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I. INTRODUCTION

The absence of provisions dealing specifically with adolescents in current HIV-AIDS[1] policies conspicuously reflects how policymakers treat adolescents. The most extensive federal HIV-AIDS policy, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990,[2] symbolizes the lack of attention to adolescents. Ryan White, an adolescent who lost his life to AIDS, fought so successfully for AIDS awareness that the CARE Act was named in his honor.[3] Yet, his Act fails even to mention adolescents.[4] The exclusion of adolescents from an Act named after an adolescent symbolizes how policy-

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1. The term "HIV-AIDS" refers to the human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS). HIV is a virus that damages the immune system, rendering the body vulnerable to a variety of opportunistic infections, malignancies, and neurologic complications. AIDS refers to a group of conditions associated with a serious decline in immune function as a result of HIV infection. *See Centers for Disease Control, U.S. Dep't of Health & Human Servs., Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome*, 36 MORBIDITY & MORTALITY WKLY. REP. 3S, 4S-6S (Supp. 1S 1987) (identifying factors used by the Centers for Disease Control (CDC) to define an AIDS case).

2. Pub. L. No. 101-381, 104 Stat. 576 (1995) (codified at 42 U.S.C.A. § 300ff-90 (West Supp. 1995)).

3. Ryan White was a teenager when he first fought to attend school in Kokomo, Indiana. *See* RYAN WHITE & ANN M. CUNNINGHAM, RYAN WHITE: MY OWN STORY 68-97 (1991). He was a teenager when he died in 1990, at the age of 18. *Id.* at 244.

4. The legislation fails to make specific reference to adolescents. Title I of the CARE Act provides emergency funding to metropolitan areas with large numbers of AIDS cases and requires funding be directed "for services for infants, children, women, and families with HIV disease." 42 U.S.C.A. §§ 300ff-11 to -17 (West Supp. 1995) (establishing an Emergency Relief Grant Program). Title II calls for establishing local consortia to allocate funding for health care and support services for the needs of "infants, children, women, and families with HIV disease." 42 U.S.C.A. §§ 300ff-27 to -28 (West Supp. 1995) (establishing a program for HIV Care Grants). Title III provides for outpatient "early intervention services," without reference to any population. 42 U.S.C.A. §§ 300ff-41 to -49 (West Supp. 1995) (establishing a fund for Early Intervention Services).

makers have yet to recognize adolescents and their needs.[5] Practically, this omission means that the policymakers and researchers do not consider the difficulty of including the needs of adolescents in policies and research which are meant (at least implicitly) to include them.[6]

The place of adolescents in current HIV-AIDS policies reflects the tendency to lump adolescents' needs with those of children or, alternatively, with those of adults.[7] This tendency continues despite consid-

5. Advocates link the omission of adolescents from the Ryan White Act to their inability to have adolescents' needs recognized. *See* Lawrence J. D'Angelo, *Public Policy, HIV Disease, and Adolescents, in* ADOLESCENTS AND AIDS: A GENERATION IN JEOPARDY 249, 256-57 (Ralph J. DiClemente ed., 1992).

> [A]dvocates for adolescents generally have found that carving out any services for adolescents has been difficult . . . Adolescents find themselves having access to care because they are pregnant or because they are gay, rather than because they are adolescents, at risk for HIV infection, or infected by HIV and in need of age-appropriate services.

Id.

