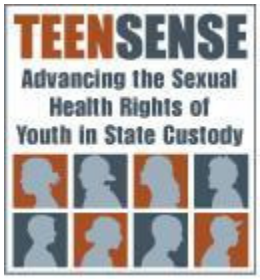
Juvenile InJustice

The Unfulfilled Rights of Youth in State Custody to Comprehensive Sexual Health Care

THE CENTER FOR HIV LAW & POLICY

TEENSENSE
Advancing the Sexual Health Rights of Youth in State Custody



JUVENILE INJUSTICE:
THE UNFULFILLED RIGHTS OF YOUTH IN STATE CUSTODY TO COMPREHENSIVE SEXUAL HEALTH CARE

A Publication of The Center for HIV Law and Policy
Teen SENSE Initiative

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MISSION STATEMENT

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EXECUTIVE STATEMENT

Sexual health care—including disease prevention, diagnosis, treatment, and an understanding of human sexuality—is central to reaching and maintaining a healthy adulthood. Such health care is particularly important for youth confined in state foster and detention facilities, who are at serious risk for acquiring sexually transmitted infections (STI) and HIV. The long term health of youth requires that they be provided adequate sexual health care, which experts agree must include medical care, scientifically accurate and inclusive sexuality education, and, in the institutional context, a staff trained to understand, respect, and respond to the health and safety needs of all youth in their custody, including the specific needs of lesbian, gay, bisexual, transgender, and questioning youth (LGBTQ youth).

Despite the extraordinary public health crisis—and the corresponding opportunity for intervention—that state confinement of high risk youth presents, not one state has explicit and enforceable policies. Such policies are critical to ensure that the institutions responsible for the well-being of adolescents in their care provide these essential elements of health care. In the absence of specific policy directives, sexual health care for youth in state custody is episodic at best and, more frequently, utterly ignored.

The Center for HIV Law and Policy's Teen SENSE (**S**exual health and **E**ducation **N**ow in **S**tate **E**nvironments) initiative was created to respond to this crisis. Teen SENSE brings together medical experts, educators, government agencies, advocates, youth, and others to ensure that all young people in state facilities have access to comprehensive sexual health care—including medical care, accurate and LGBTQ-inclusive sexuality education, and a staff trained to respond to the health care needs of youth in state custody. Teen SENSE relies on the principle that providing youth this care is required not only by common sense and ethics, but by law. Teen SENSE believes that youth in state facilities have the affirmative legal right to comprehensive sexual health care, a right secured by international human rights law and by federal and state law. This right is in turn shaped and supported by industry-wide health care standards for the care of youth and the operation of correctional facilities.

This memorandum outlines the legal foundation for the affirmative right of youth in state facilities to comprehensive sexual health care. This right has strong support in international human rights instruments and norms that protect the rights of youth in state custody to health and safety in general, and impose obligations on government to assure youth in its care receive services such as medical care, counseling, and sexuality education. On the domestic level, U.S. federal courts have long interpreted the United States Constitution to require that state officials provide substantive services for the health, safety, and well-being of minors in their custody. This obligation encompasses an array of services, from medical and mental health care to procedures and training to ensure that staff members possess the understanding and skills to keep all youth in their charge free from harm. Information and education is necessary for adolescents to make informed decisions about health care and is a central part of these medical and mental health services. Other federal constitutional rights, such as the right to privacy and the Equal Protection Clause, protect youths' rights to access contraception and make procreative decisions, and ensure that LGBTQ youth in state facilities are afforded care and protection and are not endangered due to identifying as or being perceived as LGBTQ.

Appendices A and B supplement the memorandum with guidance from the private sector and state law. Appendix A provides a background of professional guidelines for the sexual health care of youth in detention facilities. Appendix B, using New Jersey as an example, demonstrates how state law can serve as an additional source of law affirming the right of youth in state facilities to comprehensive sexual health care.

I. Introduction

A. A Public Health Crisis Among Youth in State Custody

All sexually active young people in the United States are at some risk for sexually transmitted infections (STIs) and HIV, and many are currently living with an STI or HIV. Recent U.S. Centers for Disease Control and Prevention (CDC) reports estimate that 47.8% of U.S. high school students have had sexual intercourse at least once and 38.5% of sexually active high school students had not used a condom at last sexual intercourse.[1] Since the beginning of the HIV epidemic in the United States, a conservatively estimated 40,000 children and teens have been diagnosed with HIV and represent an estimated 2% of the people who have died from AIDS.[2] The CDC reported that about 4883 young people in the United States were diagnosed with HIV or AIDS in 2004, accounting for approximately 13% of new diagnoses in the country.[3] Each year in the United States, nearly 9.1 million 15-24 year olds are infected with STIs other than HIV.[4]

Youth in state custody in particular face increased risks that require a concerted response from the state that has assumed responsibility for their care.[5] Out-of-home youth have a greater likelihood of participating in high-risk behaviors including substance abuse and high-risk sexual activity.[6] Adolescents in correctional care facilities report sexual activity at earlier ages and greater rates of STIs than their counterparts.[7] Likewise, youth in out-of-home care may be more prone to risk-taking behaviors and therefore are more likely to engage in sexual activity, drug use, and other behaviors that place them at higher risk of contracting STIs and HIV.[8] For many youth, the pathway into state custody included a period of time living on the streets and engaging in these high-risk behaviors, often in exchange for shelter, food, or money, increasing their chances of contracting STIs or HIV or being victims of sexual assault. Federal agencies such as the CDC and the National Institute of Justice recognize that juveniles in confinement are disproportionately at risk for HIV and STIs.[9] HIV rates among youth of color, who are disproportionately represented in juvenile detention facilities,[10] are also rising. In a 2007 report of 34 states with long-term surveillance, 72% of people

[1] Ctrs. For Disease Control and Prevention, *Sexual and Reproductive Health of Persons Aged 10-24 Years—United States, 2002-2007*, 58 MMWR 1, 51-52 (2009).
[2] Ctrs. For Disease Control and Prevention, HIV/AIDS SURVEILLANCE REPORT, 2004 32 (2005).
[3] Ctrs. For Disease Control and Prevention, *HIV/AIDS Among Youth: Fact Sheet* (2008), *available at* http://www.cdc.gov/hiv/resources/factsheets/PDF/youth.pdf.
[4] Hillard Weinstock et al., *Sexually Transmitted Diseases Among American Youth: Incidence and Prevalence Estimates*, 36 PERSP. ON SEXUAL AND REPROD. HEALTH 6, 6 (2004).
[5] RANDI FEINSTEIN, ET. AL., THE LESBIAN AND GAY YOUTH PROJECT OF THE URBAN JUSTICE CENTER, JUSTICE FOR ALL? A REPORT ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDERED YOUTH IN THE NEW YORK JUVENILE JUSTICE SYSTEM 18-20 (2001), available at http://www.urbanjustice.org/pdf/publications/lesbianandgay/justiceforallreport.pdf.
[6] Society for Adolescent Medicine, *Health Care for Incarcerated Youth: Position Paper of the Society for Adolescent Medicine*, 27 J. OF ADOLESCENT HEALTH 73, 73 (2000).
[7] American Academy of Pediatrics, *Health Care for Children and Adolescents in the Juvenile Correctional Care System*, 107 PEDIATRICS 799, 800 (2001).
[8] MADELYN FREUNDLICH, CHILDREN'S RIGHTS, JUVENILE RIGHTS DIVISION OF THE LEGAL AID SOCIETY, LAWYERS FOR CHILDREN, TIME RUNNING OUT: TEENS IN FOSTER CARE 28-29 (2003) [hereinafter TIME RUNNING OUT].
[9] REBECCA WIDDOM & THEODORE HAMMET, NATIONAL INSTITUTE OF JUSTICE, HIV/AIDS & STDS IN JUVENILE FACILITIES 1, 3 (1996).
[10] In New Jersey, for example, 67% of the adolescents admitted to the juvenile justice system were African-American and 18% were Latino. This ratio has not varied significantly for decades. BRUCE B. STOUT, ASSOCIATION FOR CHILDREN OF NEW JERSEY, CONNECTING THE DOTS, NEW JERSEY JUVENILE JUSTICE: PAST, PRESENT AND FUTURE (2003), available at http://www.acnj.org/main.asp?uri=1003&di=305&dt=0&chi=2.

aged 13–19 given a diagnosis of HIV/AIDS were African-American, non-Hispanic; 13% were Hispanic; and 13% were white, non-Hispanic.[11] This is in stark contrast to the racial proportion of the general population of high school students, which is 62% white, non-Hispanic; 17% African-American, non-Hispanic; and 15% Hispanic.[12]

These health threats are particularly relevant for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth, who may be more likely to be funneled through the juvenile justice system. According to a recent study, LGBTQ youth are disproportionately represented in the juvenile justice system, comprising as much as 13% of the youth in detention facilities.[13] Rejection and abuse by parents and peers has led to disproportionate rates of homelessness among LGBTQ youth, as well as higher rates of substance abuse and survival crimes such as theft, prostitution, and drug sales, paving their way into the state custody system and state detention in particular.[14] LGBTQ youth who are comfortable enough to explore their sexuality often find themselves in juvenile detention because consensual expression of their sexual identity has been construed as sexual assault or statutory rape.[15]

Once in the system, LGBTQ youth face additional threats to their sexual health and safety due to their LGBTQ status.[16] LGBTQ youth routinely face harassment, discrimination, isolation, and abuse.[17] The threats and violence these youth face is well documented by numerous sources, including a recent U.S. Department of Justice study that revealed that LGBQ youth in detention were nearly twice as likely to sexually victimized than straight youth in detention, and nearly ten times more likely than straight youth to be sexually victimized by other youth.[18] This social stigma, discrimination, and harassment encourage high-risk activity among LGBT youth.[19] Silenced by shame or fear of violence and harassment, many LGBTQ youth do not disclose their sexual orientation and gender identity, resulting in an inability to obtain adequate sexual health care.[20] Even where staff may be well-intentioned, the inability to recognize and respond to the unique sexual health care needs of LGBTQ youth leaves these individuals without adequate health care. For

[11] CTRS. FOR DISEASE CONTROL AND PREVENTION, HIV/AIDS SURVEILLANCE IN ADOLESCENTS AND YOUNG ADULTS (2009), http://www.cdc.gov/hiv/topics/surveillance/resources/slides/adolescents/index.htm.
[12] *Id.*
[13] The EQUITY PROJECT, HIDDEN INJUSTICE: LESBIAN, GAY, BISEXUAL, AND TRANSGENDER YOUTH IN JUVENILE COURTS [hereinafter Hidden Injustice] 44 (2009).
[14] *See* HIDDEN INJUSTICE, *supra* note 13, at 66-78; Hahn, *supra* note 16, at 121-24.
[15] *See* HIDDEN INJUSTICE, *supra* note 13, at 62-63; Hahn, *supra* note 16, at 123.
[16] *See generally id.*; Rudy Estrada & Jody Marksamer, *Lesbian, Gay, Bisexual and Transgender Young People in State Custody: Making the Child Welfare and Juvenile Justice Systems Safe for All Youth Through Litigation, Advocacy, and Education*, 79 TEMP. L. REV. 415 (2006); Peter A. Hahn, *The Kids Are Not Alright: Addressing Discriminatory Treatment of Queer Youth in Juvenile Detention and Correctional Facilities*, 14 B.U. PUB. INT. L. J. 117 (2005); *Elimination of Prison Rape: Focus on Juveniles: Hearing Before the National Prison Rape Elimination Commission* (2006) [hereinafter Bidwell testimony] (testimony of Robert Bidwell, M.D.), available at http://www.nprec.us/docs/boston_natureofproblem_bidwell.pdf.
[17] *See* Hahn, *supra* note 16, at 124-127; Estrada & Marksamer, *supra* note 16.
[18] *See* U.S. DEP'T OF JUSTICE, SEXUAL VICTIMIZATION IN JUVENILE FACILITIES REPORTED BY YOUTH, 2008-09 11 tbl.8 (2010); *see also* Estrada & Marksamer, *supra* note 16; Hahn, *supra* note 16; Bidwell testimony, *supra* note 16.
[19] *See, e.g.,* Susan M. Blake et al., *Preventing Sexual Risk Behaviors Among Gay, Lesbian, and Bisexual Adolescents: The Benefits of Gay-Sensitive HIV Instruction in Schools*, 91 AM. J. OF PUB. HEALTH 940, 944 (2001) (demonstrating correlation between lack of gay-sensitive instruction and increased risks for HIV, pregnancy, suicide, and victimization).
[20] *See* HIDDEN INJUSTICE, *supra* note 13, at 44, 111-12.

example, transgender youth who are unable to receive appropriate hormone therapy face negative health consequences, including depression, suicide attempts, and self-treatment.[21]

CHLP's recent visits to New Jersey juvenile detention facilities and interviews with their residents revealed examples of the unique problems LGBTQ youth face in state custody. In 2009, CHLP visited juvenile detention facilities in New Jersey to discuss sexual health care with confined youth and discovered that residents in these juvenile detention facilities face significant homophobia, both from staff and other residents. Youth in the female juvenile detention facilities who identified as lesbian, bisexual, or questioning stated that some staff members harassed them, called them derogatory names, and told them they should be involved with males and not other females. In the male juvenile detention facilities, youth stated that any resident who identified as gay, bisexual, transgender, or questioning would be subject to harassment and violence from other youth. The youth in the males facilities stated that no residents in the facility openly identified as GBTQ, and that the threat of being harassed or beaten prevented any GBTQ youth from doing so.

The significant and compelling sexual health needs of these youth require a concerted response on behalf of the state facilities in which these youth reside. Unlike their counterparts outside state custody facilities, youth in state facilities often do not have continuous access to the public school system or to a parent for their health education.[22] They also lack access to outside resources that provide medical care, counseling, information, and support.[23] Incarcerated youth and youth living in congregate care depend on the state to meet these needs. Because of the role of child welfare and correctional care systems in providing a safe harbor for minors, these systems have a unique opportunity to help improve the health of vulnerable children and adolescents in their care. As the United States Department of Justice recommends:

> [A] unique opportunity exists to prevent HIV infection, improve public health, and provide important preventative and therapeutic services for youths who may have no other means of accessing them . . . . In order to take full advantage of this opportunity, more juvenile systems should make counseling, education and voluntary HIV testing available.[24]

Yet, despite this enormous public health need, and the corresponding opportunity to respond to it, the sexual health care needs of youth in state custody facilities are being overlooked by the very institutions that are responsible for their care and well-being.[25] Professional consensus is that sexual health care is vital to these young people, but this rarely translates into actual routine medical tests and treatment for youth in state custody. Typically, no consistent, enforceable policies exist to ensure that youth are provided basic sexual medical care such as routine, voluntary STI and HIV testing and counseling. State laws differ on the content of the sexuality education youth in state custody must receive, or even if they must receive this education at all. Even where state law mandates sexuality education, there are no official policies to guide facilities on the content of the education, how it must be provided, and how to adapt it to the specific needs of the youth in their care. LGBTQ youth, meanwhile, continue to face discrimination, harassment, and violence on the

[21] *See id.* at 111-12.
[22] *See* TIME RUNNING OUT, *supra* note 8, at 58-60.
[23] *See id.*
[24] Widdom & Hammet, *supra* note 9, at 10.
[25] CHILD WELFARE LEAGUE OF AMERICA, CWLA BEST PRACTICE GUIDELINES: SERVING LGBT YOUTH IN OUT-OF-HOME CARE 7, 54-55 (2006), [hereinafter CWLA LGBT Best Practices]; FEINSTEIN, *supra* note 5, at 7, 25-41; Time Running Out, *supra* note 8, at 34.

basis of their sexual orientation or gender identity,[26] which hinders their ability to receive adequate sexual health care.[27]

CHLP's visits to juvenile detention facilities and interviews with youth illustrated that, despite efforts by dedicated staff, youth's sexual health needs often go unmet. Several youth interviewed stated that health care providers did not raise several sexual health care issues with youth. Although youth wanted to understand how to protect themselves from STIs, unwanted pregnancy, and HIV, medical staff did not offer this information. Youth also expressed uncertainty as to whether they had been tested for certain STIs or HIV, and, if they had been tested, concerns that they had not been informed of their test results. Female residents expressed the desire to visit more often health care providers, such as Planned Parenthood, for sexual health care. Some were too embarrassed to ask to go in addition to their annual scheduled visit, and, for those who did ask, visits were often delayed for several months. Youth also expressed dissatisfaction with the amount and quality of their sexuality education. They reported receiving conflicting information, and little or no information about how to protect themselves from STIs and HIV, especially during same-sex activity. Many youth also stated that their medical information was not kept confidential. They reported that all staff members knew if they had an STI, and that staff members often told residents about other residents' STIs, or distributed medication in a way that made residents' STIs obvious.

Neglecting the sexual health care needs of youth yields serious and irreversible consequences. Mounting evidence shows that childhood circumstances such as exposure to infectious diseases or lack of a sense of autonomy and control over one's surroundings have an enduring effect on health. These effects simply cannot be erased by advantaged conditions in adulthood.[28] According to a National Institutes of Health longitudinal study of morbidity and mortality over a twenty-four-year period, "childhood experiences often set-up cascading events over life that have dramatic effects on adult health."[29] Therefore, "economic and education policies that are targeted at children's well-being are implicitly health policies with effects that reach far into the adult life course."[30] Childhood medical services that include regular examinations, STI/HIV testing, and education that promotes understanding, respect, empowerment, and reduced risk-taking confer health benefits that cannot be recaptured in later life. Clearly, youth in state custody—and LGBTQ youth in particular—require programs that effectively target and meet their needs.

B. The Teen SENSE Initiative

Because of the role of child welfare and correctional care systems in providing a safe harbor for minors, these systems have a unique opportunity to help improve the health of vulnerable children and adolescents in their care. As the United States Department of Justice recommends:

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[26] *See* TIME RUNNING OUT, *supra* note at 8, at 34; Hahn, *supra* note 16, at 126-27.

