 849, 854 (8th Cir. 1995) (internal quotations omitted). Indeed, the Constitution in general provides youth in state custody with stronger protections than civilly committed adults. As the Eighth Circuit has stated, "the evolving standards of decency against which courts evaluate the constitutionality of conditions certainly provide greater protections for juveniles than for adults." See *Kierst*, 56 F.3d at 854.

If staff members are going to follow through with concepts explained at trainings, they must understand why what they are learning is important and be able to demonstrate a commitment to supporting the youth in their care.

To demonstrate competency, participants will be able to:

- Articulate their legal and ethical responsibilities to treat all youth fairly and with respect.
- Understand the positive impact that educated and sensitive adults can have on youth in state custody.
- Understand that youth will follow the positive example of staff members as easily as they will follow disrespectful behavior by staff.

Appendix:
Sexuality and Healthy Relationships, Sexual Orientation, and Gender Roles and Identity

This section provides supplemental materials for staff and trainers on key information pertaining to sexuality, sexual orientation, and gender roles and gender identity. The following was adapted from the Teen SENSE Model Sexual Health Education Standards.

Sexuality and Healthy Relationships

- Staff should be able to understand the concept of sexuality as the expression of human sexual feeling and a natural, healthy part of being human.
    - Staff should be able to discuss the concept of sexuality as including how a person feels about his or her body, whether a person feels masculine or feminine or somewhere in between, the way a person dresses, the way a person moves, how a person speaks, who the person is attracted to and falls in love with and the way a person acts and feels about other people in general. Staff should be able to address other aspects of sexuality that are not listed above, as this list is not meant to be exclusive.
    - Staff should understand that sexuality is multifaceted and has biological, social, psychological, spiritual, ethical, and cultural dimensions.
    - Staff should understand that most people, regardless of biological sex, gender, age, ability, and culture are sexual beings, though sexual expression is not necessarily a significant part of some people's lives.
    - Staff should be able to identify how sexuality can be more rewarding and positive when expressed in a non-exploitive way.
    - Staff should understand that sexuality is experienced in a variety of ways at different stages and points in people's lives, and that everyone has his or her own way of expressing his or her sexuality to others and feeling or experiencing it for himself or herself.

Sexuality, Society, and Culture

- Sexuality & Society:
    - Staff should be able to discuss the messages society gives youth about how they are supposed to act, date, and sexually behave; how these messages can often conflict with messages from their family and community; how these messages may differ depending on their gender and age; and how these messages contribute to peer pressure. Staff should understand the diversity of views on sexuality and the importance of making independent decisions.
    - Staff should practice the ability to critically evaluate messages from different sources and establish guidelines for their own behavior.
- Sexuality & the Media: Staff should be able to discuss and describe the profound effect media has on sexual information, values, and behavior; ways in which the media's portrayal of sexuality is realistic and unrealistic; and the messages youth have received from television, movies, music videos, and on the internet, including whether these messages are accurate.
    - Staff should be able to identify stereotypes reflected in the media and how these stereotypes can negatively affect them and their opinion about certain groups of people, including LGBTQ individuals, and gender roles.

- Sexuality & Religion: Staff should be able to discuss and describe how various religions' views about sexuality affect people's sexual attitudes, behaviors, and sexual decision-making and the conflict that can occur between people's values and religious beliefs in the context of sexuality.
    - Staff should understand how gender roles and beliefs about sexual orientation have historically been affected by religion and how, although LGBTQ people have historically been excluded from many religious congregations, a growing number of congregations now openly welcome members of the LGBTQ community. Staff should be encouraged to discuss ways that religion has affected their feelings about sexuality or the feelings of someone they know.
- Sexuality and the Law: Staff should be familiar with the U.S. laws governing sexual and reproductive rights. This particularly pertains to the following:
    - The Supreme Court has ruled that, to a certain extent, people have the right to make personal decisions concerning sexuality and reproductive health matters, such as abortion, contraception, sterilization, and engaging in same-sex sexual relationships.
    - State laws govern the age of consent for sexual behaviors.
    - Some states and cities have passed laws banning discrimination on the basis of sexual orientation. Staff should be familiar with relevant laws in their city or state.
    - The Supreme Court recently ruled that state laws restricting certain types of sexual behavior between consenting adults are unconstitutional. Consenting adults, regardless of gender or sexual identity, cannot be criminally prosecuted for engaging in a sexual relationship.
    - Courts across the United States are currently debating legal issues concerning same-sex marriage and many states have passed same-sex marriage bills.
    - Public nuisance behavior, such as exhibitionism and voyeurism, are illegal in most states.
    - Prostitution is illegal in all states except for Nevada.
    - Child pornography – a visual depiction of a minor engaging in sexually explicit conduct – is illegal in all states.
    - Some federal and state laws protect individuals from harassment in jobs, schools, and state institutions if the harassment is based on the individual's sex, identified or perceived sexual orientation, or gender identity.