6. D'Angelo, *supra* note 5, at 256-58 (noting the barriers to proper recognition of an adolescent's needs). The failure to recognize adolescents as a category in need of tailored services has unfortunately caused them to be excluded from clinical trials for drugs and therapies for HIV infection. Karen Hein, *Fighting AIDS in Adolescents*, 7 ISSUES SCI. & TECH. 67, 67 (Spring 1991) (noting the failure of "HIV research, prevention, and service programs" to include adolescents). The failure to include adolescents is particularly acute when dealing with disenfranchised youth, such as infected youth in foster care. *See generally* Judith M. Martin & Henry S. Sacks, *Do HIV-Infected Children in Foster Care Have Access to Clinical Trials of New Treatments?*, 5 AIDS & PUB. POL'Y J. 3, 3-4, 6-7 (1990) (discussing survey results showing that although "a large proportion of HIV-infected children are placed in foster care . . . they cannot enroll in clinical trials" or in experimental therapies); Briar McNutt, *The Under-Enrollment of HIV-Infected Foster Children in Clinical Trials and Protocols and the Need for Corrective State Action*, 20 AM. J.L. & MED. 231, 232 (1994) (citing a nationwide survey conducted in 1989 revealing "that less than two percent of foster children diagnosed as HIV positive were participating in clinical trials" and since that time, "enrollment of HIV-infected foster children has improved only slightly"); Deborah Weimer, *Beyond Parens Patriae: Assuring Timely, Informed, Compassionate Decisionmaking for HIV-Positive Children in Foster Care*, 46 U. MIAMI L. REV. 379 (1991) (discussing the failure of the present foster care system, researchers, and governmental agencies to provide HIV positive foster children with access to medical trials and experimental treatment programs).

7. Despite the peculiar place of adolescents in the HIV-AIDS epidemic, *see infra* notes 21-73 and accompanying text, leading textbooks continuously fail to offer special consideration. For example, TEXTBOOK OF AIDS MEDICINE (Samuel Broder, et al. eds., 1994), a text of mammoth proportions, mentions adolescence only twice. In both instances, the text mentions adolescents briefly as a group worthy of special consideration for prevention efforts. *See also* Wanda K. Jones & James W. Curran, *Epidemiology of AIDS and HIV Infection in Industrialized Countries, in* TEXTBOOK OF AIDS MEDICINE 91, 102-03 (stating that efforts to prevent new HIV infections must reach and include school students); Gwendolyn B. Scott, *Special Considerations in Children, in* TEXTBOOK OF AIDS MEDICINE 169, 170 (suggesting that adolescents are an "important population to target for education and prevention" of HIV). Unfortunately, the text never details how to meet the special needs of adolescents, nor does it detail

erable evidence that adolescence is a distinct period in human development[8] which mandates qualitatively different approaches to health issues.[9]

Going further than formal HIV-AIDS policy, the American legal system explicitly attempts to deny the existence of a formal period of adolescence.[10] Yet, the same system covertly continues to carve out a place for them.[11] How HIV-AIDS affects adolescents, how reforms

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what those needs actually are. The failure to address the needs of adolescents and the tendency to view their needs like those of children pervades social welfare and mental health literature. *See, e.g.*, CHILDREN AT RISK IN AMERICA: HISTORY, CONCEPTS, AND PUBLIC POLICY 20-25, 126-34 (Roberta Wollons ed., 1993) (collection of essays regarding children, not adolescents, considered to be at risk); ROBERT DESJARLAIS ET AL., WORLD MENTAL HEALTH: PROBLEMS AND PRIORITIES IN LOW-INCOME COUNTRIES 155-78 (1995); DAVID A. HAMBURG, TODAY'S CHILDREN: CREATING A FUTURE FOR A GENERATION IN CRISIS (1992); DONA SCHNEIDER, AMERICAN CHILDHOOD: RISKS AND REALITIES (1995).

8. The period is one of transition from childhood to adulthood. For a historical examination of adolescents' personhood, see Roger J.R. Levesque, *The Internationalization of Children's Human Rights: Too Radical for American Adolescents?*, 9 CONN. J. INT'L L. 237, 243-51 (1994).

9. Effective health promotion requires recognition of adolescence as a developmental stage in its own right, not a mere transition to adulthood. *See, e.g.*, HANDBOOK OF CLINICAL RESEARCH AND PRACTICE WITH ADOLESCENTS (Patrick H. Tolan & Bertram J. Cohler, eds., 1993); PROMOTING THE HEALTH OF ADOLESCENTS: NEW DIRECTIONS FOR THE TWENTY-FIRST CENTURY (Susan G. Millstein et al. eds., 1993).