[27] Indeed, in an initial meeting with juvenile justice officials in one jurisdiction, a supervisory staff member responsible for adolescent sexuality education frankly confessed that many sexuality education instructors had neither the knowledge nor the comfort level to discuss issues of sexual orientation, gender identity, and the concerns of LGBTQ youth.

[28] MARK D. HAYWARD, PENN. STATE UNIVERSITY, THE LONG ARM OF CHILDHOOD: THE INFLUENCE OF EARLY LIFE CONDITIONS ON ADULT MORBIDITY & MORTALITY (2004), http://www.rand.org/labor/aging/rsi/rsi_papers/2004_hayward4.pdf.

[29] *Id.*

[30] Mark D. Hayward & Bridget K. Gorman, *The Long Arm of Childhood: The Influence of Early-Life Social Conditions on Men's Mortality*, 41 DEMOGRAPHY 87, 87 (2004).

> Juvenile facilities may be prime settings for intensive HIV/STD education . . . . since virtually all confined juveniles are eventually discharged, behavioral interventions could benefit not only the youths themselves but persons they encounter once released.
>
> . . . .
>
> Thus, a unique opportunity exists to prevent HIV infection, improve public health, and provide important preventative and therapeutic services for youths who may have no other means of accessing them. . . . In order to take full advantage of this opportunity, more juvenile systems should make counseling, education and voluntary HIV testing available.[31]

This public health opportunity requires programs that effectively address the needs of youth in state custody. Studies consistently demonstrate that HIV prevention is most successful when it is a component of comprehensive sexual health care that includes regular testing for STIs and HIV, as well as a comprehensive sexuality education component that provides youth with the information necessary to make healthful choices from adolescence to adulthood. Such comprehensive sexuality education must be grounded in tolerance and scientifically accurate research about sexuality, safer sex, substance abuse, violence, and sexually transmitted diseases. Moreover, in order to reach all youth, it must be inclusive of all sexual and gender identities and take into account the varying sexual health and prevention needs of all youth.

These services, however, will have little effect if they are impeded by an environment of stigma and intimidation. All staff who have contact with youth—and in particular staff that provide health care and education—must be trained to understand and respond to the health and safety needs of youth. This is particularly important in the context of LGBTQ youth, who face discrimination, isolation, and even violence. If these youth are unable to identify their needs to staff, and if staff members are not trained to recognize these needs, the health and safety of these youth will continue to suffer.

In response to this public health threat, the Center for HIV Law and Policy's Teen SENSE (Sexual health and Education Now in State Environments) has created model standards for the sexual health care of youth in state custody, which we hope to see implemented in facilities ranging from youth detention centers to congregate foster care. The Teen SENSE initiative operates under the principle that providing adolescents comprehensive sexual health care is not only good policy, but is also required by law. Comprehensive sexual health care is the right of teens in custody, and the responsibility of the state that holds them in its custody.

This memorandum sets forth a legal basis for the common sense conclusion that child welfare and correctional care systems have a responsibility to help improve the health of vulnerable adolescents in their care. It describes the rights of youth in state facilities to comprehensive sexual health care—and the corresponding obligations of the state—under international human rights law and federal constitutional law. Youth in congregate foster care facilities and detention centers[32] have limited or

[31] Widdom & Hammet, *supra* note 9, at 4, 10.

[32] This memorandum focuses on the rights of minors in congregate foster care facilities and detention centers, where youth have little access to outside services. The rights of minors committed to mental health facilities, or placed with foster families or in day care facilities, are beyond the scope of this paper, as these placements raise additional issues related to their enrollment in public schools and their contact with foster families. However, we hope that this paper initiates and provides guidance for future discussion and advocacy toward ensuring all youth in state custody are provided comprehensive sexual health care.

no access to the traditional avenues of sexuality education—namely, parents and schools. When minors are in the state's care, the state must affirmatively act to ensure their health. For youth living in congregate care or within the auspices of the juvenile justice system, the state has assumed the roles of parent and the public school system, creating corresponding obligations to ensure their well-being.

These legal rights are supported by the strong consensus among professional organizations that sexual health care must be comprehensive and include sexuality education in order to be effective. Appendix A provides a brief background of professional guidelines for the sexual health care of youth in congregate care and detention facilities as outlined by the National Commission on Correctional Health Care, demonstrating the need for policies that ensure these standards are met.

Appendix B discusses the role of state constitutions, statutes, and regulations, which often provide youth in state custody with even stronger guarantees of sexual health care. As an example of such guarantees, Appendix B looks at New Jersey law concerning the rights of youth in state custody, and the corresponding obligations of the state. New Jersey was selected as the pilot jurisdiction for Teen SENSE because it provides an example of rich legal protections accompanying a significant need for comprehensive sexual health care among youth in state custody. New Jersey's state constitution, Law Against Discrimination, and regulations provide strong legal protections for the rights of youth in state custody. Teen SENSE has formed a multidisciplinary team of advocates and service providers that work with state agencies to implement comprehensive sexual health care and to ensure the rights of all youth in state care are respected, protected, and fulfilled.

II. Legal Protections Concerning the Sexual Health Care of Youth in State Custody

A. What is Sexual Health Care?

Throughout this memorandum, the term "sexual health care" is used to refer to comprehensive care that encompasses medical services, sexuality education, and a staff that is trained to respond to the sexual health needs of youth in custody. This is because the Teen SENSE initiative is founded on a principle that has since been reinforced countless times by experts in the field: comprehensive sexual health care encompasses not only sexual medical care, but also the information necessary to make healthy choices as well as a safe environment for youth to access medical care and information. For youth taken from their homes and placed in the state's custody and care, this means:

- Sexual medical care that adequately meets the full range of needs of individual youth in state facilities, accounts for the particular needs of this high-risk population, and is inclusive of the needs of all sexual orientations and gender identities

- Comprehensive sexuality education that is scientifically sound, culturally appropriate, and inclusive of the needs of all sexual orientations and gender identities

- A staff that is trained to understand, respect, and respond to the health and safety needs of all youth in their custody, particularly the needs of LGBTQ youth

This definition of sexual health care reflects the realities of young life and of confinement. It recognizes that health cannot be supported and maintained exclusively through medical care; rather, health requires that a person's environment is supportive of and responsive to each person's health

needs. This is even more critical in the context of youth, who are still acquiring the information and skills necessary for sexual health. And it is perhaps most critical for youth in state custody, who rely entirely on the state to provide them with the medical care, education, and environment to support their sexual health.

The connection between health, education, and environment finds ample support among health and education experts. Leading researchers endorse HIV-prevention techniques such as disseminating information on risk reduction methods, reducing discrimination against people with HIV, and addressing the physiological, emotional, and cultural contexts of behavior.[33] National medical organizations devoted to the care of youth such as the American Academy of Pediatrics and the Society for Adolescent Medicine (SAM) also recommend that all minors have continuous, on-going, age-appropriate sexuality education.[34] In particular, SAM endorses community-based HIV/AIDS prevention and education that includes the importance of both abstinence and risk-reduction and is sensitive to the needs of LGBTQ youth.[35] The CDC Guidelines for Effective School Education to Prevent the Spread of AIDS state that HIV/AIDS prevention education is particularly appropriate and effective when couched within a comprehensive health education program.[36] In the context of youth in detention, the CDC recommends that juvenile corrections officials work with public health systems and community-based organizations to strengthen HIV/AIDS prevention programs, including formulating and implementing comprehensive sexuality education.[37] Studies have also shown that HIV-prevention is more likely to be successful when programs are LGBTQ-inclusive.[38] All staff who have contact with youth—and in particular staff that provide health care and education—must be trained to understand, respect, and respond to the health and safety needs of all youth. If LGBTQ youth are unable to communicate their needs safely to staff, and if staff members are not trained to respect these needs, the health and safety of these youth will continue to suffer.

Understanding inclusive and comprehensive sexuality education and staff training as a health care need also demystifies and destigmatizes these issues. It furthers the understanding that homophobia and sexual health ignorance are not merely cultural or education issues—they are public health threats to which the state has an obligation to respond with public policy that is grounded in medical and social science.

B. International Law and Human Rights Principles

1. Introduction

The understanding that sexual health requires not only medical care, but also education and a safe and respectful environment, is endorsed by the United Nations, which defines "reproductive health care," in part, as:

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[33] Widdom & Hammet, *supra* note 9, at 4.
[34] Society for Adolescent Medicine, *HIV Infection & AIDS in Adolescents: An Update of the Position of the Society for Adolescent Medicine,* 38 J. OF ADOLESCENT HEALTH 88 (2006); Society for Adolescent Medicine, *supra* note 6, at 73; American Academy of Pediatrics, *supra* note 7, at 802.
[35] Society for Adolescent Medicine*, supra* note 34, at 88.
[36] CENTERS FOR DISEASE CONTROL AND PREVENTION, GUIDELINES FOR EFFECTIVE SCHOOL HEALTH EDUCATION TO PREVENT THE SPREAD OF AIDS (2003), http://www.cdc.gov/HealthyYouth/sexualbehaviors/guidelines/guidelines.htm.
[37] CDC *supra* note 2.
[38] *See, e.g.*, Blake, *supra* note 19.

> the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.[39]

International institutions and agencies, including the United Nations, view health care for individuals in state confinement as a public health issue and the responsibility of every nation's government. Under the international human rights framework, individuals confined by the government have an affirmative right to health care that meets all their basic needs. Such health care is also vital to ensure the health of the general population; because those in state confinement eventually will return to their communities, inattention to their sexual health needs invariably harms the health of the communities they rejoin.[40] The international human right framework creates substantial obligations for governments to ensure that the rights of individuals and, subsequently, communities to adequate sexual health care are protected.

2. Using International Standards in the United States

While subsection three sets forth numerous international standards supporting the rights of youth in state custody to comprehensive health care, it is vital to first understand the relevance of these international standards in the United States.

This section discusses international legal norms that are derived from several sources. Several of the sources discussed are treaties, also known as "conventions," which the United States has either signed and ratified, or has signed without ratifying. Under international law, the United States is bound to uphold obligations under the treaties it has ratified. Where the United States has signed but not ratified a treaty, it is obligated not to act contrary to the purpose of the convention under Article 18 of the Vienna Convention on the Law of Treaties (a separate treaty governing treaty interpretation and adherence that the United States has ratified).[41] Another source of international law is "customary international law"—norms established by the customs of nations, which may or may not also be reflected in treaties, declarations, and other international agreements. Finally, this section also cites documents that are non-binding in themselves but that interpret binding treaty obligations or customary international law.

The role of these international obligations in U.S. law is complex and often contradictory. Under U.S. law, treaties and customary international law are binding law, but do not necessarily give rise to a private right of action. The Constitution declares that treaties are the "supreme Law of the Land"[42] and federal common law has accorded the same status to customary international law.[43] However, it

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[39] International Conference on Population and Development, Cairo, Egypt, Sept. 5-13, 1994, *Programme of Action*, Ch. 7.2, U.N. Doc. A/CONF.171/13 (1994).

[40] U.N. OFFICE ON DRUGS AND CRIME, UNAIDS, & WORLD HEALTH ORGANIZATION, HIV/AIDS PREVENTION, CARE, TREATMENT AND SUPPORT IN PRISON SETTINGS: A FRAMEWORK FOR AN EFFECTIVE NATIONAL RESPONSE 8 (2006).

[41] Vienna Convention on the Law of Treaties art. 18, May 23, 1969, 1155 U.N.T.S. 331, 336 (entered into force on Jan., 27, 1980); *see also* Jean Koh Peters, *How Children Are Heard in Child Protective Proceedings, in the United States and around the World in 2005: Survey Findings, Initial Observations, and Areas for Further Study*, 6 NEV. L.J. 966, 969 (2006).

[42] U.S. CONST., art. VI, cl. 2.

[43] *See* RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW OF THE UNITED STATES § 102 cmt. j. (1987); *see also* Scott L. Cummings, *The Internationalization of Public Interest Law*, 57 DUKE L. J. 891, 983-84 (2008); *c.f.* Beharry v. Reno, 183

is difficult to bring private causes of action in U.S. courts under international law because of significant procedural obstacles. For example, U.S. law distinguishes between "self-executing" and "non-self-executing" treaties, meaning that ratification in itself does not create a private cause of action under a treaty. Moreover, the United States often ratifies treaties with "reservations" limiting their legal effect and ability to be enforced through private actions in courts. As a result, while the U.S. is bound by the treaties it ratifies and by customary international law, it is difficult to enforce international law in U.S. courts.

However, even without creating a private cause of action, international human rights law can still play a vital role in U.S. jurisprudence. Public interest lawyers have successfully used international human rights treaties and other documents interpreting international human rights law to inform judges' decisions by framing domestic legal issues in a broader international context.[44] Many courts, including the U.S. Supreme Court, have been receptive to domestic legal arguments that incorporate international human rights norms as a source of support. The Supreme Court has relied on international human rights standards in finding unconstitutional laws prohibiting sodomy,[45] laws allowing the imposition of the death penalty for juveniles[46] and defendants with mental retardation,[47] and in upholding race-conscious remedial measures in school admissions.[48]

The importance of international human rights norms is not limited to treaties that the United States has ratified. While ratification demonstrates the formal incorporation of an international agreement into U.S. law, courts have also relied on non-ratified treaties, customary international law, and general state practice in their decisions. For example, in *Roper v. Simmons*, the Supreme Court cited the Convention on the Rights of the Child (CRC), a treaty that the U.S. has not ratified but which is widely acknowledged as customary international law,[49] in determining that the execution of minors is unconstitutional.[50] The Court also looked to the practice of other states in making its determination.[51] At least one federal court in the United States has explicitly cited sections of the CRC as customary international law that is binding on United States courts.[52]

The international human rights standards set forth below can provide a useful framework for U.S.-based advocacy. While it is difficult to bring a private cause of action under these standards, they can play a critical role in claims founded in domestic law. For example, as outlined below, where domestic constitutional law requires a particular standard of care for youth in state custody, international human rights law and practices can help interpret that standard of care.[53] They may also

F.Supp.2d 584, 597-601 (E.D.N.Y. 2002) (stating that the Convention on the Rights of the Child is binding on U.S. courts as a source of customary international law), *rev'd on other grounds*, Beharry v. Ashcroft, 329 F.3d 51 (2d Cir. 2003).

[44] *See* Cummings, *supra* note 43, at 985-87.

[45] *See* Lawrence v. Texas, 539 U.S. 558, 573 (2003).

[46] *See* Roper v Simmons, 543 U.S. 551, 575-78 (2005).

[47] *See* Atkins v. Virginia, 536 U.S. 304, 316 n.21 (2002).

[48] *See* Grutter v. Bollinger, 539 U.S. 306, 344 (2003) (Ginsburg, J., concurring).

[49] *See, e.g.*, Barbara Atwood, *The Voice of the Indian Child: Strengthening the Indian Child Welfare Act through Children's Participation*, 50 ARIZ. L. REV. 127, 139-40 (2008) (citing the Convention as the "consensus of world opinion regarding children's rights").

[50] 543 U.S. at 575-78.

[51] *See id.*

[52] *See Beharry*, 183 F.Supp.2d at 597-601.

[53] *C.f.* Sarah H. Cleveland, *Our International Constitution*, 31 YALE J. INT'L L. 1, 86 (2006) (noting that international human rights norms are relevant to jurisprudence determining whether a particular form of conduct "shocks the conscience" or is "implicit in the concept of ordered liberty").

be useful for framing issues in the context of international practice, particularly where a U.S.-based practice falls out of line with a general international consensus.[54]

3. Relevant International Standards

Several relevant rights and corresponding international instruments that protect the right to sexual health care for youth in state custody are set forth below.

Protected Right	International Human Rights Instrument	Corresponding Obligations of the United States
The right to the highest attainable standard of health	• Art. 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)[55] • Art. 24 of the Convention on the Rights of the Child (CRC)[56] • Art. 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[57]	• The United States has signed but not ratified these treaties. It has an obligation not to act contrary to the purpose of the convention under Article 18 of the Vienna Convention (which the United States has ratified).
The right to life and security of person	• Art. 6 of the CRC • Art. 6 of the International Covenant on Civil and Political Rights (ICCPR)[58] • Art. 3 of the Universal Declaration of Human Rights ("Universal Declaration")	• See above in CRC entry of chart. • The United States has signed and ratified the ICCPR, making it binding on the United States. • The Universal Declaration is non-binding, but is considered customary international law.
The right to liberty	• Art. 3 of the Universal Declaration[59] • Art. 9 of the ICCPR	• See above in Universal Declaration entry in chart. • See above in ICCPR entry in chart.
The right to privacy	• Art. 17 of the ICCPR • Art. 16 of the CRC	• See above in ICCPR entry in chart. • See above in CRC entry in chart.

[54] *See id.* at 79.
[55] International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR].
[56] Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3 [hereinafter CRC].
[57] Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter CEDAW].
[58] International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR].
[59] Universal Declaration of Human Rights, G.A. Res. 217A, U.N. GAOR 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948) [hereinafter Universal Declaration].

The right to non-discrimination, equal protection, and equality before the law	• Art. 3 and Art. 26 of the ICCPR • The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)[60] • CEDAW	• See above in ICCPR entry in chart. • The United States has signed and ratified ICERD, making it binding on the United States. • See above in CEDAW entry in chart.
The right to education	• Article 28 of the CRC • Article 13 of the ICESCR	• See above in CRC entry in chart. • See above in ICESCR entry in chart.