Sexual Orientation

- Staff should understand that:
    - Sexual orientation refers to a person's physical and/or romantic attraction to an individual of the same and/or different gender,
    - Sexual orientation can fall across a spectrum, and that one's understanding and identification of his/her sexual orientation may change over the course of his/her lifetime. Staff should understand that sexual orientation is only one aspect of who a person is. Staff should also understand that gay and lesbian romantic relationships are just as fulfilling as heterosexual relationships and that LGBTQ people may form families and have children just as successfully as heterosexual people.
    - Staff should understand that LGBTQ and heterosexual people come from all countries, cultures, races, ethnicities, socio-economic backgrounds, and religions, and that scientific theories have concluded that sexual orientation cannot be changed by therapy or medicine.

  - Staff should be able to identify discrimination against, rejection of, and harassment of LGBTQ youth by peers, family, schools, and others. Staff should also be able to identify the effects such behavior can have on LGBTQ youth. Such effects include causing LGBTQ youth to be afraid to identify as LGBTQ and at increasing risk of depression, dropping out of school, homelessness, and substance abuse.
- Staff should understand that people of all sexual orientations deserve respect and have the right to express their sexual orientation and identity. Staff should be able to discuss strategies for reporting harassment of themselves or others based on sexual orientation.
- Staff should be able to identify and discuss the concepts of heterosexism, internalized homophobia, and how such phobias can contribute to LGBTQ adolescent isolation.
- Staff should understand the concept of coming out and why coming out can be important to an individual.
- Staff should be able to identify the additional challenges and threats LGBTQ youth of color may face due to both racism and homophobia.
- Staff should understand how the above listed challenges can lead to increased mental health difficulties, such as depression and increased substance abuse among LGBTQ youth. Staff should understand that, despite these challenges, the majority of LGBTQ youth lead normal, productive lives and develop resilient adaptations to social biases and mistreatment.

Gender Roles & Gender Identity

- Staff must be able to define gender roles, gender identification, and gender stereotypes. Staff should understand that gender identification may include male, female, or other (e.g. intersex, cross-gender, etc.) identification. Gender expression may not necessarily match gender identity. Staff should also understand that the way a person expresses his or her gender does not necessarily have anything to do with whether that person is heterosexual, gay, lesbian, or bisexual.
- Staff should understand and be able to recognize and describe the following definitions and concepts:
  - Transgender: "Transgender" describes people whose internal sense of gender (gender identity) doesn't match what society expects of them based on their biological sex. Transgender is also used as a general term to describe many different identities that exist such as "transsexual," "drag king," "drag queen," "crossdresser," "genderqueer," "shapeshifter," bigendered," and "androgyne." Transgender people are often described as: Male-to-female (M-to-F), or Female-to-male (F-to-M), or by the gender they currently identify with ("male identified" or "female identified").
  - Transsexuals: described people who have had, are in process of, or are planning sex-reassignment surgery. They may also use hormonal means to change parts of the body to match their own understanding of gender without having a complete genital sex-reassignment surgery.
  - Androgynes: describes androgynous presentation. Androgyne behavior combines both genders or is gender-neutral.
- Staff should be able to understand the concept of gender identity as something that may change over the course of an individual's lifetime, and that transgender people report experiencing conflict over gender assignment throughout childhood and adolescence.
- Staff should understand that gender identity is just one part of who a person is and discuss the need to respect people of all gender identities. Staff should be able to identify gender

discrimination, harassment, and violence, discuss the harms of discriminating against someone because of their gender identity, the impact that it has on individuals, and the need to report discrimination to a trusted adult, school official, or law enforcement authority.

- Staff should be aware that there is some federal, state, and local legal protection from discrimination based on gender identity, and youth should be aware of the laws in the city and state in which they reside.