10. There is a great deal of contradiction in laws regarding adolescents. Some laws are founded upon the perception that teenagers are innocent and immature, while others are based on the perception that they are competent and sophisticated. For example, the Supreme Court's view of minors' confessions as voluntary arguably conflicts with its refusal to grant minors due process protections against preventive detention or civil commitment by parents. *Compare* Fare v. Michael C., 442 U.S. 707 (1979) (determining the voluntary nature of a confession when the accused is a minor) *with* Schall v. Martin, 467 U.S. 253 (1984) (relaxing minors' due process protections in context of pretrial detention and finding that such detention does not amount to a due process violation) *and* Parham v. J.R., 442 U.S. 584 (1979) (subordinating minors' due process liberty interests to those rights of parents to retain a substantial and even dominant role in the decision to civilly commit a minor to an institution). Thus, although the Supreme Court has said that children possess fundamental rights that states must protect, exactly what those rights are and in what situations they preempt parental rights or the state's rights remains somewhat unclear. *See generally* Levesque, *supra* note 8, at 252-64, 291-93 (suggesting that although there exists an increasing recognition of adolescents' individual rights, such rights have been limited and subordinated to adults and that some courts are reluctant even to recognize that adolescents do have rights).

11. Case law increasingly recognizes the legal rights of minors. *See, e.g.*, Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52 (1976) (noting that minors "are protected by the Constitution and possess constitutional rights"); Breed v. Jones, 421 U.S. 519 (1975) (recognizing the constitutional protection against "double jeopardy" under the Fifth Amendment in the transfer of a minor from juvenile court to a court having general criminal jurisdiction); Goss v. Lopez, 419 U.S. 565 (1975) (holding that students facing temporary suspension from public schools have interests entitling them to the protection offered by the Due Process Clause and this due process required that the student be given notice and an opportunity to be heard); Tinker v. Des Moines Indep.

have attempted to prevent the spread of HIV and assist those with HIV-AIDS, and how the seeming inability of reform efforts to adequately address the crisis all serve to highlight the need to transform conceptions of adolescence and the need to reshape adolescents' human rights.[12] The demands and urgencies placed upon the American legal system by the HIV-AIDS epidemic has challenged the uncertain place of adolescents. This epidemic prompts us to recognize adolescents' special needs and reinforces the need to reexamine their place in contemporary jurisprudence. Yet, policymakers and leading commentators have been content simply to note that the epidemic raises complex legal issues for adolescents.[13]

This Article begins by detailing the peculiar place of adolescents in the HIV-AIDS epidemic.[14] Next, this Article analyzes the current legal

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Community Sch. Dist., 393 U.S. 503 (1969) (holding that a regulation prohibiting the wearing of armbands in schools was an unconstitutional denial of a student's right of expression under the First Amendment because students are persons who are "possessed of fundamental rights which the State must respect"); *See also* Levesque, *supra* note 8, at 241-42 n.21 (listing a series of citations addressing adolescents' rights).

12. It is important to recognize that the discourse about the HIV-AIDS epidemic tends to recapitulate many of the themes of contraception, abortion, and STD policies. *See* Barry D. Adam, *The State, Public Policy, and AIDS Discourse*, 13 CONTEMP. CRISES 1, 3-9 (1989).

13. HOUSE SELECT COMM. ON CHILDREN, YOUTH, AND FAMILIES, 102D CONG., 2D SESS., A DECADE OF DENIAL: TEENS AND AIDS IN AMERICA (Comm. Print 1992) [hereinafter DECADE OF DENIAL—1992 CONGRESSIONAL HEARINGS]. Although the Committee Report did note that the HIV epidemic raises "complicated legal and ethical issues for adolescents," it did not offer explicit suggestions for legal reform. *Id.* at 13.