The right to the highest attainable standard of health includes the right to prevention, treatment, and control of diseases. The Committee on Economic, Social and Cultural Rights, the purpose of which is to provide authoritative guidance on the provisions of the International Covenant on Economic, Social and Cultural Rights (ICESCR), has interpreted this right to impose an obligation on states to take the actions necessary for the "prevention, treatment and control of the epidemic, occupational and other diseases," including the "establishment of prevention and education programmes for behavior-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health."[61] Moreover, the Convention on the Rights of the Child (CRC) interprets this right to require states to "ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health," defining a "child" as a person under the age of 18.[62] Further interpretation can be found in the International Guidelines on HIV/AIDS and Human Rights ("International Guidelines"), a document put forth by the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS ("UNAIDS"), which is a coordinated effort of ten United Nations system organizations.[63] The International Guidelines state that in order to meet their obligations to ensure the right to the highest attainable standard of health, "States should ensure the provision of appropriate HIV-related information, education and support, including access to services for sexually-transmitted diseases, to the means of prevention (such as condoms and clean injection equipment) and to voluntary and confidential testing with pre- and post-test counseling, in order to enable individuals to protect themselves and others from infection."[64] To do this, "States may have to take special measures to

[60] International Convention on the Elimination of All Forms of Racial Discrimination, Mar. 7, 1966, 660 U.N.T.S. 195 [hereinafter ICERD].
[61] *See* Comm. on Econ., Soc. & Cultural Rights, General Comment 14: The right to the highest attainable standard of health, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000); *see also* HUMAN RIGHTS WATCH, IGNORANCE ONLY: HIV/AIDS, HUMAN RIGHTS AND FEDERALLY FUNDED ABSTINENCE-ONLY PROGRAMS IN THE UNITED STATES 41-42 (2002) [hereinafter IGNORANCE ONLY].
[62] CRC, *supra* note 56, at arts. 1, 24(2)(e).
[63] Office of the High Comm'r for Human Rights & Joint U.N. Programme on HIV/ AIDS (UNAIDS), *International Guidelines on HIV/AIDS and Human Rights* (2006 Consolidated Version), U.N. Doc. HR/PUB/06/9 (2006) [hereinafter *International Guidelines*]. UNAIDS brings together ten organizations of the United Nations system: the United Nations High Commissioner for Refugees; the United Nations Children's Fund; the United Nations World Food Programme; the United Nations Development Programme; the United Nations Population Fund; the United Nations Office on Drugs and Crime; the International Labour Organization; the United Nations Educational, Scientific, and Cultural Organization; the World Health Organization; and the World Bank.
[64] *Id.* at 100.

ensure that all groups in society, particularly marginalized groups, have equal access to HIV-related prevention, care and treatment services."[65]

Other rights also create obligations on the part of states to provide comprehensive sexual heath care for youth in state custody. The right to life creates positive obligations on states to take measures to protect public health, particularly in the face of epidemics.[66] A state's failure to provide information about HIV prevention can have serious consequences for the right to life.[67] Quarantining youth with HIV also infringes on their right to liberty or security of person, as would testing or treating them without their consent.[68] The right to education includes "the right to receive HIV-related education, particularly regarding prevention and care," and imparts an obligation on states "to ensure . . . that appropriate means are found so that effective HIV information is included in educational programmes inside and outside schools" and to promote through education "understanding, respect, tolerance and non-discrimination in relation to persons living with HIV."[69] The right to be free from discrimination protects youth living with HIV from discrimination in the context of their education, health care, and other aspects of their care.[70]

The CRC also provides protections in the context of sexual health that are specific to youth. The CRC protects youth from discrimination on the basis of their HIV status, sexual orientation, and gender.[71] The CRC also creates numerous requirements for states to ensure the availability of adolescent sexual health services as well as HIV counseling, testing, treatment, and care.[72] Moreover, laws, policies, strategies, and practices must address all forms of discrimination that contribute to increasing the impact of the epidemic.[73] Strategies should promote education and training that are explicitly designed to change attitudes of discrimination and stigmatization associated with HIV.[74] To this end, youth have the right to access adequate information related to HIV prevention and care through formal and informal channels.[75] Effective HIV prevention requires states to refrain from censoring, withholding, or intentionally misrepresenting health-related information, including sexuality education and information.[76]

The CRC also requires states to "ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality."[77] Effective prevention programs "are only those that acknowledge the realities of the lives of adolescents, while addressing sexuality by ensuring equal access to appropriate information, life skills, and to

[65] *Id.*
[66] *See* Human Rights Comm., General Comment 6: The right to life, ¶ 5, U.N. Doc. HRI/GEN/1/Rev.1 (Apr. 30, 1982).
[67] IGNORANCE ONLY, *supra* note 61, at 43.
[68] *See International Guidelines*, *supra* note 63, at 95-96.
[69] *Id.* at 96-97.
[70] *See id.* at 83-84, 96-97.
[71] Comm. on the Rights of the Child, General Comment 3: HIV/AIDS and the rights of the child, ¶¶ 8-9, U.N. Doc. CRC/GC/2003/3 (Mar. 17, 2003).
[72] *See id.* ¶¶ 20-24, 28.
[73] *See id.* ¶ 9.
[74] *See id.*
[75] *See id.* ¶ 16.
[76] *See id.*
[77] *Id.*

preventative measures."[78] Protection of these rights is particularly important among youth most vulnerable to HIV, including "children in detention" and "children living in institutions."[79]

The rights outlined above are all equally applicable to youth residing in state institutions. Under the United Nations Rules for the Protection of Juveniles Deprived of their Liberty,[80] "[j]uveniles deprived of their liberty shall not for any reason related to their status be denied the civil, economic, political, social or cultural rights to which they are entitled under national or international law, and which are compatible with the deprivation of liberty."[81] These rules also protect the rights of juveniles in state custody to an education suited to their needs and abilities that is designed to prepare them for return to society and is provided by qualified teachers; the right to adequate medical care that is both preventative and remedial, including treatment for substance abuse, with the informed consent of the juvenile; and the right to have their medical files kept confidential.[82] Moreover, the United Nations Committee on the Rights of the Child issued General Comment No. 10, which reinforces the applicability of the CRC's protections to children in the juvenile justice system, as well as outlining additional protections. These include the right not to be discriminated against on the basis of the youth's involvement in the juvenile justice system; the right to treatment consistent with the youth's sense of dignity and worth; the right to treatment that reinforces the youth's respect for the human rights and freedoms of others; the right to treatment that takes into account the youth's age and promotes the youth's reintegration into society; the right to the prevention of violence in the youth's treatment; the right to education to suit the youth's needs and abilities and to prepare the youth to return to society; and the right to an initial medical examination upon admission and adequate medical care throughout the youth's stay in the facility.[83] In all decisions made in the context of the administration of juvenile justice, the best interests of the youth must be taken as primary consideration—thus, the traditional objectives of criminal justice, such as retribution, must give way to rehabilitation objectives.[84]

These sources of law provide strong support for the argument that international law requires states to provide for a broad range of health care needs for adolescents in its custody. This includes providing appropriate sexual health care in a manner consistent with the evolving capacities of the adolescent, such as the education necessary for youth to make sexual health care decisions, and staff training to ensure that youth can safely access sexual health care.

[78] *Id.* ¶ 11.
[79] *Id.* ¶ 30.
[80] G.A. Res. 45/113, U.N. Doc. A/RES/45/113 (Dec. 14, 1990). The rules are non-binding, but are considered an interpretation of the CRC. Geraldine Van Bueren, United Nations Rules for the Protection of Juveniles Deprived of Their Liberty, *available at* http://child-abuse.com/childhouse/childrens_rights/dci_pr25.html.
[81] G.A. Res. 45/113, *supra* note 80, Annex ¶ 13.
[82] *See id.* Annex ¶¶ 19, 38, 49-55.
[83] *See* Comm. on the Rights of the Child, General Comment 10: Children's rights in Juvenile Justice, ¶¶ 6-8,13, 89, U.N. Doc. CRC/C/GC/10 (Apr. 25, 2007).
[84] *See id.* ¶ 10.

C. United States Constitutional Law

1. Introduction

It is well established that minors have fundamental rights and liberty interests similar to those of adults.[85] Federal courts have upheld the substantive due process and privacy rights of young people, as well as their right to enjoy equal protection under the law.[86]

States must take affirmative steps to ensure that individuals' rights are preserved. As described below, detained individuals, by virtue of their confinement, possess constitutional rights to services not generally guaranteed to others.[87] Minors in custody are in custody due to civil actions. Even 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. As set forth below, civil commitment comes with greater constitutional protection than imprisonment for a crime. Because the state has taken a young person into its custody, it must take affirmative steps to ensure the health, safety, and well-being of the youth in its care and to preserve his or her rights.[88] In the context of youth, this must include the provision of medical services, mental health services, and staff training adequate to ensure the physical and psychological well-being of the youth in their care. Minors must also have the information and training necessary to effectuate their right to health care and to make informed, healthful decisions. These services are also necessary to accomplish the goal of the child welfare and juvenile justice systems, *i.e.*, to return minors as healthy, whole, and responsible individuals to their communities. This section also argues that the state must afford access to contraception to youth who, by virtue of their detention, rely on the state for these services. Finally, failure to meet the safety and health needs of LGBTQ youth in particular may violate their right to equal protection under the law.

2. Substantive Due Process Right to Sexual Health Care

a. Conditions of Civil Confinement: Substantive Due Process and Youngberg

[85] *See* Haley v. Ohio, 332 U.S. 596 (1948) (protection of the Fourteenth Amendment applies in a state trial of a 15-year-old boy); In re Gault, 387 U.S. 1 (1967) ("neither the Fourteenth Amendment nor the Bill of Rights is for adults alone"); In re Winship, 397 U.S. 358 (1970) (12-year-old boy, charged with an act that would be a crime if committed by an adult, was entitled to procedural safeguards contained in the Sixth Amendment).

[86] Planned Parenthood of Se. Pa., Inc. v. Casey, 505 U.S. 833 (1992); Carey v. Population Services, Int'l, 431 U.S. 678 (1977).

[87] DeShaney v. Winnebago County Dep't of Soc. Servs., 489 U.S. 189, 199-200 (1989); Youngberg v. Romeo, 457 U.S. 307, 317 (1982); Estelle v. Gamble, 429 U.S. 97, 103 (1976).

[88] The Supreme Court indicated approval of this reasoning in *DeShaney v. Winnebago County Department of Social Services*, in which it stated that, although the state had no obligation to protect a minor in her parents' custody, "(h)ad the State by the affirmative exercise of its power removed (the minor) from free society and placed him in a foster home operated by its agents, we might have a situation sufficiently analogous to incarceration or institutionalization to give rise to an affirmative duty to protect." 489 U.S. 189, 201 n.9. In fact, numerous circuit courts have held that, when a state takes a child into its custody, it has a corresponding obligation under the Due Process Clause to protect the health and safety of the youth in their custody. *See* Santana v. Collazo, 714 F.2d 1172, 1179 (1st Cir. 1983); Doe v. N.Y. City Dep't of Social Services, 649 F.2d 134, 141-42 (2d Cir. 1981); A.M. v. Luzerne County Juvenile Det. Ctr., 372 F.3d 572, 579 (3d Cir. 2004); Alexander S. v. Boyd, 876 F.Supp. 773, 788-89 (D.S.C. 1995), *aff'd and rev'd in part on other grounds*, 113 F.3d 1373 (4th Cir. 1997); Meador v. Cabinet for Human Resources, 902 F.2d 474, 476 (6th Cir. 1990); K.H. ex rel. Murphy v. Morgan, 914 F.2d 846, 848-49 (7th Cir. 1991); White v. Rochford, 592 F.2d 381, 383 (7th Cir. 1979); A.J. v. Kierst, 56 F.3d 849, 854 (8th Cir. 1995); Gary H. v. Hegstrom, 831 F.2d 1430, 1432 (9th Cir. 1987); Yvonne L. v. N.M. Dep't of Hum. Servs., 959 F.2d 883, 893-94 (10th Cir. 1992); Taylor v. Ledbetter, 818 F.2d 791, 795 (11th Cir. 1987).

The Due Process Clause of the Fourteenth Amendment provides that a state shall not deprive persons of life, liberty, and property without due process of law. While the plain language of the Due Process Clause merely prohibits certain state actions, it also imposes affirmative duties on the state in various circumstances. When the state takes custody of an individual, whether by pre-trial detention (after an arrest but before a conviction) or civil commitment, that individual's Fourteenth Amendment substantive due process rights require that the state take affirmative steps to protect her health and safety, including the provision of adequate physical and mental health care.

In the seminal case *Youngberg v. Romeo*, 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.[89] Although the Supreme Court has not had the opportunity to apply *Youngberg*'s analysis to minors in custody, the reasoning of *Youngberg* applies equally to these minors, whom the state assumes custody of 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. 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."[90] 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."[91]

b. Substantive Due Process and the Sexual Health Care of Youth in State Custody

Although the Supreme Court has not yet delineated the precise contours of a state's responsibility to the minors in its custody, there is ample jurisprudence that can be used to support the argument that the state has a responsibility under the substantive Due Process Clause to provide comprehensive sexual health care to youth in its custody. As set forth below, this argument finds support in jurisprudence that has held that the state facilities have the responsibility to create policies to monitor and maintain the physical and psychological well being of minors in their custody; to provide minimally adequate training to allow those in custody to enjoy their due process rights; to provide information necessary to make informed health care decisions; and to rehabilitate youth in its care. Taken together and examined in light of the importance of comprehensive sexual health care to the health and safety of youth in state custody, these principles support the argument that the state must provide youth with comprehensive sexual health care.

While there are no cases affirming the right to sexual health care specifically, courts have affirmed the state's obligations to create policies to ensure the physical and psychological well-being of youth, including providing adequate medical services, education, and training to rehabilitate youth. Federal courts interpreting *Youngberg* have held that juvenile detention facilities violate the substantive due process rights of the minors in their custody when they fail to create adequate policies to monitor and maintain the physical and psychological well-being of those minors. In *A.M. v. Luzerne County*

[89] *Youngberg v. Romeo*, 457 U.S. 307, 321-22 (1982).
[90] A.J. v. Kierst, 56 F.3d 849, 854 (8th Cir. 1995) (quoting Santana v. Collazo, 714 F.2d 1172, 1179 (1st Cir. 1983) (internal quotations omitted).
[91] *Id.* (quoting Gary H. v. Hegstrom, 831 F.2d 1430, 1437 n. 3 (9th Cir. 1987) (Ferguson, J., concurring)).

Juvenile Detention Center, the Third Circuit allowed a juvenile's suit against a detention center to go forward on the theory that the detention center had insufficient policies to ensure the physical safety and psychological well-being of those in its custody.[92] Similarly, in *Alexander S. v. Boyd*, the federal district court for the District of South Carolina held that a state detention center's policies violated the Fourteenth Amendment by failing to provide adequate education to special-needs youth, adequate medical services due to a shortage of nurses, and adequate programming geared toward correcting the behavior of youth in custody.[93] Given that comprehensive sexual health care is necessary for the physical and psychological well-being of youth—particularly at-risk youth in state custody—these cases support the state's affirmative obligation to provide it to youth in their care. These cases also demonstrate that, in meeting its obligations, a state facility must provide policies to protect the youth in its custody through appropriate medical care and education, and by providing a staff trained to meet the needs of youth, including special-needs youth. In the context of sexual health care, this includes formal policies that guarantee sexual medical care, sexuality education, and a staff trained to understand, respect, and respond to the needs of youth in its care, including LGBTQ youth.

This argument is supported by professional standards that require state facilities to provide medical care, sexuality education, and staff training as part of minimum health care requirements for youth in state custody. One example of such standards is the National Commission on Correctional Health Care (NCCHC) *Standards for Health Services in Juvenile Detention and Confinement Facilities*[94] (hereinafter NCCHC Standards), which is outlined in Appendix A. The NCCHC Standards require, as part of their minimum health care standards, that youth have access to health care—including sexual health care—without barriers, and requires facilities to offer youth health education that includes comprehensive family planning, HIV and AIDS education, prevention of sexual and other physical violence, and information on sexually transmitted diseases.[95] The NCCHC Standards also require that both staff and inmates receive HIV education that includes information on modes of transmission, prevention, treatment, and disease prevention, and that is "culturally sensitive and scientifically accurate."[96]

Moreover, in the context of LGBTQ youth, cases such as *A.M.* and *Alexander S.*, as well as the NCCHC Standards, support the argument that states must ensure that their staff is trained to understand and respond to the high risk of physical, sexual, and emotional abuse that many LGBTQ youth in state custody face so that their physical safety, as well as their psychological well-being, can be assured. LGBTQ youth must not be forced to hide their identities and must be able to obtain sexual health services without fear of physical or psychological harm. If LGBTQ youth are not safe in state facilities because of their sexual orientation or gender identity, or if health care staff ignore their health care needs or discourage them from seeking sexual health care, their safety and well-being will suffer. Homophobia and heterosexism are not merely unacceptable social ills—they are threats to the health and safety of these youth.[97] Because the Fourteenth Amendment requires juvenile detention facilities to ensure the health and well-being of the youth in their care, it also

[92] 372 F.3d 572, 583-85 (3d Cir. 2004).
[93] 876 F.Supp. 773, 787-89, 790, 797 (D. S.C. 1995).
[94] NAT'L COMM'N ON CORR. HEALTH CARE, STANDARDS FOR HEALTH SERVICES IN JUVENILE DETENTION AND CONFINEMENT FACILITIES (2004) [hereinafter NCCHC Standards].
[95] *Id.* at 3, 87-88, 151, 212-13.
[96] *Id.* at 212-13.
[97] *See supra* notes 13-21 and accompanying text.

requires that such facilities take steps to ensure that their staff is adequately trained to ensure the safety of LGBTQ youth and to address the health care needs of the LGBTQ populations.