Earlier hearings were also marked by an absence of a discussion of legal concerns. *See, e.g., AIDS and Teenagers: Emerging Issues, 1987: Hearings Before the Select Subcomm. on Children, Youth, and Families of the House of Representatives*, 100th Cong., 1st Sess. (1987) [hereinafter *AIDS and Teenagers—1987 Congressional Hearings*]. In the 1987 hearings, the only mention of legal issues was to emphasize that there are issues. *Id.* at 91-92 (statement of Karen Hein, M.D.) (raising potential issues involved in the testing and treatment of minors, particularly the role of parents). *See also id.* at 124-25 (statement of Ron Packard, Congressman) (noting that all persons have rights for confidentiality, privacy, etc., as well as the right not to get a disease, and that the effort to balance those rights "is going to be a very difficult process").

Commentators have not done much either. The *Carnegie Report*, an influential review of the literature related to adolescents' access to health care, epitomizes this failure to offer suggestions. The *Carnegie Report* simply concluded by noting that there were different interests which needed to be considered. JOSEPHINE GITTLER ET AL., CARNEGIE COUNCIL ON ADOLESCENT DEVELOPMENT, ADOLESCENT HEALTH CARE DECISION-MAKING: THE LAW AND PUBLIC POLICY 55 (1990). This paper notes that "it will not be an easy task for public policy makers to balance the interests of the adolescent's parents, health professionals and the State in order to allocate adolescent health care decision-making authority among these actors." *Id.* Quite paradoxically, despite being a report about *adolescents'* decision-making authority, the authors omit the interests of adolescents in their concluding summary. *Id.*

14. *See infra* part II.

policies, and their failures, in the adolescent HIV-AIDS public school and health settings.[15] This Article then proposes that the crisis underscores the urgent need to rethink "adolescent jurisprudence," and suggests ways to improve adolescent jurisprudence in the HIV-AIDS epidemic context.[16] This jurisprudence acknowledges that adolescents differ markedly from children[17] and recognizes that children's rights[18] inadequately protect adolescents. Similarly, it acknowledges that adult rights inadequately protect minors, for concepts of adult rights fail to recognize adolescents' particular vulnerabilities.[19] This Article ultimately concludes that although adolescents have unique needs which are not being met, existing legal mandates, if utilized properly, could adequately protect adolescents' needs.[20]

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15. *See infra* part III.

16. *See infra* part IV. I have discussed elsewhere the need to reconsider the place of adolescents in American jurisprudence. *See* Levesque, *supra* note 8, at 240-43, 251, 291-93. In that article, I detailed the need to reconsider the place of adolescents, much as international law urges us to reconsider the conception of minors. *Id.* In this article, I take the discussion one step further and discuss some of the substantive features of adolescent jurisprudence.

17. A major and most obvious difference is the increased capacity adolescents have to judge situations. *See* Elizabeth S. Scott et al., *Evaluating Adolescent Decision Making in Legal Contexts*, 19 L. & HUM. BEHAV. 221 (1995).

18. Although the place of adolescents in children's rights has been ignored, the notion of children's rights has a formidable history. *See generally* Roger J.R. Levesque, *International Children's Rights Grow Up: Implications for American Jurisprudence and Domestic Policy*, 24 CAL. W. INT'L L.J. 193 (1994) [hereinafter Levesque, *International Children's Rights*] (reviewing the development of children's rights in American jurisprudence and in the international context); Roger J.R. Levesque, *Children's Rights for a Postmodern World*, 19 FORDHAM INT'L L.J. 832 (1995) (reviewing GERALDINE VAN BUEREN, THE INTERNATIONAL LAW ON THE RIGHTS OF THE CHILD (1995)). For recent reviews of the children's right movement, see JOSEPH M. HAWES, THE CHILDREN'S RIGHTS MOVEMENT: A HISTORY OF ADVOCACY AND PROTECTION (1991); MARY A. MASON, FROM FATHER'S PROPERTY TO CHILDREN'S RIGHTS: THE HISTORY OF CHILD CUSTODY IN THE UNITED STATES (1994).

19. This perception led to the establishment of a separate justice system in which adolescents who commit crimes are treated as less responsible than adults who commit similar offenses. *See, e.g.*, Roger J.R. Levesque & Alan J. Tomkins, *Revisioning Juvenile Justice: Implications of the New Child Protection Movement*, 48 WASH. U. J. URB. & CONTEMP. L. 87 (1995) (suggesting as sound a "new family and community based juvenile justice system" in which youths "would be rehabilitated within their families and communities instead of being incarcerated in adult jails or institutionalized"); Roger J.R. Levesque, *Is There Still a Place for Violent Youth in Juvenile Justice?*, AGGRESSIVE & VIOLENT BEHAV. REV. J. (forthcoming Spring 1996). The perception of particular vulnerabilities is seen throughout various parts of the legal system. For example, vulnerabilities justify the infancy doctrine in contract law, which nullifies contracts executed by minors. *See generally* Larry A. DiMatteo, *Deconstructing The Myth of the "Infancy Law Doctrine": From Incapacity to Accountability*, 21 OHIO N.U. L. REV. 481 (1995) (reviewing the evolution of the infancy law doctrine from a single rule voiding contracts to a multitude of rules limiting the scope of the single rule).

20. *See infra* part V.

II. THE PECULIAR PLACE OF ADOLESCENCE IN THE HIV-AIDS EPIDEMIC

HIV-AIDS has quickly spiraled into one of the deadliest and most frightening communicable diseases of all time.[21] No segment of the population is immune from its reach. The virus has crossed age, gender, ethnic, social, racial, and economic lines.[22]

This Part first describes the demographics of HIV-AIDS within the adolescent community,[23] and details the problem of late recognition of "at-risk" adolescents.[24] Next, it describes how adolescents typically transmit HIV-AIDS, and explains how adolescents' knowledge of factors to reduce risk of HIV-AIDS transmission does not change their risky behavior.[25] This Part then describes how policymakers have failed to develop comprehensive HIV-AIDS prevention programs or to utilize basic psychological knowledge in combating HIV-AIDS,[26] and emphasizes that those adolescents who are most at-risk are ignored by current HIV-AIDS policies.[27]

A. Demographics of the AIDS Virus Within the Adolescent Community

Despite the scope of HIV-AIDS' reach, it has spread disproportionately throughout the population. The latest national statistics report that there are slightly under 1,200 adolescent AIDS cases in the United States.[28] Relatively speaking, these numbers are quite small, with adolescents comprising a mere one percent of the total diagnosed AIDS cases.[29]

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21. As of 1994, the World Health Organization reported that 4 million persons worldwide had developed AIDS and 17 million had become infected with the AIDS virus. Geofrey Cowley & Mary Hager, *The Ever-Expanding Plague*, NEWSWEEK, Aug. 22, 1994, at 37.

22. CENTERS FOR DISEASE CONTROL AND PREVENTION, UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES, HIV/AIDS SURVEILLANCE REPORT 4 (Dec. 1993) [hereinafter CENTERS FOR DISEASE CONTROL AND PREVENTION, HIV/AIDS SURVEILLANCE REPORT] (table citing AIDS cases reported in the United States through December 1993, categorized by sex, age at diagnosis, and race/ethnicity).

23. *See infra* part II.A.

24. *See infra* part II.B.

25. *See infra* part II.C-D.

26. *See infra* part II.E-F.

27. *See infra* part II.F.

28. Anontia Novello, *Let's Deal With Reality of Teens and AIDS*, MIAMI HERALD, Oct. 31, 1993, at 5M (reporting that as of March 31, 1993, there were 1167 13 to 19-year-olds diagnosed with AIDS reported to the Centers for Disease Control).

29. CENTERS FOR DISEASE CONTROL AND PREVENTION, U.S. DEP'T HEALTH & HUMAN SERVS., HIV/AIDS SURVEILLANCE REPORT 12 (Feb. 1993) [hereinafter U.S. DEP'T HEALTH

The highly uneven spread of AIDS within the adolescent population presents a dramatically different picture than that of other age groups. In contrast to adults, minority youths account for a disproportionately high percentage of adolescents with AIDS.[30] In addition, among teenagers, girls make up a much higher percentage of AIDS cases than women from other age groups. For adolescents, the ratio of males-to-females is approximately three to one; for older-aged groups the ratio is thirteen to one.[31] Even manners of transmission differ from other age groups: adolescent AIDS is more likely to be transmitted by heterosexual activity.[32] Thus, not only are adolescent cases distributed unevenly within cognizable groups, the manifestation of the virus during adolescence diverges dramatically from that of other developmental periods.