At least one federal district court has already held that a state violated the rights of youth in its custody by failing to develop policies, procedures, and staff training necessary for understanding and protecting LGBTQ youth.[98] In *R.G. v. Koller*,[99] the District Court of Hawaii examined the conditions at the Hawaii Youth Correction Facility (HYCF), where youth who identified as or were perceived to be LGBT were subject to pervasive verbal and physical harassment by guards and other youth. The court found that the pervasive verbal abuse in the form of homophobic slurs harmed the youth in HYCF's care.[100] The court noted that, because youth in custody "cannot retreat to the safety of their home and family at the end of the day . . . name-calling and other identity-based harassment based on actual or perceived sexual orientation or gender identity by guards at HYCF often is acutely damaging to wards who have been entrusted to the state's care by the family court."[101] The court held that HYCF violated the Due Process Clause by failing to maintain policies and training to protect LGBT youth, adequate staff and supervision, a functioning grievance system, and a classification system to protect vulnerable youth.[102] While the court stated that it did not suggest that the Constitution requires particular policies or safeguards, it made clear that "failure to adopt any professionally acceptable methods of maintaining order and safety," including "failure to adopt policies and procedures and to provide training regarding how to ensure the safety of LGBT wards" violated the due process rights of the youth in HYCF custody.[103]

Additional cases support the need for sexual medical care and sexuality education in state facilities by discussing the state's obligation to provide those in its custody with care, information, and training. In *Youngberg*, the Supreme Court held that, at minimum, the state must provide those in its custody due to civil actions "adequate food, shelter, clothing, and medical care," as well as the "minimally adequate training" necessary to ensure that those confined can enjoy their due process rights.[104] The state was therefore obligated to provide a mentally retarded man confined to a state institution training that would assure his bodily safety and a minimum of physical restraints because such training was necessary in order to protect the man's right to safety within the facility.[105] While *Youngberg* did not concern the sexual health of youth in state custody, it has implications for the state's obligations in this context. Given the frequent high-risk behavior of juveniles in state custody, adequate medical care undoubtedly must include sexual health care. In the same way denial of training impeded the *Youngberg* plaintiff's ability to enjoy his right to safety, the denial of information and education regarding sexual health impedes the ability of youth in state custody to enjoy their due process rights to health and safety by preventing them from being able to make informed health care decisions, and avoid, recognize, and treat sexual health problems.

Implicit support for the state's obligation to provide sexuality education can also be found in cases recognizing that information is necessary for individuals to exercise the right to refuse medical

[98] R.G. v. Koller, 415 F.Supp.2d 1129, 1157 (D. Haw. 2006).
[99] *Id.*
[100] *Id.* at 1143-44.
[101] *Id.* at 1143-44.
[102] *Id.* at 1156-57.
[103] *Id.* at 1157. The court also held that the use of isolation of LGBT youth for their "protection" violated the Due Process Clause. *See id.* at 1154-56.
[104] Youngberg v Romeo, 457 U.S. 307, 319, 324 (1982).
[105] *See id.* at 324.

treatment.[106] Those in state custody have a right to either choose or refuse medical treatment. State custodians have a corresponding constitutional obligation to ensure that those in its custody have the information necessary to make an informed decision about whether to accept or refuse a certain medical treatment. As the Second Circuit confirmed:

> An individual cannot exercise his established right to refuse medical treatment in a meaningful and intelligent fashion unless he has sufficient information about the proposed treatment. Absent knowledge of the risks or consequences that a particular treatment entails, a reasoned decision about whether to accept or reject that treatment is not possible. We therefore hold that, in order to permit prisoners to execute their right to refuse unwanted treatment, there exists a liberty interest in receiving such information as a reasonable patient would require to make an informed decision as to whether to accept or reject proposed medical treatment.[107]

Similarly, sexuality education provides the necessary information for youth to make decisions about their sexual health. Youth need information about relevant risks and consequences in order to decide whether to request or consent to a test or treatment for HIV, STIs, or pregnancy, whether to carry a pregnancy to term, and several other medical care decisions. While counseling is necessary in the context of a medical visit, youth need more information than can be provided in the course of a medical examination. In order to make truly informed medical decisions, youth need comprehensive sexuality education that teaches them about their risks and their options, and helps them make appropriate health care decisions.

A state's due process obligation to provide comprehensive sexuality education to youth in its custody is also supported by the "parens patriae" theory. The parens patriae theory allows the state to act to protect vulnerable individuals, and is the source of the state's authority to take youth into its custody due to neglect, abuse, or delinquency.[108] It has also been interpreted to provide that youth in state custody are entitled to receive rehabilitative services under the Due Process Clause. It relies on the Supreme Court's holding in *Jackson v. Indiana*, which stated that "[at] the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."[109] Many courts have reasoned that, because minors are taken into custody for the purpose of protection and rehabilitation, confinement that does not rehabilitate is therefore inconsistent with the Due Process Clause.[110] As set forth in Part I, comprehensive sexual

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[106] *See* Pabon v. Wright, 459 F.3d 241 (2d Cir. 2006); Benson v. Terhune, 304 F.3d 874, 884 (9th Cir. 2002); White v. Napoleon, 897 F.2d 103, 113 (3d Cir. 1990).

[107] *Pabon*, 459 F.3d at 249-50.

[108] *See* BLACK'S LAW DICTIONARY 1144 (8th ed. 2004); Andrea L. Dennis, *Collateral Damage? Juvenile Snitches in America's "War" on Drugs, Crime, and Gangs*, 46 AM. CRIM. L. REV. 1145, 1147 (2009).

[109] Jackson v. Indiana, 406 U.S. 715, 738 (1972).

[110] *See*, *e.g.*, Nelson v. Heyne, 491 F.2d 352, 359-60 (7th Cir. 1974); Alexander v. Boyd, 876 F.Supp. 773, 795-96 (D. S.C. 1995); Morgan v. Sproat, 432 F.Supp. 1130, 1135 (S.D. Miss. 1977); Pena v. New York State Div. for Youth, 419 F.Supp. 203, 206-07 (S.D.N.Y. 1976); Martarella v. Kelley, 349 F. Supp. 575, 585 (S.D.NY. 1972); Inmates of Boys' Training Sch. v. Affleck, 346 F.Supp. 1354, 1364-65 (D.R.I. 1972); K. Edward Green, *Mental Health Care for Children: Before and During State Custody*, 13 CAMPBELL L. REV. 1, 32-33 (1990). In his concurring opinion in *O'Connor v. Donaldson*, Chief Justice Burger noted that, in the context of minors adjudicated delinquent, there are reasons for a state taking custody of a minor other than rehabilitation, such as the protection of society. 422 U.S. 563, 582-83 (1975). However, courts have continued to employ the *parens patriae* theory, reasoning that states must still provide rehabilitative treatment even though rehabilitation is not the *sole* purpose of custody over minors. *See Alexander*, 876 F.Supp. at 796. Regardless, Chief Justice Burger's concurrance is not binding.

health care, including sexuality education, is vital to the psychological development and the development of mature, responsible behavior among the at-risk youth in state custody. Thus, in order to properly rehabilitate youth, states must provide comprehensive sexual health care.

Minors in state custody have a right to safety, medical care, mental health care, and life skills training—even if the general population may not have such legal rights—because the state has taken those youth from their homes and assumed responsibility for their well-being. Where education and counseling are necessary for a person in custody to exercise these constitutional rights, the liberty interest is extended to education and counseling. In the context of youth in state custody, states must provide comprehensive sexual health care to allow youth to enjoy their due process rights. As one court noted, minors in state custody are by "nature in a developmental phase of their lives," in which "[p]ositive efforts are necessary to prevent stagnation, which, for children, is synonymous with deterioration."[111]

3. Constitutional Right to Privacy and Access to Contraception

a. Introduction

Access to contraception is an important issue for youth in state custody. While most juvenile detention facilities separate males and females from each other, which may obviate the need for contraception, the issue of contraception access is pertinent in congregate care foster facilities in which male and female juveniles do have contact. Moreover, females who do not have contact with males may wish to begin hormonal contraceptive treatments in anticipation of their departure because these contraception methods may not become effective immediately. This subsection argues that, in these contexts, the state may not deny minors in its custody access to contraceptives.

In addition to their due process rights to health care, minors have federal constitutional privacy rights in the context of forming, making decisions about, and conducting intimate personal relationships. The privacy right to reproductive decision-making was originally recognized in *Griswold v. Connecticut* when the Supreme Court invalidated a state law prohibiting the use of contraception counseling and contraceptives.[112] *Griswold* emphasized the right of privacy within the marital context. Less than a decade later, in *Eisenstaedt v. Baird*, the right was expanded to encompass unmarried persons.[113] In so holding, the Court articulated that "if the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[114] The opinions in *Griswold* and *Eisenstaedt* provided the foundation for the decision in *Roe v. Wade* and subsequently *Planned Parenthood of Southeastern Pennsylvania, Inc. v. Casey*, which upheld a woman's fundamental right to elect to have an abortion.[115]

In *Casey*, reaffirming the constitutional protection of personal decisions regarding marriage, procreation, contraception, family relationships, child rearing and education, the Court stated that

[111] Doe v. New York City Dep't of Social Servs., 670 F.Supp. 1145, 1175 (S.D.N.Y. 1987)
[112] Griswold v. Connecticut, 381 U.S. 479, 485 (1965).
[113] Eisenstaedt v. Baird, 405 U.S. 438, 454-55 (1972).
[114] *Id.* at 453.
[115] Roe v. Wade, 410 U.S. 113 (1973); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992); *see also Moore v. City of E. Cleveland*, 431 U.S. 494, 499 (1977) (protecting "freedom of personal choice in matters of . . . family life" as one of the constitutionally protected liberties).

> [t]hese matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to the personal dignity and autonomy, are central to liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mysteries of human life.[116]

This rationale led the Court in 2003 in *Lawrence v. Texas* to invalidate a statute criminalizing same-sex sexual conduct.[117] There, the Court defined the central issue as their obligation to define "the liberty of all, not to mandate our own moral code."[118] Implicit to the "ordered concepts of liberty" are the personal choices of whether to engage in sexual activity and define our associational relationships regardless of marriage, procreation, or sexual orientation.

b. Minors' Access to Contraception in State Custodial Facilities

In the areas of pregnancy, abortion, and disease prevention, individuals hold fundamental privacy rights even when they are under the age of majority. As stated by the Supreme Court:

> Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights.[119]

While the Supreme Court has not delineated the precise contours of minors' privacy rights, in *Carey v. Population Services, International* the Court held that the state may not prohibit minors from accessing contraception.[120] Although the state may attempt to prevent teen pregnancy by discouraging sexual activity among minors,[121] a state may not discourage teen sexual activity by interfering with a minor's access to contraception.[122]

The nature of state custody supports the argument that states must provide youth in their care with access to contraception. The right to privacy, like other fundamental rights, does not disappear because of the fact of detention; even where those in state custody are convicted of a crime, "[p]rison walls do not form a barrier separating prison inmates from the protections of the Constitution."[123] In circumstances where individuals have been convicted of a crime, the United States Supreme Court has insisted that prisoners be accorded constitutional rights such as due process, first amendment speech rights, and freedom from racial discrimination and free exercise of religion.[124] For example, incarcerated women retain their privacy right to elect to terminate their pregnancies.[125] In the context of youth in state custody, failure to provide access to contraception is tantamount to prohibition. When a state takes a minor into a state-run facility, it essentially prevents the minor from accessing outside resources. Thus, in order to avoid the prohibition the Supreme

[116] *Casey*, 505 U.S. at 851.
[117] Lawrence v. Texas, 539 U.S. 558 (2003).
[118] *Id.* at 571.
[119] Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74 (1976).
[120] *See* Carey v. Population Servs. Int'l, 431 U.S. 678 (1977).
[121] *See* Michael M. v. Superior Court of Sonoma County, 450 U.S. 464, 470 (1981).
[122] *See Carey*, 431 U.S. 678; *see also* Planned Parenthood of S.E. Pa., Inc. v. Casey, 505 U.S. 833, 899 (1992) (upholding state parental consent laws only when a judicial by-pass procedure is available to the minors).
[123] Turner v. Safley, 482 U.S. 78, 84 (1987).
[124] Hudson v. Palmer, 468 U.S. 517, 523 (1984); Wolff v. McDonald, 418 U.S. 539, 555-56 (1974); Pell v. Procunier, 417 U.S. 817 (1974); Cruz v. Bento, 405 U.S. 319 (1972); Lee v. Washington, 390 U.S. 333 (1968).
[125] Monmouth County Corr. Inst. Inmates v. Lanzaro, 834 F.2d 326, 340-41 (3d Cir. 1987).

Court rejected in *Carey*, a state facility must allow youth in its custody with means to access contraception.

While the state may curtail the rights of those in its custody to a certain extent, this argument does not justify prohibiting minors in custody from accessing contraception. The state may curtail the rights of prisoners convicted of a crime to the extent that the exercise of those rights interferes with legitimate penological objectives such as safety and security.[126] In the context of youth in state custody, a more stringent standard than the "legitimate penological objective" test may be applicable, particularly for juveniles in congregate foster care. This is because there is arguably no "penological" goal at interest in the custody of youth who are civilly committed. As the Second Circuit has noted, the "legitimate penological objective" test is particularly ill-suited for juveniles who, rather than having committed actions that would constitute a crime for an adult, have been taken into state custody for their own safety, or because they ran away from their homes, failed to attend school, or violated a court order.[127]

However, even assuming that the "legitimate penological objective" test—and not a more stringent one—applies, denying minors access to contraception does not serve a rational penological objective. Even if the state seeks to pursue the legitimate penological goal of preventing sex among minors in its custody, the state may not deny minors access to contraception to serve this goal. In *Carey*, the Court invalidated a New York law that prevented the sale of contraception to people under the age of sixteen.[128] The state argued that the statute prohibiting the distribution of contraception had "the important symbolic effect of communicating disapproval of sexual activity by minors."[129] The Court rejected this justification, holding that, even if the state is allowed to prohibit sexual activity among minors, the state may not attempt to send a message about the dangers of sexual activity by interfering with minors' access to contraception.[130] As Justice Stevens stated in his concurring opinion:

> Although the State may properly perform a teaching function . . . an attempt to persuade by inflicting harm on the listener is an unacceptable means of conveying a message that is otherwise legitimate. The propaganda technique used in this case significantly increases the risk of unwanted pregnancy and venereal disease. It is as though a State decided to dramatize its disapproval of motorcycles by forbidding the use of safety helmets. One need not posit a constitutional right to ride a motorcycle to characterize such a restriction as irrational and perverse.[131]

This reasoning applies equally to minors in state custody; it is irrational and perverse to attempt to discourage sexual activity among minors in state custody by interfering with their access to contraception. To echo Justice Stevens' reasoning, one need not demonstrate that minors in state custody have a constitutional right to engage in sexual conduct in order to conclude that the sate may not attempt to deter such conduct by forbidding access to contraception.

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126 *Hudson*, 468 U.S. 517 at 524; *Wolff*, 418 U.S. at 556.
127 N.G. v. Connecticut, 382 F.3d 225, 234-35 (2d Cir. 2004). Although the *N.G.* case considered the constitutionality of a search, its language regarding whether the "legitimate penological goal" standard should apply to minors in custody is equally applicable outside the context of searches.
128 431 U.S. 678 (1977).
129 *See id.* at 715 (Stevens, J., concurring).
130 *See id.* at 699 (plurality opinion); *id.* at 713-16 (Stevens, J., concurring).
131 *See id.* at 715 (Stevens, J., concurring).

c. Limitations on Minors' Privacy Rights

The Supreme Court has held that the state has somewhat more leeway in taking actions that infringe on the privacy rights of minors than it does with adults.[132] Where adults are concerned, the government cannot infringe on this right without a compelling justification.[133] Minors' right to privacy, in contrast, may be restricted without passing this test if the restriction serves a "significant state interest . . . that is not present in the case of an adult."[134] The Supreme Court has identified three reasons justifying greater restrictions on the privacy rights of minors: (1) the peculiar vulnerability of minors; (2) the inability of minors to make critical decisions; and (3) the importance of the parental role in child rearing.[135]

All three of these justifications argue *in favor* of the state providing comprehensive sexual health care, including access to contraception and information about how to protect themselves from HIV, STIs, and unintended pregnancy. The minors in state custody are particularly vulnerable, given the high proportion of minors who have been subject to physical, emotional, and sexual abuse, and those who may have engaged in high-risk behaviors, such as trading sex for necessities or drugs. This vulnerability and their potential inability to make critical decisions are exacerbated by a lack of accurate information. Without the knowledge and tools to protect themselves, at-risk minors are even more vulnerable and less likely to make safe and healthful decisions regarding their sexuality. Moreover, where the state has assumed the parental role by taking the minor into custody, the "importance of the parental role in child rearing" speaks to the importance of the state's role in providing information and guidance; in many instances of minors in state custody, the state is the only entity undertaking this parental role and is therefore the only source of information and guidance to these at-risk youth.