B. Late Recognition of "At-Risk" Adolescents

The peculiarity of adolescents' encounters with AIDS does not stop at its incidence. An equally peculiar aspect of the epidemiology of AIDS in adolescence is that a decade passed before adolescents were recognized as "at risk."[33] Since this recognition, however, concern

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& HUMAN SERVS., HIV/AIDS SURVEILLANCE REPORT] (relating only to the United States).

30. *See* SCOTT W. HENGGELER ET AL., PEDIATRIC AND ADOLESCENT AIDS: RESEARCH FINDINGS FROM THE SOCIAL SCIENCES 26 (1992) (advising that although African American and Hispanic American adolescents represent only 14% and 8%, respectively, of the population, they constitute 36% and 18%, respectively, of adolescent AIDS cases.). Statistics from other samples report that 41% of adolescents with AIDS are white, that 37% are black and that 20% are Hispanic. *See AIDS and Teenagers—1987 Congressional Hearings*, *supra* note 13, at 89 (statement of Karen Hein, M.D.) (noting that in the nation as a whole, roughly 60% of AIDS cases are white).

31. *See AIDS and Teenagers—1987 Congressional Hearings*, *supra* note 13, at 89 (statement of Karen Hein, M.D.).

32. Approximately 40% of teen AIDS cases were contracted by bisexual or homosexual teens, compared to 66% of AIDS cases in the nation as a whole. *Id.* at 90. The ratio is changing as teen AIDS is increasingly transmitted through heterosexual activity. For example, the number of persons aged 13 to 19 who contracted the AIDS virus through heterosexual transmission increased by 65% between 1991 and 1992. NAT'L COMM'N ON AIDS, AIDS: AN EXPANDING TRAGEDY, THE FINAL REPORT OF THE NAT'L COMM'N ON AIDS 6 (1993); Kevin W. Smith et al., *HIV Risk Among Latino Adolescents in Two New England Cities*, 83 AM. J. PUB. HEALTH 1395, 1398 (1993) (finding that nearly all risk is attributable to heterosexual intercourse). These findings are important because they indicate the high risk that adolescent females face. *See AIDS and Teenagers—1987 Congressional Hearings*, *supra* note 13, at 90 (statement of Karen Hein, M.D.) (noting that female partners of high-risk people account for 13% of adolescents AIDS cases in New York, compared to 2% among adults in New York and 4% in the United States as a whole).

33. *See generally* DECADE OF DENIAL—1992 CONGRESSIONAL HEARINGS, *supra* note 13, at 2-3 (discussing the lack of governmental recognition and response to the growing epidemic of adolescents with HIV-AIDS). During the "decade of denial," however, some

has mounted, increasing with the dramatic rise in the number of adolescent AIDS cases[34] and with research revealing that reported AIDS cases represented a small proportion of the cases of HIV infection among adolescents.[35] This concern escalated when epidemiological research revealed that twenty to twenty-nine year-olds comprised about one-fifth of all AIDS cases, and that given HIV's long latency

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leading researchers noted the urgent need for intervention. In 1990 the National Research Council reiterated the urgency by detailing the extent of adolescents' risky behaviors. AIDS: THE SECOND DECADE 151-201 (Heather G. Miller et al. eds., 1990). The Institute of Medicine and the National Academy of Sciences were the first to notice the urgency of the situation. INSTITUTE OF MEDICINE, NAT'L ACADEMY OF SCIENCES, CONFRONTING AIDS: DIRECTIONS FOR PUBLIC HEALTH, HEALTH CARE, AND RESEARCH 111 (1986). This landmark report identified prevention of HIV infection among adolescents as an "urgent necessity." *Id.*

34. Adolescent AIDS cases have increased by 77% in the early 1990s. Karen Hein, *Adolescents at Risk for HIV infection, in* ADOLESCENTS AND AIDS: A GENERATION IN JEOPARDY 3-17 (Ralph J. DiClemente ed., 1992). The latest figures reveal, for example, that the number of adolescents with AIDS increased by 65% between 1991 and 1992. *See* Novello, *supra* note 28.

35. A series of surveys which examined the per capita rate of HIV, also known as seroprevalence surveys, selected population groups and demonstrated that HIV infection has significantly penetrated the adolescent population. For small HIV seroprevalence studies of adolescents, see Donald S. Burke et al., *Human Immunodeficiency Virus Infection in Teenagers, Seroprevalence Among Applicants for U.S. Military Service,* 263 JAMA 2074, 2074 (1990) (screening 1,141,164 military applicants for HIV infection; .034% tested positive); Lawrence J. D'Angelo et al., *Human Immunodeficiency Virus Infection in Urban Adolescents: Can We Predict Who Is at Risk?*, 88 PEDIATRICS 982, 982-83 (1991) (finding that .37% of 3520 adolescents receiving ambulatory care at Children's National Medical Center in Washington, D.C. tested positive); Helene D. Gayle et al., *Prevalence of Human Immunodeficiency Virus Among University Students,* 323 NEW ENG. J. MED. 1538, 1539 (1990) (conducting HIV screening of 12,000 college students at 19 universities; 0.2% tested positive); Michael E. St. Louis et al., *Human Immunodeficiency Virus Infection in Disadvantaged Adolescents, Findings from the U.S. Job Corps*, 266 JAMA 2387, 2388 (1991) (screening 137,209 adolescents entering the Job Corps for HIV infection; 0.36% tested positive); Rachel A. Stricof et al., *HIV Seroprevalence in a Facility for Runaway and Homeless Adolescents,* 81 AM. J. PUB. HEALTH 46, 50 (Supp. 1991) (stating that 2667 runaway and homeless adolescents were screened; 5.3% tested positive).

The reason that these small studies are important is that, to date, there are no national epidemiological studies of HIV infection among adolescents. For a description of the inadequacies of existing data on the scope of HIV infection among adolescents, see DECADE OF DENIAL—1992 CONGRESSIONAL HEARINGS, *supra* note 13, at 33-35; AIDS: THE SECOND DECADE, *supra* note 33, at 148-51, 166-67. The major limitations of seroprevalence studies that include adolescents is that they rely on nonprobability samples and are therefore not necessarily representative of particular groups of adolescents or the population of adolescents as a whole.

As with AIDS, HIV infection prevalence rates vary by race, ethnicity, and sex. For a summary of the data, see AIDS: THE SECOND DECADE, *supra* note 33, at 160-65; OFFICE OF TECHNOLOGY ASSESSMENT, ADOLESCENT HEALTH—VOL. II: BACKGROUND AND EFFECTIVENESS OF SELECTED PREVENTION AND TREATMENT SERVICES, OTA-H-466, II-262 to II-263 (1991).

period, most of those cases were contracted during teen years.[36] These results confirmed that adolescents were at higher risk than previously imagined.

C. Adolescents and Transmission of HIV-AIDS

Still another unusual aspect of the adolescent HIV-AIDS epidemic is its transmission. Contrary to common perceptions of HIV-AIDS transmission, adolescents are at risk simply because they are engaging in "normal" adolescent behavior. Adolescence is a period of experimentation with socially approved adult behaviors, such as heterosexual activity.[37] Adolescence is also marked by the exploration of alternatives, both in terms of sexual activity and various forms of delinquent behavior.[38] It is this normal experimentation which has grown problematic.