4. The Equal Protection Clause Requires Staff Training to Ensure a Safe Environment for LGBTQ Youth

Violence toward LGBTQ youth is a common problem among youth in congregate homes and juvenile detention facilities.[136] LGBTQ youth are routinely the target of discrimination, harassment, violence and sexual assault from peers, foster parents, and even from group care facility staff.[137] While the exact percentage of LGBTQ youth in state custody is not known, it is estimated that they represent 4-10% of the foster care and juvenile justice system populations.[138] Many of these young people are in out-of-home care as a consequence of their LGBT identity, including those who have been rejected, neglected, or abused by their families of origin, those who have been forced to live on

[132] *See* Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74 (1976) (noting that "the State has somewhat broader authority to regulate the activities of children than of adults").
[133] *See* Griswold v. Connecticut, 381 U.S. 479, 486 (1965) (protecting liberty interest in sexual intimacy within marriage), Eisenstaedt v. Baird, 405 U.S. 438, 453-54 (1972) (protecting liberty interest in sexual intimacy outside of marriage); *Carey*, 431 U.S. at 686; Roe v. Wade, 410 U.S. 113, 165-66 (1973); *Casey*, 505 U.S. at 833 (right to abortion); Loving v. Virginia, 388 U.S. 1, 12 (1967) (recognizing liberty interest in marriage); Zablocki v. Redhail, 434 U.S. 374, 383-84 (1978); Boddie v. Connecticut, 401 U.S. 371, 376 (1972).
[134] *Danforth*, 428 U.S. at 75; *Carey*, 431 U.S. at 693.
[135] *See* Bellotti v. Baird, 443 U.S. 622, 634 (1979). While *Bellotti* considered the constitutionality of laws interfering with minors' access to abortion, the language cited was not limited to abortion cases.
[136] TIME RUNNING OUT, *supra* note 8, at 34; CWLA LGBT BEST PRACTICES, *supra* note 25, at 6, 49-50.
[137] CWLA LGBT BEST PRACTICES, *supra* note 25, at 6, 49-50.
[138] FEINSTEIN, *supra* note 5, at 1.

the streets and engage in illegal behavior to survive, and those who have been labeled "sex offenders" because their behavior is perceived as deviant or perverse.[139]

Under the Equal Protection Clause, policies that discriminate against LGBTQ individuals must at least be justified by a rational relationship to a legitimate state interest, and may be held to a higher standard.[140] LGBTQ youth must be provided the same degree of protection from harm in state custody as their non-LGBTQ peers. The Supreme Court has held that the Equal Protection Clause, which provides that no State shall "deny to any person within its jurisdiction the equal protection of the laws," prohibits arbitrary discrimination on the basis of sexual orientation.[141]

In order to comply with this requirement, state officials must afford LGBTQ youth in their care the same protections from harassment and violence as non-LGBTQ youth, even if that means that state institutions must provide additional training to staff and students to ensure a respectful and safe environment for LGBTQ youth. Students across the country have successfully stated equal protection claims against school officials for their failure to protect students from peer harassment and harm on the basis of sexual orientation.[142] In these cases, administrators' failure to respond to the harassment of LGBTQ students and school districts' failure to adequately train teachers, students, and administrators about the districts' harassment policies was evidence that the administrators and school districts either acted with deliberate indifference or intentionally discriminated against the LGBTQ students.[143] Because there is no "rational basis for permitting one student to assault another based on the victim's sexual orientation," such discrimination constitutes a violation of the equal protection rights of youth who identify as or are perceived to be LGBTQ.[144]

In *Flores v. Morgan High School District*, former students who identified as or were perceived by other students as lesbian, gay, or bisexual, sued school administrators and the school district alleging that the response, or lack thereof, to student-to-student harassment based on their sexual orientation denied them equal protection.[145] One student received pornography and threatening notes referring to her sexual orientation in her locker, which was met with indifference by the assistant principal.[146] Another student was beaten by six other students while being called gay slurs, yet only one of the six students involved was punished.[147] Two female students in a relationship were subjected to anti-gay comments, sexual gestures, and had an object thrown at them, but the assistant principle refused to investigate the incident.[148] Another student was subjected to name-calling and food-throwing. The campus monitor refused to take any action to stop this, even when it occurred in her presence, and one campus monitor even started a rumor about the student engaging in sexual activities with another student on campus.[149] The same student complained to a teacher that her classmates in

[139] *Id.* at 7-8; CWLA LGBT Best Practices, *supra* note 25, at 3.
[140] *See* Romer v. Evans, 517 U.S. 620, 631-35 (1996).
[141] *Id.* at 635 (Colorado amendment prohibiting legislative, judicial or executive action designed to protect gays and lesbians from discrimination violated the Equal Protection Clause); s*ee also City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985); Yick Wo v. Hopkins, 118 U.S. 356 (1886).
[142] Flores v. Morgan High School District, 324 F.3d 1130 (9th Cir. 2003); Nabozny v. Podlesny, 92 F.3d 446 (7th Cir. 1996); Flores v. Morgan High School District, 324 F.3d 1130 (9th Cir. 2003).
[143] *Flores*, 324 F.3d 1130; *Nabozny*, 92 F.3d 446.
[144] *Flores*, 324 F.3d 1138; *Nabozny*, 92 F.3d at 558.
[145] *Flores*, 324 F.3d 1130.
[146] *Id.* at 1133.
[147] *Id.*
[148] *Id.*
[149] *Id.*

physical education class harassed her. The teacher refused to take any action against the harassers, but instead suggested the student change clothes away from the locker room so her classmates would not feel uncomfortable.[150]

The plaintiffs brought suit alleging that the administrators and the school district violated their equal protection rights by treating their complaints of harassment differently than other types of harassment complaints, and the defendants moved for summary judgment.[151] The Ninth Circuit found that there was sufficient evidence for a jury to find that, while district policies made clear no harassment would be tolerated, the plaintiffs' harassment was treated differently based on their sexual orientation, since the plaintiffs were harassed and the school administrators and district acted with deliberate indifference towards their complaints for years.[152] The court also found that the district failed to adequately train teachers, students, and campus monitors about the policies prohibiting harassment on the basis of sexual orientation.[153] Specifically, while there was training on sexual harassment, this training was limited and did not specifically deal with sexual orientation discrimination.[154] The defendants also inadequately communicated anti-harassment policies to students despite the defendants' awareness of hostility towards gay students.[155] Given this evidence, the court found that a jury could conclude "that there was an obvious need for training and that the discrimination the plaintiffs faced was a highly predictable consequence of the defendants not providing that training."[156]

Nabozny v. Podlesney demonstrates that harassment need not be widespread to constitute an equal protection violation—failure to respond to the needs of just one youth can violate that youth's equal protection rights. In *Nabozny*, the plaintiff suffered significant harassment and violence at the hands of his peers over the course of several years because he identified as gay, including being beaten repeatedly, urinated on, and pinned down and subjected to a mock rape.[157] School administrators took no action, and even told the plaintiff on different occasions that he should "expect" such behavior if he was "going to be so openly gay" and that he deserved his treatment because he was gay.[158] As a result of this harassment and abuse, the plaintiff attempted suicide twice and was diagnosed with Post Traumatic Stress Disorder.[159] The District Court granted summary judgment for the defendants, and the Seventh Circuit overturned the decision with regard to the plaintiff's equal protection claims. The Court of Appeals held that there was sufficient evidence that the administrators had treated Nabozny differently than other students because of his sexual orientation, and that there was no conceivable rational basis for allowing him to be subject to harassment and abuse based on his sexual orientation.[160]

These cases prohibit schools from providing LGBTQ students with fewer protections for their safety or a lesser standard of discipline for their harassers because of their LGBTQ status. In the

[150] *Id.*
[151] *Id.* at 1132.
[152] *Id.* at 1135-36.
[153] *Id.* at 1136.
[154] *Id.*
[155] *Id.*
[156] *Id.*
[157] *Nabozny,* 92 F.3d at 451-53.
[158] *Id.*
[159] *Id.*
[160] *Id.* at 457-58.

context of juvenile detention facilities or congregate foster care, the Equal Protection Clause requires that these facilities adequately train their staff to protect LGBTQ youth from violence and harassment due to their LGBTQ status. This includes training to ensure that staff members are not only familiar with harassment policies, but are also trained to adequately respond to harassment that targets LGBTQ youth. Failure to do so will, as in *Flores* and *Nabozny*, result in violation of the equal protection rights of LGBTQ youth in the facilities' care.

The need for adequate training of staff is indeed stronger in the context of juvenile detention facilities and congregate foster care than in public schools. Unlike schools, such facilities are solely responsible for the safety, health, and education of youth in their care. As described in the previous subsection, these facilities have a due process obligation to ensure the safety of youth in their care. The above cases demonstrate that the Equal Protection Clause requires that these facilities provide youth in their care no less safe an environment than afforded to non-LGBTQ youth, even if that means the state must take affirmative steps to train staff to respond to LGBTQ-based harassment and violence.

The Equal Protection Clause also requires juvenile detention and congregate foster care facilities to provide necessary training to ensure the sexual health needs of LGBTQ youth are met. As described in the previous subsection, the state has due process obligations to ensure that these facilities provide a safe environment for youth as well as rehabilitative services and, as part of this obligation, must ensure that their health and educational needs are met. Because the Equal Protection Clause prohibits these facilities from discriminating against LGBTQ youth in its provision of services, these facilities must take necessary steps to ensure that LGBTQ youth are not provided less adequate sexual health and sexuality education services than their peers. Thus, physicians must be trained to provide sexual health care to youth that takes into account same-sex sexual practices or transgender health needs; failure to do so constitutes the delivery of poorer health care for LGBTQ youth than non-LGBTQ youth based on their LGBTQ status. Similarly, a sexuality education curriculum that does not address or is hostile to same-sex relationships or transgender individuals fails to provide these youth with the education they need based on their LGBTQ status.

The consequences for states' failure to provide safe and supportive environments for LGBTQ youth are dire, and have been recognized by courts. *Harper v. Poway Unified School District* is particularly notable for its enlightening discussion on the harm that discriminatory language and actions have on LGBTQ youth.[161] While the case did not concern the equal protection rights of LGBTQ youth, in holding that a student's anti-gay shirt was not protected by the First Amendment, the Ninth Circuit opined,

> The demeaning of young gay and lesbian students in a school environment is detrimental not only to their psychological health and well-being, but also to their educational development. Indeed, studies demonstrate that academic underachievement, truancy, and drop-out are prevalent among homosexual youth and are the probable consequences of violence and verbal and physical abuse at school.[162]

[161] Harper v. Poway Unified School District, 445 F.3d 1166 (9th Cir. 2006), *vacated on other grounds*, 549 U.S. 1262 (2007).
[162] *Id.* at 1178-79.

The Court also noted that anti-gay verbal assaults "may destroy the self-esteem of our most vulnerable teenagers and interfere with their educational development."[163]

The Ninth Circuit's words, written in the context of school environments, are even more powerful in the context of juvenile detention and congregate foster care. These facilities have taken the affirmative obligation to care for and nurture these youth. If LGBTQ youth are not safe in these facilities, then they are unsafe where they sleep, eat, bathe, learn, and grow; if their health and educational needs are not met by these facilities, youth have no opportunity to seek care and education elsewhere. Consequently, the harms that befall youth subject to harassment and hostility in school environments are magnified in the context of state custody, where youth have little or no ability to escape the environment that the state creates for them. The state's obligations to ensure a non-discriminatory environment are critical to the health, safety, and well-being of these youth.

5. Parental Challenges to Sexuality Education

While facilities may be concerned about parental objection to the provision of sexuality education, federal courts across the country have held that sexuality education programs that offend the religious sensibilities and teachings of the parents of the students do not violate the constitutional rights of those parents, and thus schools may include these programs over parental objection.[164] For example, in *Brown v. Hot, Sexy & Safer Productions, Inc.,* the First Circuit refused to find a "broad-based right to restrict the flow of information" when students were compelled to attend a sexually explicit AIDS-awareness seminar that contained humorous skits about oral sex, masturbation, same-sex sexual activity, and condom usage.[165] Similarly, the Ninth Circuit dismissed a parents' case involving a school-administered survey about sex and violence, stating that "no constitutional provision prohibits the dissemination of information to children."[166] Courts have upheld such curricula even where parents were not informed of the curricula or given the opportunity to remove their child from that portion of the instruction.[167]

D. State Law Protections

Advocates may also find support for the right of minors in state custody to comprehensive sexual health care under state law. State law protections often exceed those of federal law, and can provide fertile ground for civil rights claims. Similarly, regulations and agency guidelines promulgated under state law that set minimum requirements for facilities for youth in state custody often provide

[163] *See id.* at 1179.

[164] *See* Parker v. Hurley, 514 F.3d 18 (1st Cir. 2008); Fields v. Palmdale School District, 427 F.3d 1197, 1208 (9th Cir. 2005)(dismissing claim that school survey about sex distributed at elementary school students violated parent's freedom or religion and privacy rights); Brown v. Hot, Sexy & Safer Productions, 68 F.3d 525, 529, 534 (1st Cir. 1995); Cornwell v. State Bd. of Educ., 314 F. Supp. 340 (D. Md. 1969) (rejecting free exercise challenge to compulsory sex education program where only alleged infringement is distaste of message), *aff'd*, 428 F.2d 471 (4th Cir. 1970); Hopkins v. Hamden Bd. of Educ., 289 A.2d 914 (Conn. C.P. 1971) (rejecting free exercise challenge to compulsory sex education program on grounds that the study of sexual matters outweighs free exercise rights; *see also* Monteiro v. Tempe Union High School District, 158 F.3d 1022 (9th Cir. 1998) (rejecting parents' suit alleging that curriculum, which included books with educational value but that used racists terms, violated their Equal Protection rights); Davis v. Page, 385 F. Supp. 395 (D.N.H. 1974).

[165] *Brown*, 68 F.3d at 529, 534).

[166] Fields v. Palmdale School District, 427 F.3d 1197, 1208 (9th Cir. 2005) (dismissing claim that school survey discussing sex distributed to elementary school students violated parent's freedom or religion and privacy rights).

[167] *See, e.g.*, *Parker*, 514 F.3d at 106-07; *Brown*, 68 F.3d at 534.

specific requirements pertaining to medical care, education, and staff training, as well as protections for the rights of youth. While an outline and discussion of these laws, regulations, and guidelines for each state is beyond the scope of this memorandum, Appendix B provides an example of how such resources can be interpreted and used to protect the rights of youth in state custody to comprehensive sex education. Appendix B analyzes the rights of youth in state custody under New Jersey law. Specifically, it looks to the state constitution, statutes, and regulations to argue that minors in New Jersey's custody have an affirmative right under New Jersey law to comprehensive sexual health care. Advocates are encouraged to use Appendix B as a guide for research and advocacy in other states.

III. Conclusion

The public health crisis facing youth in state facilities requires an immediate and sustained response. Youth in state facilities face significant health challenges and, in the context of sexual health, these challenges can be life-threatening. These youth need medical care, education, and counseling to make healthful choices, and a safe, respectful environment in which they can obtain the information and medical assistance necessary to address their health concerns.

The Teen SENSE initiative is founded on the principle that comprehensive sexual health care for youth in state custody is required not only by common sense, but also by the law. When the state takes a minor into its custody, it has an affirmative obligation to provide that minor with an environment in which her physical and psychological needs are met—an environment in which she is safe and in which she can also thrive. Given the realities that today's youth face, such an environment simply cannot exist without confidential, respectful medical care and counseling that addresses all youths' sexual health concerns, education and information that enables youth to make healthful decisions about their sexual health, and an environment where all youth—including LGBTQ youth—can live without fear. It is imperative that all youth in state custody are able to live in an environment where their physical and psychological concerns are addressed without stigma or reproach. These rights are secured under both international and domestic legal protections that recognize the rights of youth and the corresponding obligations of the facilities that take them into their care.

In addition to the legal arguments set forth above, the attached Appendix provides support for advocates seeking to protect the health of youth in state custody. Appendix A provides an outline of professional standards for the care of youth in state custody, demonstrating the importance of comprehensive sexual health care and the numerous requirements needed to ensure its adequacy. Appendix B provides an outline of the law of New Jersey as an example of additional protections that can be found under state law. CHLP encourages advocates to use these appendices for guidance to further the rights of youth to comprehensive sexual health care in their states' facilities.

APPENDIX A: PROFESSIONAL GUIDELINES FOR THE CARE OF YOUTH IN CONGREGATE CARE AND DETENTION FACILITIES

This Appendix demonstrates that the legal arguments outlined in the main document and Appendix B are supported by the professional standards issued for the health care of youth in confinement. The national standards for acceptable requirements for health services for youth in confinement include sexual medical care, counseling, and culturally sensitive and scientifically accurate sexuality education and staff training on sexual health issues. These minimal standards demonstrate the professional and expert consensus that comprehensive sexual health care is vital to the health, safety, and well-being of youth in state facilities and that the state is therefore obligated to provide it.

Professional standards for the health care of youth in confinement are delineated by the *Standards for Health Services in Juvenile Detention Facilities and Confinement* (hereinafter the NCCHC Standards) *Facilities*, published by the National Commission on Correctional Health Care (NCCHC).[168] The NCCHC, an outgrowth of a program of the American Medical Association, operates the national certification program for correctional health programs.[169] The NCCHC Board has representatives from thirty-six supporting organizations, including the American Academy of Pediatrics, American Bar Association, American Association of Correctional Psychology, American Jail Association and the Society of Adolescent Medicine.[170] The NCCHC also solicited and received input for the development of its standards from correctional health professionals, facility administrators and national associations in health, corrections, and law.[171] The NCCHC Standards therefore incorporate the recommendations of experts in this field, including those who work with correctional youth.[172] Their ultimate goal is to improve the health of youth in detention, strengthen organizational effectiveness, and reduce the risk of adverse legal judgment against facilities.[173] The 73 NCCHC Standards are grouped into nine categories, including Health Care Services and Support, Juvenile Care and Treatment, Health Promotion and Disease Prevention, Health Records, and Medical-Legal Issues.[174] Between revisions, the NCCHC adopts position statements on important issues such as the administrative management of HIV in corrections, women's health in correctional settings, and health care funding for incarcerated youth.[175]

The NCCHC set forth numerous standards for the health—both physical and psychological—of youth in state confinement, which cannot be fully outlined in this Appendix. However, several specific requirements are particularly noteworthy in their support of the principle that comprehensive sexual health care is required to maintain the health of youth in state facilities. For example, the NCCHC Standards advise that, in order to survive scrutiny under the U.S. Constitution, health care delivery systems must have the means to diagnose, treat, and educate their youth regarding the diseases associated with HIV and AIDS.[176] The NCCHC Standards require

[168] NAT'L COMM'N ON CORR. HEALTH CARE, STANDARDS FOR HEALTH SERVICES IN JUVENILE DETENTION FACILITIES AND CONFINEMENT FACILITIES (2004) [hereinafter NCCHC Standards].
[169] *See id.* at vii.
[170] *See id.* at vii-viii.
[171] *See id.* at v.
[172] *See id.*
[173] *See id.*
[174] *See id.* at viii.
[175] *See id.* at 209-253.
[176] *See id.* at 148, 151.

access to care and emphasize that health care must be available without barriers.[177] The NCCHC also emphasizes that youth in detention have the right to informed consent and the right to refuse treatment.[178] Even where a juvenile is required to give "blanket" consent for treatment by the health services staff upon admission to the facility, written consent is still required for any invasive procedure, including invasive diagnostic tests.[179] Juveniles may not be punished for refusing treatment.[180] For example, a physician drawing blood for an HIV test must provide counseling that enables the youth to make an informed decision and obtain written consent. Should the juvenile refuse a test, he or she may not be punished.

Medical care alone, however, is insufficient to meet the HIV prevention and treatment needs of youth; it must be accompanied by appropriate counseling and education. The NCCHC Position Statement on Administrative Management of HIV in Corrections states that "HIV/AIDS education should be provided to all staff and inmates in jails, prisons, and juvenile confinement facilities."[181] Such education should include information on "modes of transmission, prevention, treatment, and disease progression" and should be "culturally sensitive and scientifically accurate."[182] The NCCHC recommends that "massive educational efforts should be undertaken" for all youth and staff, including both correctional and medical staff.[183] Furthermore, the NCCHC requires counseling in the provision of HIV and all other medical care sufficient for the patient to understand treatment, stating that the "right to refuse treatment is useless without the knowledge of the proposed treatment."[184]

The NCCHC Standard entitled "Health Promotion and Education" sets forth additional obligations for facilities with regard to sexual health care. For example, facilities must offer health education, defined as "information on preventing disease and maintaining a healthy lifestyle," to all juveniles.[185] Subjects include chronic diseases and disabilities, comprehensive family planning, HIV infection and AIDS, prevention of sexual and other physical violence, and sexually transmitted diseases.[186] All aspects of this standard must be addressed by written policy and defined procedure, rather than informal ad-hoc actions.[187] No one instructional method is mandated; instead the health staff is encouraged to use creative and motivational methods to deliver the information in a way that engages participants.[188]

The NCCHC Standard entitled "Family Planning Services," "intends that all juveniles must be educated and prepared for responsible sexual behavior. . . ."[189] Written, accurate information, age-appropriate programs, and contraceptive publications should be available to both males and females.[190] Counseling and social services regarding all aspects of sexuality should be available either

[177] *See id.* at 3.
[178] *See id.* at 136-38, 151-52.
[179] *Id.* at 137.
[180] *See id.* at 138.
[181] *See id.* at 212.
[182] *Id.* at 212.
[183] *Id.* at 213.
[184] *See id.* at 151-52.
[185] *Id.* at ¶ 87 (Standard Y-F-01).
[186] *Id.* at ¶ 88.
[187] *See id.* at 87.
[188] *See id.* at 88.
[189] *Id.* at 117.
[190] *Id.*

inside the facility or by referral to appropriate community agencies.[191] Working with community resources is recommended to assist with developing programs.[192] Like the Standard on health education, the NCCHC directs youth detention facilities to implement all aspects of this standard through written policy and defined procedure.[193]

The above examples do not represent the comprehensive requirements of the NCCHC with regard to sexual health care; advocates are encouraged to review the standards in full for further discussion of NCCHC standards, particularly with regard to health examinations and mental health care. Additional experts and professional organizations have also set forth recommended standards for the care of minors. Among these are the American Medical Association's Guidelines for Adolescent Preventive Services, and the Region II Male Involvement Advisory Committee's Guidelines for Male Sexual and Reproductive Health Services, which set forth numerous requirements for the sexual health care of youth, including STI and HIV testing and treatment that includes pre- and post-test counseling; comprehensive and inclusive sexuality education; mental health screening; and health care specific to the needs of LGBTQ youth.[194] Because of the depth and breadth of these standards, a comprehensive analysis of them is beyond the scope of this paper.

With these professional standards in mind, Teen SENSE has developed Model Standards for the sexual health care of youth in state facilities. The Model Standards, drafted by a collaboration of national experts in medical care, youth rights, sexuality education, care of youth in detention, and LGBTQ issues, provide a comprehensive review of the best practices for the sexual health care for youth in state facilities as agreed upon by the professional community. If you are interested in obtaining a copy of these standards or to contributing to the Teen SENSE project, please email info@hivlawandpolicy.org.

[191] *Id.* at 116.
[192] *Id.* at 117.
[193] *See id.* at 116.
[194] *See, generally* REGION II MALE INVOLVEMENT ADVISORY COMMITTEE, GUIDELINES FOR MALE SEXUAL AND REPRODUCTIVE HEALTH SERVICES (2005); AMERICAN MEDICAL ASSOCIATION, GUIDELINES FOR ADOLESCENT PREVENTIVE SERVICES (GAPS): RECOMMENDATIONS MONOGRAPH (1997).

APPENDIX B: NEW JERSEY LAWS PROTECTING THE RIGHTS OF YOUTH IN STATE CUSTODY TO COMPREHENSIVE SEXUAL HEALTH CARE

I. Introduction

New Jersey law provides strong support for the right of youth in state custody facilities to comprehensive sexual health care.[195] This Appendix outlines this legal foundation, focusing on the state constitution, statutes, and regulations that protect the rights of youth. New Jersey's state constitution provides strong rights to due process, privacy, and equal protection, including the right to reproductive health services and the right to control one's body and reproductive capabilities. These constitutional provisions belong to "old and young alike,"[196] and the New Jersey Supreme Court has found that the state constitution provides greater protections for minors in these areas than the U.S. Supreme Court has interpreted the federal constitution to provide. New Jersey also has a complex scheme of statutory and regulatory law that mandates high-quality medical services, informed consent, the availability of STI/HIV testing for minors, access to abortion services, and comprehensive medical care for minors under the auspices of the Department of Children and Families and the Juvenile Justice Commission. Under the New Jersey Law Against Discrimination, the oldest and most comprehensive anti-discrimination statute in the nation, and a settlement in a federal class action law suit to improve services to youth in the child welfare system, New Jersey also must develop and implement policies and training to staff to prevent harassment and violence against LGBTQ youth.

Though New Jersey's laws provide an excellent legal foundation to support the right of youth in state custody to comprehensive sexual health services, New Jersey has no official guidelines that would ensure such services are provided in a consistent and effective manner. The Teen SENSE initiative, which works to secure comprehensive sexual health care for youth in state custody, has already begun to bridge this gap. Teen SENSE focuses on ensuring that the policies and resources are in place to help facilities provide youth with the comprehensive sexual health care that is necessary to their well being and supported by state law and professional practice. The following sections outline the state-specific legal foundation supporting Teen SENSE's work in New Jersey.

II. The New Jersey Constitution

Like all states, New Jersey must guarantee its citizens, at minimum, the protections delineated in the federal constitution. Part IIC of the main document discusses how these protections can be used to support the right of minors in state custody facilities to comprehensive sexual health care. States, however, are free to accord their citizens additional protections and to create additional corresponding state obligations. This section describes some of the additional protections afforded by New Jersey's state constitution that support the right of minors in state facilities to comprehensive sexual health care.

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[195] As in the main document, the phrase "comprehensive sexual health care," is defined as sexual health care that includes medical care, inclusive and comprehensive sexuality education, and the support of a staff trained to understand, respect, and respond to the needs of youth, including LGBTQ youth. *See supra* Part IIA of the main document.

[196] State v. Lowery, 230 A.2d 907, 912-13 (N.J. Super. Ct. Law Div. 1967); *cf.* Planned Parenthood v. Farmer, 762 A.2d 620, 626, 638-39 (N.J. 2000) (noting that federal constitutional rights extend to minors and finding stronger protections under the state constitution for minors' privacy rights in the context of an abortion statute mandating parental consent).

As in its federal counterpart, the right to privacy is not explicitly delineated in the text of the New Jersey Constitution. However, it is well-settled by New Jersey courts that the rights to privacy and equal protection are implicit in Article 1, paragraph 1 of the New Jersey Constitution, which states that,

> All persons are by nature free and independent, and have certain natural and inalienable rights, among which are those of enjoying and defending life and liberty, of acquiring, possessing, and protecting property, and of pursuing and obtaining safety and happiness.[197]

The New Jersey right of privacy protects individuals' autonomy in making "personal and intimate" decisions.[198] It includes the right of consenting adults to engage in sexual conduct,[199] the right to decide whether or not to become a parent by using contraception,[200] the right to an abortion, and the right to refuse life-saving medical intervention.[201] The New Jersey Supreme Court has recognized that the right to control one's body and future is "fundamental to individual liberty" and that it is the "principle of individual autonomy that lies at the heart of . . . reproductive decisions."[202] The New Jersey Supreme Court has held that the state constitution is "more expansive . . . than that of the United States Constitution" and may provide greater privacy and equal protection rights.[203] New Jersey courts have "not hesitated, in an appropriate case, to read the broad language of Article 1, paragraph 1, to provide greater rights than its federal counterpart."[204]

New Jersey jurisprudence demonstrates that the right to privacy in matters of reproduction requires that individuals have a meaningful choice in sexual health decisions. Holding that the right of privacy includes the right to sterilization, the New Jersey Supreme Court explained, "What is at stake is not simply a right to obtain contraception or to attempt procreation. Implicit in both these complementary liberties is the right to make a meaningful choice between them."[205] In its discussion of the right to privacy the New Jersey Supreme Court often has cited wrongful life cases—civil cases in which the plaintiff sues the doctor for failing to provide information that would have led the plaintiff to avoid or terminate a pregnancy.[206] In these cases, the parents' rights were violated because they were "precluded . . . from making an informed choice" as to whether or not to choose to conceive or terminate a pregnancy given the risks of certain birth defects.[207] This line of cases underscores the fact that the right to privacy includes the right to make informed choices about sex, procreation, contraception, and abortion.

Minors also must be accorded a meaningful choice in these matters under New Jersey constitutional law. Accordingly, the New Jersey Supreme Court struck down a state law requiring parental

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[197] N.J. CONS. art. 1, § 1; *see* Right to Choose v. Byrne, 450 A.2d 925, 933 (N.J. 1982).
[198] *See* Planned Parenthood v. Farmer, 762 A.2d 620, 625 (N.J. 2000).
[199] Lewis v. Harris, 908 A.2d 196 (N.J. 2006); State v. Saunders, 381 A.2d 333, 345-46 (N.J. 1977) (Schreiber, J., concurring).
[200] *See In re* Grady, 426 A.2d 467, 474 (N.J. 1981) (citing Griswold v. Connecticut, 381 U.S. 479, 484 (1965)); *Saunders*, 381 A.2d at 340.
[201] *In re* Conroy, 186 A.2d 1209, 1222-23 (N.J. 1985); *In re* Quinlan, 355 A.2d 647, 663 (N.J. 1976).
[202] *Farmer*, 762 A.2d at 632-33.
[203] *Id.* at 629; Right to Choose v. Byrne, 450 A.2d 925, 933 (N.J. 1982) (mandating Medicaid funding for abortions necessary to preserve the "health and welfare" of the woman).
[204] *Farmer*, 762 A.2d at 633.
[205] In re Grady, 426 A.2d at 474.
[206] *See* J.B. v. B.M., 783 A.2d 707, 716 (N.J. 2001); *Farmer*, 762 A.2d at 630; *Right to Choose*, 450 A.2d at 933.
[207] *See* Schroeder v. Perkel, 432 A.2d 834, 837 (N.J. 1981); Berman v. Allan, 404 A.2d 8, 14 (N.J. 1979).

notification of a minor seeking an abortion.[208] Despite the fact that the U.S. Supreme Court had upheld a similar restriction under the federal constitution, the New Jersey Supreme Court held that the statute did not comport with the requirements of the state constitution. The court noted that "the State has recognized a minor's maturity relating to her sexuality, reproductive decisions, substance-abuse treatment and placing her children for adoption."[209] Even though the statute at issue did not prohibit minors from obtaining an abortion, it created a significant obstacle to a minor's ability to make an autonomous choice to have an abortion. As the court stated, "the principle of individual autonomy . . . lies at the heart of a woman's right to make reproductive decisions."[210]

This jurisprudence implicitly supports the right of minors in state facilities to comprehensive sexual health care. Taken together, these cases demonstrate the strong protections the New Jersey constitution provides to ensure that minors are able to make meaningful, informed decisions about their sexual health. Because the state, by taking minors into physical custody, has become the sole source of information, education, and medical care for detained youth, it must provide them with the medical care and the information necessary to protect their sexual health.

III. Minors' Right to Medical Decision-making Under New Jersey Law

Youth in state facilities also have the right to information and counseling to help them make decisions about their sexual health care as part of their right to exercise informed consent. In the context of youth in state facilities, the state has removed youth from their homes, schools, and other sources of information. As their sole source of information, state facilities must provide youth with the counseling and education necessary in order to make informed sexual health care decisions.

New Jersey's law provides specific protections for minors' informed consent to sexual health care. The primary minor consent statute, which governs the diagnosis and treatment of HIV and STIs, states in relevant part:

> The consent to the provision of medical or surgical care or services by a hospital, public clinic, or the performance of medical or surgical care or services by a physician, licensed to practice medicine, when executed by a minor who is or believes that he may be afflicted with a venereal disease, or who is at least 13 years of age and is or believes that he may be infected with the human immunodeficiency virus or have acquired immune deficiency syndrome, or by a minor who, in the judgment of a treating physician, appears to have been sexually assaulted, shall be valid and binding as if the minor had achieved his or her majority, as the case may be….[211]

The consent of a minor under the above circumstances "shall be considered confidential information between the physician . . . and his patient . . ." and the consent of no other person, including but not limited to a parent, custodian or guardian, is necessary.[212] Thus, as a matter of state law, a minor that is at least thirteen years of age may obtain health care if the minor suspects an

[208] *Farmer*, 762 A.2d at 638-39.
[209] *Id.* at 638.
[210] *Id.* at 632-33.
[211] N.J. STAT. ANN. § 9:17A-4 (2010).
[212] *Id.*

HIV infection, and any person of any age who believes that he or she has a STI may seek diagnosis as if he or she were an adult. Although the statute only discusses treatment for STIs and HIV, minors in state custody also have a right to provisions of services related to pregnancy under various New Jersey administrative regulations.[213]

New Jersey consent laws support the right of youth to the information necessary to make decisions about medical care. Under New Jersey law, "consent" is presumed to mean "informed consent."[214] The doctrine of informed consent arises out of and is directly linked to the patient's right to self-determination[215] In a series of three cases involving self-determination in medical care, the New Jersey Supreme Court "re-affirmed the common law right of a person to control his own body as a basic societal concept" and also recognized this part of a federal and state constitutional right of privacy."[216] In order to ensure informed consent, a patient must have a clear understanding of the risks and benefits of his or her health care options.[217]

In the context of sexual health care, because New Jersey allows minors to consent to HIV and STI testing and pregnancy-related services, youth must have the information necessary to be able to make informed decisions about these services, including all the necessary information to understand their risks, symptoms, and treatment options. Such information is the right of *all* youth and must be specific to their health care needs, including the needs of LGBTQ youth. For LGBTQ youth, informed consent would be meaningless if counseling and education excluded the information pertinent to their sexual health care decisions.

In sum, New Jersey youth have the right to access HIV, STI, and pregnancy-related medical care, and those that are providing this care must give youth the information necessary for them to make informed choices about the options related to their care. In the context of youth in state facilities, the state has an obligation as the only source of services and information to provide the care and counseling necessary to effectuate these rights. Moreover, these rights are inclusive of *all* youth, and thus care, counseling, and education must take into account the needs of LGBTQ youth.

IV. The Statutory and Regulatory Rights Specific to Minors in State Custody

A. Introduction

New Jersey has a complex statutory and regulatory scheme to provide for the health, safety, and welfare of minors in out-of-home placement. Several regulations define the minimum health care services that agencies must provide to minors in their care, including sexual health care and sexuality

[213] The right to this treatment is discussed more fully below in the sections pertaining to New Jersey's regulations governing the care of minors in custody.
[214] *In re* Farrell, 529 A.2d 404, 410 (N.J. 1987).
[215] Canesi v. Wilson, 730 A.2d 805, 812-13 (N.J. 1999).
[216] Farrell, 529 A.2d at 410-11 (citing *In re* Conroy, 486 A.2d 1209, 1221-23 (N.J. 1985); *see also In re* Jobes, 529 A.2d 434 (N.J. 1987) (incompetent patient does not lose her right to refuse life-sustaining treatment and where the patient has clearly expressed intentions about medical treatment, those intentions will be respected); *In re* Peter, 529 A.2d 419 (N.J. 1987) (court sets forth guidelines for removing life-sustaining nasogastric tube for a nursing home patient in a persistent vegetative state but not expected to die in the near future). In the common law, the right to self-determination is generally reserved for adults; however, the New Jersey Legislature has clearly spoken by declaring minors competent in matters of sexual and reproductive health. N.J. STAT. ANN. § 99:17A-4 (2010).
[217] *Farrell*, 529 A.2d at 410; *accord* Conroy, 486 A.2d at 1222.

education. While it is clear that New Jersey intends to provide for all of its youth, the language used to express the minimum requirements differs depending on the agency or type of home or facility to which a minor is committed.

Minors removed from their parents because of abuse or neglect are placed with the Department of Children and Families (DCF). Within DCF, minors may be placed in foster homes (resource families), or in 24-hour care facilities known as (1) residential facilities, which serve youth with emotional or behavioral problems or physical disabilities and offer drug treatment and psychiatric services or (2) smaller children's group homes, which serve minors with behavioral and emotional problems who do not require a more restrictive facility for their own or others' protection.[218] As discussed below, all minors placed with DCF are protected by the Child Placement Bill of Rights (CPBRA).[219] Moreover, the DCF Commissioner is authorized by the legislature to promulgate rules and regulations to implement the CPBRA and to establish standards of care for out-of-home minors, called the Manual of Requirements. A settlement agreement also sets forth state obligations to provide comprehensive health care for youth in the child welfare system. As discussed below, these sources of law entitle these youth to high quality services that will engender their mental, emotional, and physical well-being.

Minors pending trial or adjudicated delinquent are usually placed with the Juvenile Justice Commission (JJC) rather than with the DCF. The JJC operates two types of facilities: (1) detention facilities called "secure facilities"[220] and (2) "residential community homes," which are less restrictive facilities for juveniles who have committed less serious offenses or are nearing the end of their sentences and preparing to return home.[221] As discussed below, there are few regulations that monitor the health care and education of youth in secure facilities, and residential community homes are not run by codified standards but rather by ad hoc policies.[222] Minors may also be detained in county-run detention facilities. While county facilities are not operated by the JJC, the JJC sets forth regulations for them under Title 13 of the New Jersey Administrative Code, known as the Manual of Standards. Youth in JJC and county-run facilities are also legally entitled to comprehensive sexual health care.

B. DCF Residential Facilities and Group Homes

1. Background

Both group homes and residential facilities provide shelter and care on a 24-hour basis. Group homes typically serve minors with behavioral and emotional problems who do not require a more restrictive facility for their own or others' protection. They include supervised transitional living

[218] N.J. ADMIN. CODE §§ 10:127-1.2 and 10:128-1.2 (2010). *See also* Dep't of Child. and Fam. Servs., Types of Regulated Programs, http://www.state.nj.us/dcf/divisions/licensing/types.html (last visited Mar. 29, 2010). DCF also licenses psychiatric facilities, as well as temporary shelters for families in crisis, which are beyond the scope of this memorandum.
[219] N.J. STAT. ANN. § 9:6B-2 (2010). The CPBRA is discussed more fully, *infra* Section IV.B.
[220] N.J. ADMIN. CODE § 10:73-1.2 (2010). Secure facilities are full care institutions providing all services on the grounds of the facility, including education, vocational programming, counseling and medical services. Secure facilities employ correctional officers to maintain security. *See* Juvenile Justice Comm'n, JJC Secure Facilities http://www.state.nj.us/lps/jjc/secure.htm (last visited Mar. 29, 2010).
[221] N.J. ADMIN. CODE § 10:73-1.2 (2010); *see also* Juvenile Justice Comm'n, Residential Community Homes, http://www.nj.gov/oag/jjc/residential_community.html (last visited Mar. 29, 2010).
[222] E-Mail, from Robert Montalbano, New Jersey Justice Commission (April 9, 2007) (on file with author).

homes for adolescents 16 years old or older in preparation to live independently. [223] Group homes also include teaching family and treatment homes and alternative care homes for minors who need varying levels of "strong professional support."[224] Residential facilities house minors placed with DCF who have emotional or behavioral problems or physical disabilities, and they offer drug treatment and psychiatric services.[225]

2. Legal Protections Specific to the Sexual Health Care of Youth in DCF Facilities: General

It is New Jersey public policy to provide for the health and safety of youth in foster care facilities. The Legislature has declared that, by virtue of their placement, the State has an affirmative obligation to provide services to effectuate the "best interests" and the "safety of the child," which is "paramount."[226] To this end, all minors placed with DCF are protected by the Child Placement Bill of Rights (CPBRA). The CPBRA delineates an array of important rights, including rights to medical care, well-being, safety, and education:

> A child placed outside the home shall have the following rights, consistent with the health, safety and physical and psychological welfare of the child and as appropriate to the individual circumstances of the child's physical or mental development:
>
> . . .
>
> k. to services of a high quality that are designed to maintain and advance the child's mental and physical well-being:
>
> . . .
>
> m. To receive an educational program which will maximize the child's potential;
>
> n. To receive adequate, safe and appropriate food, clothing and housing;
>
> o. To receive adequate and appropriate medical care; and
>
> p. To be free from unwarranted physical restraint and isolation.[227]

In the context of sexual health, CPBRA implicitly provides comprehensive sexual health care. In 2006, the New Jersey Department of Human Services (DHS)[228] stated that the CPBRA implicitly:

[223] N.J. ADMIN. CODE § 10:128-1.2(b)(3) (2010).
[224] *Id.*
[225] N.J. ADMIN. CODE § 10:127-1.2 (2010).
[226] N.J. STAT. ANN. § 9:6B-2(b) (2010).
[227] N.J. STAT. ANN. § 9:6B-4 (2010).
[228] At the time, DHS was responsible for the Division of Youth and Family Services as part of the Office of Children's Services. In 2006, the New Jersey State Legislature made changes to various statutory provisions of law to transfer the functions of the Office of Children's Services in the Department of Human Services to the newly established Department of Children and Families and reallocate reporting responsibilities of various agencies to the newly created department. *See* the Senate Budget and Appropriations Committee Statement to the Senate, dated July 7, 2006, under the notes in N.J. STAT. ANN. § 9:3A-1 for related statutory changes made by this chapter.

- recognize[s] minors' right of access to reproductive and sexual health care and education;
- ensure[s] provisions of services related to sexually transmitted diseases, pregnancy and Human Immunodeficiency Virus (HIV);
- recognize[s] a minor's right to autonomy and privacy in accessing sexual health services; and
- assure[s] freedom from discriminatory treatment on the basis of gender, gender identity and sexual orientation.[229]

In 2005, federal district court held that minors have a private right of action to secure CPBRA rights.[230] The court found that a civil remedy was consistent with the underlying purpose of the legislative scheme and noted that private enforcement provides the necessary power behind the legislation to ensure that the responsible agencies uphold the rights of the minor.[231] CPBRA therefore both establishes the right of youth in DCF custody to sexual health care and affords these youth the power to enforce that right.

Additional regulatory mandates support minors' rights to comprehensive sexual health care in residential and group homes. Residential and group homes are subject to the Manual of Requirements for Residential Care Facilities promulgated under Title 10 of the Administrative Code, with which facilities must comply in order to be licensed.[232] In addition to explicitly incorporating the CPBRA by reference in a section discussing Children's Rights,[233] the Manual of Requirements outlines Health Requirements, for both group homes and residential facilities. The Health Requirements state that the residential and group homes must "prepare and implement a comprehensive health plan to ensure that each child's medical . . . and other health needs are met adequately and promptly."[234] Sexual health care is implicit in this standard because, as discussed in the main document, sexual health care is vital to ensure that youth's medical needs are met. Moreover, in the context of foster family care, the Department of Human Services—which, at the time, assumed DCF's responsibilities with regard to the care of youth in state custody[235]—interpreted "[a]ppropriate medical care" to include mental health, sexual health, and reproductive care services.[236] While this interpretation was made in the context of youth in foster homes, there is no reason to believe that youth in residential and group homes are entitled to a lesser standard of medical care; on the contrary, common sense dictates that the isolation of these youth in state facilities may entitle them to *more*, not fewer, services.

The Health Requirements discussed in the Manual of Requirements also provide for counseling and sexuality education. The Health Requirements state that

[229] 38 N.J. Reg. 969(a), Comment & Response 27.
[230] K.J. ex rel Lowery v. Div. of Family Servs., 363 F. Supp. 2d 728, 746 (D.N.J. 2005).
[231] *Id.* at 741, 746.
[232] N.J. ADMIN. CODE §§ 10:127-1.1 and 10:128-1.1 (2010).
[233] N.J. ADMIN. CODE § 10:127-3.2 (2010).
[234] N.J. ADMIN. CODE §§ 10:127-7.1 and 10:128-7.1 (2010).
[235] *See supra* note 228 and accompanying text.
[236] 38 N.J. Reg. 969(a), Comment & Response 32 (responding to proposed changes to N.J. ADMIN. CODE § 10:122C-6.5(d)).

1. The facility shall discuss the physiological changes experienced during adolescence with children in the facility; and

2. The facility shall instruct children about sexually responsible behavior including how to protect themselves from pregnancy and sexually transmitted diseases including AIDS.[237]

The Health Requirements also state that, as part of a general medical practices the facility shall ensure that any "medical . . . psychological and psychiatric treatment or medication administered to a child is explained to the child."[238]

In sum, youth in DCF residential and group homes are entitled to comprehensive sexual health care under the CPBRA and the Manual of Requirements. These sources of law set forth explicit and implicit guarantees of medical services, psychiatric services, counseling, sexuality education, and other services necessary to assure the sexual health of youth in these facilities.

3. Legal Protections Specific to the Sexual Health Care of Youth in DCF Facilities: The Charlie & Nadine H. v. Corzine Modified Settlement Agreement

New Jersey has additional obligations to youth in the DCF system under the Charlie & Nadine H. v. Corzine Modified Settlement Agreement (MSA). In July 2006, New Jersey entered into the MSA to settle a class action lawsuit aimed at improving longstanding problems in the state child welfare system.[239] The district court appointed the Center for the Study of Social Policy (CSSP) in Washington, D.C. as a third-party monitor to independently assess the state's actions and periodically report to the parties and the public on its progress. The CSSP will monitor the MSA in its two phases of implementation. Phase I (July 2006—December 2008) is primarily focused on building a strong infrastructure within the DCF to ensure the safety of minors in the DCF system and the existence of service delivery systems exist to meet minors' health, mental health, educational, and developmental needs.[240] Phase II (January 2009 to termination) is focused on the state's ability to sustain defined performance goals.[241] The CSSP issued monitoring reports in February 2007, October 2007, April 2008, October 2008, and April 2009, the last of which monitors progress from July 1, 2008 through December 31, 2008.

The most recent report affirms DCF's obligation to provide comprehensive medical care to youth in their custody[242] and demonstrates some of the progress DCF has made in reaching that goal. It describes the state's obligations as including the provision of:

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[237] N.J. ADMIN. Code §§ 10:127-7.6 and 10:128-7.6 (2010).
[238] N.J. ADMIN. Code §§ 10:127-7.3 and 10:128-7.3 (2010).
[239] CTR. FOR THE STUDY OF SOCIAL POLICY, PERIOD I MONITORING REPORT FOR CHARLIE & NADINE H. V. CORZINE, JULY 1-DECEMBER 31, 2006, 1-2 (2007), *available at* http://www.cssp.org/uploadFiles/Final_NJ_Monitoring_Report_02_23_07.pdf [hereinafter PERIOD I MONITORING REPORT].
[240] Modified Settlement Agreement, Charlie & Nadine H. v. Corzine, 83 F. Supp. 2d 276 (D.N.J. 2000).
[241] *Id.*
[242] CTR. FOR THE STUDY OF SOC. POL'Y, PROGRESS OF THE NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES: PERIOD V MONITORING REPORT FOR *CHARLIE & NADINE H. V. CORZINE*: JULY 1-DEC. 31, 2008 88 (2009), *available at* http://www.cssp.org/uploadFiles/NJ_Period_V_Monitoring_Rpt_Fnl_022709rev.pdf [hereinafter PERIOD V

- A pre-placement assessment for youth entering out of home care
- A Comprehensive Medical Examination (CME) within the first 60 days of placement
- Periodic medical exams in accordance with federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines
- Mental health assessments for youth with suspected mental health needs
- Any follow up care needed[243]

The CME required within the first 60 days of placement includes several components of comprehensive sexual health care. The CME require a comprehensive, unclothed, head-to-toe physical examination; any laboratory and diagnostic tests that are "appropriate and medically necessary," including testing for HIV, Hepatitis B and C, Chlamydia and other STIs, Gynecological Cancer, and pregnancy; routine gynecologic and urologic care, including PAP smear, wet mount, and other gynecological cultures where appropriate; screening for substance abuse when appropriate; and an initial mental health assessment.[244] The CME also requires the state to provide "[a]ge appropriate health education and guidance to caregivers and children" including anticipatory guidance on developmental changes.[245]

Youth must also be given annual medical exams that comply with federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines.[246] The EPSDT program is the child health component of Medicaid. While each state may determine the specific components of EPSDT care, certain minimum services must be provided. To comply with federal EPSDT requirements, medical services must include, in relevant part:

- Comprehensive health and developmental history, including an assessment of both physical and mental health development. For adolescents, this should encompass areas of special concern, including peer relations. The developmental assessment should be culturally sensitive.
- Comprehensive unclothed physical exam, including an examination of all organ systems.

MONITORING REPORT] ("Under the MSA, the State is required to provide all children entering out-of-home care with comprehensive medical care.").

[243] *Id.* at 88.

[244] *See* OFFICE OF THE CHILD ADVOCATE, HEALTH MATTERS: A STUDY OF THE COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN (CHEC) PROGRAM 5-6 (2007) (outlining the requirements for New Jersey's Comprehensive Health Evaluation for Children); Period V Monitoring Report, *supra* note 242, at 93-94 (discussing the similarities and differences between CHEC and CMEs). The Comprehensive Health Evaluation for Children (CHEC) was previously DCF's only model for medical examination. While the CHEC is still used in certain areas, DCF children are increasingly receiving CMEs, which are largely the same as the CHEC, except that the CMEs use an initial mental health screening with appropriate follow-up care, rather than the CHEC's full mental health assessment for all children ages four and over. *See* Period V Monitoring Report, *supra* note 242, at 93-94.

[245] *See* OFFICE OF THE CHILD ADVOCATE, *supra* note 244, at 5-6 (outlining the requirements for New Jersey's Comprehensive Health Evaluation for Children).

[246] Period V Monitoring Report, *supra* note 242, at 88.

- Appropriate immunizations, including the HPV vaccine for adolescent girls and young women.

- Laboratory tests identified by the state as appropriate for a particular age or population. The Centers for Medicare and Medicaid Services (CMS), which oversees the EPSDT program, has advised states to consider including STD screening as part of this requirement.

- Health education designed to assist in helping the youth understand what to expect in terms of his or her development and to provide information about the benefits of healthy lifestyles and practices, including disease prevention.

- Other necessary health care, diagnostic services, and measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by or shown to have increased in severity by the screening service. This includes family planning for sexually active minors.

- Nurse-midwife services in pregnancy, birth, and the immediate postpartum period. CMS has also noted that "EPSDT can link at-risk adolescents to pre-pregnancy risk education, family planning, pregnancy testing and prenatal care. It is important that all pregnant women obtain early prenatal care and that they and newborns be cared for in a setting that provides quality services appropriate to their level of risk."

- Protections to ensure that all medical information is privileged and may only be released with the patient's permission.[247]

Although CMS does not provide more explicit requirements for EPSDT, these requirements strongly support the need for comprehensive sexual health care. A comprehensive health and development history must include sexual history in order to properly assess an individual youth's health risks. Examination of all organ systems clearly includes the reproductive system. Given the risk of STIs and HIV among youth, all youth should be provided the opportunity to be tested for STIs and HIV as part of routine the laboratory testing, and they should be provided appropriate treatment as part of "necessary health care." These risks also require sexuality education that informs youth of their risk for STIs, HIV, and unplanned pregnancy and provides information on how to prevent these health problems, as a necessary component of "[h]ealth education designed to assist in helping the youth understand what to expect in terms of his or her development and to provide information about the benefits of healthy lifestyles and practices, including disease prevention."

The importance of comprehensive sexual health care as part of EPSDT care has been recognized for decades. In 1980, the Health Care Financing Administration, the precursor to CMS, published *A Guide to Adolescent Health Care: EPSDT* (hereinafter the EPSDT Guide) to guide health care providers in administering EPSDT to adolescents.[248] The Guide states that all adolescents at risk for STIs

[247] CENTERS FOR MEDICARE AND MEDICAID SERVICES, STATE MEDICAID MANUAL 5-10 through 5-19, 5-55; Ann Clemency Kohler, New Jersey Department of Human Services, EPSDT: Preventative Health Services for Children to Age 21 (2007), available at http://eclkc.ohs.acf.hhs.gov/hslc/ecdh/Health/EPSDT/EarlyandPeriodi.htm (discussing HPV vaccine). CMS includes other necessary healthcare outlined in 42 U.S.C. § 1396d(a), which includes family planning. *See* 42 U.S.C. § 1396d(a)(4) (2010).

[248] U.S. HEALTH CARE FINANCING ADMINISTRATION, A GUIDE TO ADOLESCENT HEALTH CARE: EPSDT (1980) [hereinafter EPSDT Guide].

should be routinely screened, with their informed consent.[249] It also repeats the requirement that sexually active youth receiving EPSDT are legally entitled to family planning services and supplies, and it states that informational material should identify family planning services as available to these youth.[250] The EPSDT Guide makes clear that contraceptive devices and supplies must be available on request, along with instructions and advice about their use.[251] It encourages a "care-taking" attitude among the staff, emphasizing that "[t]his is a matter of no small importance" and that "[a]s long as there is even a chance that [failure to use contraception] is due to confusion or lack of forethought, every effort should be made to inform young people fully about the various contraceptive methods and their differing advantages and risks."[252] The EPSDT Guide also states that the provision of sexuality education provided as part of EPSDT care should "ideally should provide every adolescent with full information about the entire gamut of sexual activity and outcomes and their social-emotional components" and should include "ample opportunity for questions and answers" about the reproductive system, family planning, masturbation, same-sex relationships and practices, contraception, abortion, and STIs.[253]

While DCF is required to provide all youth with CMEs and EPSDT exams, it is currently struggling to meet its goals. The number of children receiving CMEs within 60 days of entry into care has increased from 75% in June 2007 to 79% in December 2008, falling just short of DCF's goal of 80%.[254] The percentage of youth in care for one year or more that received medical examinations in compliance with EPSDT guidelines rose from 75% in June 2007 to 77% in December 2008, again falling short of the 80% goal.[255] Thus, as of the last assessment in December 2008, over one in five youth in the DCF system received neither CMEs within their first 60 days of care nor a medical examination in compliance with EPSDT guidelines.

In addition to requiring comprehensive medical exams and annual EPSDT exams, the MSA also requires New Jersey to "develop a plan for appropriate service delivery for lesbian, gay, bisexual, transgender and questioning youth, and thereafter begin to implement a plan."[256] According to the most recent CSSP report, DCF has made "initial efforts" to improve services for youth who identify as lesbian, gay, bisexual, transgender, questioning, or intersex (LGBTQI).[257] Resources that support the LGBTQI population have been identified as part of DCF's Adolescent Services resource guide for staff, such as housing for LGBTQI youth, community-based LGBTQI associations, school-based resources, and state-wide resources.[258] DCF has also begun training and education for caseworkers on LGBTQI issues.

Many of DCF's efforts are still prospective and it is difficult to gauge the progress made. For example, the concept of "safe zones" for LGBTQI youth—places LGBTQI youth can easily recognize as free from discrimination and safe for them to discuss their sexual identity—"has been presented," but the CSSP report does not state what this presentation entailed and how active DCF

[249] *Id.* at 42-43.
[250] *Id.* at 51.
[251] *Id.* at 52.
[252] *Id.* at 51.
[253] *Id.* at 51.
[254] PERIOD V MONITORING REPORT, *supra* note 242 at 90.
[255] *Id.*
[256] *Id.* at 8; Modified Settlement Agreement, *supra* note 240, at 88.
[257] Period V Monitoring Report, *supra* note 242 at 80.
[258] *Id.* at 80.

has been or plans to be in implementing safe zones.[259] DCF has also become involved in Human Rights Campaign for All Children, a program requiring DCF to sign a pledge confirming its willingness to work with all families and conduct an assessment of their laws, policies, and practices that might have a discriminatory effect on children or families that identify as LGBTQI.[260] However, it is not clear from the CSSP report whether DCF has acted on this pledge. While DCF has "laid a beginning framework to promote better policies and practices for working with [LGBTQI] youth and their families," CSSP has not yet evaluated the implementation of this plan and its results. [261]

In sum, it is clear that the MSA reinforces DCF's obligation to provide comprehensive sexual health care for youth, including medical care, sexuality education, and staff training on LGBTQ issues. While several gains are being made to fulfill these obligations, significant progress must follow to ensure the rights of all youth in the child welfare system.

C. Juvenile Justice Facilities

1. Background

The Juvenile Justice Commission (JJC) is responsible for the administration of four detention facilities known as "secure facilities"[262] and sixteen residential community homes for minors who do not require restrictive placements.[263] In total, the secure facilities can house approximately 610 minors, and residential community homes can house approximately 392 minors.[264]

In the alternative, youth may be assigned to county detention facilities, which are short-term juvenile detention facilities that are operated by state counties. County detention facilities are available as physically restrictive placements for minors who are alleged to be delinquent but whom a court has not yet found delinquent, or short-term, rehabilitative placements for sixty consecutive days or less for minors found delinquent.[265] Approximately 12,000 minors are detained in these facilities prior to being found delinquent, and an additional 700 minors are committed to these county-run facilities for rehabilitation.[266] As discussed below, while the JJC does not operate these facilities, it does promulgate regulations for their operation.

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[259] *Id.* at 80.
[260] *Id.* at 80.
[261] *Id.* at 80.
[262] The JJC's four secure facilities are the Juvenile Medium Security Facility, the Juvenile Reception and Assessment Center, the Female Secure Care and Intake Facility, and the New Jersey Training School. N.J. ADMIN. CODE § 13:95-1, *et seq.* (2010).
[263] N.J. STAT. ANN. § 52:17B-170, *et seq.* (2010); N.J. Juvenile Justice Comm'n, Community Programs, http://www.state.nj.us/lps/jjc/community.htm (last viewed Mar. 31, 2010). According to its web site, the JJC operates fourteen residential community homes and contracts with private providers to operate two additional homes. The JJC operates day care facilities for juveniles on probation who return home in the evenings; however, these facilities are beyond the scope of this memorandum.
[264] See N.J. Juvenile Justice Comm'n, Community Programs, http://www.state.nj.us/lps/jjc/community.htm (last viewed Mar. 31, 2010). Manor Woods RCH, Albert Elias RCH and Essex RCH are designed specifically for younger male offenders between the ages of 13 and 15. The Commission has also designated certain facilities for specific categories of juvenile offenders including those who have serious substance abuse problems, sex offenders, and those juveniles who have been found delinquent, but also have serious emotional disorders.
[265] N.J. ADMIN. CODE §§ 13:92-1.2 and 13:93-1.1, 1.3 (2010).
[266] 37 N.J. Reg.. 1426(a) (May 2005).

2. Legal Protections Specific to the Sexual Health Care of Youth in Juvenile Justice Facilities

Although the CPBRA does not apply to the JJC,[267] Title 13 of the New Jersey Administrative Code includes a Manuals of Standards for county detention facilities, and also includes provisions dealing with care in secure facilities.[268] In contrast, standards for residential community homes are not codified and the facilities are run by *ad hoc* policies. As discussed below, despite the few specifics the law explicitly provides for the operation of these three types of facilities, there is a viable argument that youth in these facilities have a legal right to comprehensive sexual health care based on common-sense interpretations of Title 13, other laws, and public policy.

The Manual of Standards for county detention facilities provides that minors in county detention facilities are entitled to "necessary medical care" that "shall be made available to all juveniles in accordance with appropriate medical practices" and that "each detention facility shall have written medical policies and procedures."[269] County detention facilities are also required to provide educational, social, psychological, and mental health services.[270]

As with county facilities, the CPBRA has not been incorporated into regulations governing secure facilities. There are, however, regulations under Title 13 that entitle minors at these facilities to medical services, psychological health intervention, and education.[271] The secure facilities also provide explicit protections for the reproductive health care of young women in their custody. Pregnant girls in secure facilities have the right to carry their pregnancy to term, and the right to access an abortion, family planning, and prenatal counseling and education, birth control, test results, child placement services, religious counseling if desired by the juvenile, and appropriate postpartum care, including counseling for trauma related to the surrender of a baby.[272]

While there are few explicit provisions for the comprehensive sexual health care of youth in secure facilities and county detention facilities—and no codified provisions for residential community homes—the regulations in place and public policy can be read to provide these youth rights to comprehensive sexual health care, including sexuality education and staff training to ensure the safety and healthy of LGBTQ youth. The right to medical care guaranteed in the Manual of Standards for county detention facilities and in Title 13 for secure facilities can be interpreted to include sexual medical care. As described above, the DHS has interpreted the phrase "appropriate medical care" to include mental health, sexual health, and reproductive services.[273] While this interpretation was made in the context of youth in foster families and is not binding on the JJC, there is no reason that youth in all JJC facilities should be provided a lesser standard of what is "appropriate"; on the contrary, given their isolation from other sources of sexual health care, these services are both appropriate and necessary for their well-being.

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[267] N.J. STAT. ANN. § 9:6B-2 (2010) (listing the agencies to which the CPBRA applies and omitting the JJC).
[268] *See* N.J. ADMIN. CODE §§ 13:92-1 *et seq.* and 13:95-17.1 *et seq.* (2010).
[269] N.J. ADMIN. CODE § 13:92-9.1 (2010).
[270] N.J. ADMIN. CODE §§ 13:9-9.3, 9.4, 9.5 and 13:93-4.1 (2010).
[271] N.J. ADMIN. CODE §§ 13:95-11.1, 11.10, 11.16 (2010) (referring to juveniles in protective custody).
[272] N.J. ADMIN. CODE §§ 13:95-17.2 and 17.5; *see also* Monmouth County Correctional Institute Inmates v. Lanzaro, 834 F.2d 326, 340-41 (3d Cir. 1987) (incarcerated women constitutionally entitled to access to abortion and counseling).
[273] *See supra* note 229 and accompanying text.

Moreover, it is New Jersey public policy to provide for the health needs of youth in JJC custody. As set forth in the New Jersey Administrative Code, "[i]t is . . . the public policy of [New Jersey] to make maximum provision for the health, safety and welfare of . . . inmates under age 18 in State and county penal and correctional institutions . . . ."[274] They are entitled to "the development of competencies to enable [them] to become responsible productive members of the community" and are "entitled to the protection of the State, which may intervene to safeguard them from neglect or injury and to enforce the legal obligations due to them . . . ."[275] For the reasons discussed in the main document, the health and safety of these youth require that they are provided comprehensive sexual health care, including medical care, counseling and education to make informed decisions about their health, and a staff trained to understand, respect, and respond to their needs.

V. The New Jersey Law Against Discrimination

DCF and JJC have an immediate obligation under the New Jersey Law Against Discrimination (LAD) to protect minors from discrimination and harm as a result of their race, sex, familial status (including pregnancy), self-identified or perceived affectional or sexual orientation, self-identified or perceived gender identity or expression, and disability (including HIV status).[276] Enacted in 1945 as the first state anti-discrimination statute in the nation, the LAD ensures "that the civil rights guaranteed by the State Constitution are extended to all its citizens."[277] The LAD declares that "discrimination threatens not only the rights and proper privileges of the inhabitants of the State but menaces the institutions and foundation of a free democratic State ... [and] that because of discrimination, people suffer personal hardships, and the State suffers a grievous harm."[278] The New Jersey Supreme Court has liberally construed the LAD broadly.[279]

The LAD prohibits the DCF and JJC from creating policies that discriminate against minors based on a protected status. Thus, policies that segregate or limit the ability of youth to participate in activities because of their sexual orientation, gender identity, or HIV status violate the LAD. For example, if positions are available that train JJC youth to work in the facility's cafeteria or medical facilities, HIV-positive or LGBTQ youth cannot be prohibited from participating in these positions as a result of their HIV or LGBTQ status.[280] These youth could not be restricted in activities such as

[274] N.J. ADMIN. CODE § 30:4-7.1 (2010).
[275] N.J. STAT. ANN. § 2A:4A-21 (2010).
[276] N.J. STAT. ANN. § 10:5-4 (2010) ("All persons shall have the opportunity . . . to obtain all the accommodations, advantages, facilities, and privileges of any place of public accommodation . . . without discrimination because of race, creed, color, national origin, ancestry, age, marital status, affectional or sexual orientation, familial status, disability, nationality, sex , gender identity or expression . . . subject only to conditions and limitations applicable alike to all persons."); N.J. STAT. ANN. § 10:5-5(q) (2010) (including HIV infection or AIDS in the definition of "disability"); N.J. STAT. ANN. § 10:5-5(hh) (2010) (defining affectional or sexual orientation as "male or female heterosexuality, homosexuality or bisexuality by inclination, practice, identity or expression, having a history thereof or being perceived, presumed or identified by others as having such an orientation"); N.J. STAT. ANN. § 10:5-5(ll) (2010) (defining familial status as including pregnancy), -5(rr) (defining gender identity or expression as "having or being perceived as having a gender related identity or expression whether or not stereotypically associated with a person's assigned sex at birth").
[277] Viscik v. Fowler Equip. Co., Inc., 800 A.2d 826, 827 (2002).
[278] N.J. STAT. ANN. § 10:5-3 (2010).
[279] *Viscik*, 800 A.2d at 832-35.
[280] The ADA and the Rehabilitation Act also prohibit the JJC and DCF from discriminating against HIV-positive youth. The Equal Opportunity Employment Commission has recognized that individuals living with HIV pose no additional risk as a result of their HIV in food preparation and in all but the most invasive medical procedures, which youth working in a facility hospice would not be expected to perform. *See* U.S. Equal Opportunity Employment Commission, Questions and Answers about Health Care Workers and the Americans with Disabilities Act,

participation in sports, arts, or other activities, or placed in solitary living circumstances against their will because of their HIV-positive status or because they identify as or are perceived as being LGBTQ.

The JJC and the DCF must also take affirmative actions to protect these youth against harassment and discrimination by staff or other youth. The New Jersey Supreme Court has held that the LAD's prohibition against discrimination in public accommodations requires schools to take affirmative measures to prevent harassment based on a protected status. In *L.W. ex rel. LG v. Toms River Regional Schools*,[281] a mother filed a LAD complaint alleging that a public school district had allowed her son to be repeatedly subjected to harassment by other students due to his perceived sexual orientation. The Court held that the LAD recognizes a cause of action against a school district for student-on-student affectional orientation or sexual orientation harassment. Such a claim does not require a plaintiff to prove intentional discrimination; a school district may be found liable under the LAD for student-on-student harassment that creates a hostile educational environment when the school district knew or should have known of the harassment, but failed to take action reasonably calculated to end the harassment.[282]

Toms River strongly supports the conclusion that, under the LAD, state institutions have an obligation to implement services and training to prevent violence and harassment of youth in their care due to sexual orientation, gender identity, race, or HIV status. This argument is particularly strong in the context of a state facility that has taken a youth out of his or her home and assumed responsibility for housing, educating, and ensuring the overall safety and well-being of the youth. While schools only have youth in their care for a few hours a day, state detention facilities and congregate foster care are the sole caretakers of the youth. Because youth rely on the state for all their health, safety, and educational needs, and are in the near-constant custody of the state, state facilities in this context have much stronger obligations under the LAD to protect the youth in their care from harassment and discrimination than public schools.

VI. The Constitutional Right to Education and the New Jersey Core Curriculum Content Standards

While there is strong support of the argument that sexuality education is a necessary component of health care for minors in state custody, minors maintain the right to sexuality education in New Jersey even if it is characterized as a part of basic education curricula rather than health care. New Jersey minors have a state constitutional right to education. The New Jersey Core Curriculum Content Standards (hereinafter Core Curriculum) are standards adopted by the New Jersey State Board of Education to ensure this right pursuant to Title 6A of the New Jersey Administrative Code.[283] They apply to all students enrolled in public elementary, secondary, and adult high school

http://www.eeoc.gov/facts/health_care_workers.html (last visited Mar. 31, 2010); U.S. Equal Opportunity Employment Commission, How to Comply with the Americans with Disabilities Act: A Guide for Restaurants and Other Food Service Employers, http://www.eeoc.gov/facts/restaurant_guide.html (last visited Mar. 31, 2010).

[281] 915 A.2d 535 (N.J. 2007).

[282] As the Court articulated "that standard conforms to the Act's fundamental and laudatory goal of eradicating 'the cancer of discrimination' . . . . We thereby further the Legislature's objective of eliminating bias-based harassment from New Jersey schools embodied in the LAD and other statutes." *See Toms River*, 915 A.2d at 550 (internal citations omitted); *see also* N.J. STAT. ANN. § 18A:37-13 to -19 (2010) (establishing anti-bullying measures).

[283] N.J. ADMIN. CODE § 6A:8-1.1(c) (2010) ("The Core Curriculum Content Standards, including cumulative progress indicators, enable district boards of education to establish curriculum and instructional methodologies for the purpose of

educational programs within New Jersey.[284] The Core Curriculum requires students to receive scientifically sound sexuality education,[285] including "an understanding of physical, emotional and social aspects of human relationships and sexuality and how they support a healthy, active lifestyle," and "medically accurate information about both abstinence and contraception." [286] Students must also "learn the skills to enact behaviors to reduce or eliminate the occurrence of sexually transmitted diseases, HIV/AIDS, and unintended pregnancy" as well as "to develop and maintain healthy relationships with friends and family."[287]

Youth in state facilities should not be deprived of their constitutional right to an education consistent with the Core Curriculum. By nature of their confinement, youth in state facilities are unable to procure their education elsewhere, and rely on the state to provide them with this information and education. Thus, it is vital that the state ensure that youth in its care receive at least the minimum sexuality education guaranteed to all youth in New Jersey under the constitution.

VII. Conclusion

The above sources of law demonstrate the legal foundation in New Jersey state law for the right of youth in state facilities to comprehensive sexual health care. While Appendix B focuses on New Jersey specifically, it can be used to guide advocates in other states interpreting their own state laws and regulations. Moreover, New Jersey provides a useful starting point for developing implementation strategies as its own state law and regulations offer additional foundation for an adolescent's right to all aspects of sexual health care, including explicit protections for the needs of LGBT youth. Not only has New Jersey's constitution been interpreted to provide more expansive substantive due process, equal protection and privacy rights than its federal counterpart, but the state also has a complex statutory and regulatory scheme guaranteeing minimum health care services, including sexual health care and education, to minors in out-of-home care.

However, despite these legal protections, explicit, enforceable policies do not exist to ensure these youth are provided comprehensive sexual health care. This is particularly true for minors placed with the Juvenile Justice Commission, the governing administrative provisions of which fail to provide the necessary clarity on minors' rights to all aspects of care to date. At present, such services exist

providing students with the constitutionally mandated system of 'thorough' public school instruction."); N.J. ADMIN. CODE § 6A:8-2.1 (2010) (describing the State Board of Education's authority to adopt the Core Curriculum Standards).

[284] N.J. ADMIN. CODE § 6A:8-1.2(a) (2010).

[285] Moreover, in 2006 New Jersey took the laudable step of rejecting federal funds tied to "abstinence-only" or "abstinence-until-marriage" sexuality education, reinforcing New Jersey's commitment to comprehensive sexuality education as part of its constitutional obligation to provide adequate education. In an October 24, 2006 letter to the U.S. Department of Health and Human Services, the New Jersey department of Health and Department of Education jointly informed the federal government that curricula that conform to the federal Title V abstinence-only guidelines contradict the core curriculum standard content that has been in place for more than five years. Moreover, the governor's office cautioned that accepting federal funds accepting abstinence-only dollars may in fact cost the state money because students may require additional sex education to clarify the misinformation that is taught in abstinence only programs. *See* http://www.siecus.org/index.cfm?fuseaction=Feature.showFeature&featureID=1107 (last visited Mar. 31, 2010). New Jersey is one of fifteen states that had rejected Title V funding at the time of publication.

[286] N.J. DEP'T OF EDUC., N.J. CORE CURRICULUM OF STANDARDS, Human Relationships & Sexuality, Standard 2.4 (2009), *available at* http://www.state.nj.us/education/cccs/2009/final.htm. These guidelines cover relationships, sexuality, pregnancy, parenting, sexual orientation, and the importance of preventative health care.

[287] *See id.*

only in limited fashion in a few places, and due largely to the intercession of concerned individuals working outside of these institutions.

CHLP's Teen SENSE initiative brings experts from the public and private sector together to bridge this gap. Uniform guidelines would standardize essential care and services and better ensure that all New Jersey youth in state facilities would receive adequate and consistent care. It is time to ensure that youth with few or no other sources of care and information available to them get the services they need from the state institutions and officials to whom they have been entrusted, and who are responsible for their health and their lives. Failure to do so not only endangers their health, but also the health of the communities to which they will return.