Recent statistics illustrate this point. Research indicates that roughly fifty percent of teens report being sexually active before the age of nineteen.[39] However, many sexually active teens engage in intercourse only infrequently. For example, among sexually active teenage girls the modal reported frequency of intercourse within the month before the survey was zero.[40] Ironically, while infrequent intercourse might seem to buffer the risk of adolescents contracting HIV-AIDS, it

36. The virus is believed to have a latency period ranging from 8 to 10 years. AIDS: THE SECOND DECADE, *supra* note 33, at 149. The 20 to 29-year-old age group accounts for nearly one-fifth of all diagnosed AIDS cases. *See* CENTERS FOR DISEASE CONTROL AND PREVENTION, HIV/AIDS SURVEILLANCE REPORT, *supra* note 22, at 12, Table 7; U.S. DEP'T HEALTH & HUMAN SERVS., HIV/AIDS SURVEILLANCE, July 1992. *See also* Leo Morris et al., *Measuring Adolescent Sexual Behaviors and Related Health Outcomes*, 108 PUB. HEALTH REP. 31, 31 (Supp. 1 1993) (describing the development of questions related to the Youth Risk Behavior Surveillance System Survey of adolescent sexual behavior).

37. Adolescents are more likely than adults to acquire the virus through heterosexual transmission or exposure to contaminated blood. *See* DECADE OF DENIAL—1992 CONGRESSIONAL HEARINGS, *supra* note 13, at 25, Table 2. They are also less likely to have been infected as a result of homosexual activity or intravenous drug use. Also listed, by gender and exposure category, was the number of reported AIDS cases among adolescents and adults. *Id.*

38. *See* Laura Kann et al., *Youth Risk Behavior Surveillance—United States 1993*, 44 MORBIDITY & MORTALITY WKLY. REP. SS-1, at 11-13 (1995) (comprehensive analysis of risk-taking behaviors by adolescents, such as drug use, sexual activity, and intentional and unintentional injury). For informative reviews of recent literature on risk taking, see MARTIN PLANT & MOIRA PLANT, RISK-TAKERS: ALCOHOL, DRUGS, SEX AND YOUTH (1992); ADOLESCENTS AT RISK: MEDICAL AND SOCIAL PERSPECTIVES (David E. Rogers & Eli Ginzberg, eds., 1992).

39. *See* Karen Hein, *AIDS in Adolescence: Exploring the Challenge*, 10 J. ADOLESCENT HEALTH CARE 10S, 22S (1989) (detailing the high number of teens who engage in sexual behavior).

40. *AIDS and Teenagers—1987 Congressional Hearings, supra* note 13, at 219 (statement of Gary B. Melton, Ph.D.).

is precisely the sporadic nature of sexual activity which places youth at risk.

The irregularity of sexual activity is one reason that less than one-third of sexually active teens use condoms, and still fewer use them consistently.[41] Similarly, the intermittent nature of adolescent sexual behavior partly reflects the search for different partners. Nearly one-quarter of adolescents reporting sexual activity have sex with multiple partners.[42] Thus, over 2.3 million youths are at risk for HIV infection through sexual activity.[43] These figures are quite alarming in light of recent evidence indicating that once adolescents have become sexually active, they are unlikely to inquire about the past sexual behavior and habits of their partners.[44] Cognizant of this crisis, some commentators propose that the risks are even higher and that high-risk sexual behavior may actually even be increasing.[45]

In addition to increasing the risk of transmission by engaging in sexual activity with multiple partners, adolescents are acquiring HIV-AIDS through unprotected sexual activity. A clear indication that unprotected sexual activity creates a high risk of HIV infection among adolescents is reflected in the dramatic increase in sexually transmitted diseases (STDs). Unexpectedly, the highest increase has been among early adolescents, ten to fourteen-year-olds.[46] Middle-adolescents,

41. *See* Joseph H. Pleck et al., *Adolescent Males' Condom Use: Relationships Between Perceived Cost Benefits and Consistency*, 53 J. MARRIAGE & FAM. 733, 738 (1991) (discussing national survey of 15 to 19-year-old males that found that one-fifth used condoms 100% of the time, one-fifth never used them, and one-half used them sometimes); Kevin W. Smith et al., *HIV Risk Among Latino Adolescents in Two New England Cities*, 83 AM. J. PUB. HEALTH 1395, 1398 (1993) (noting that even when condoms are used consistently, adolescents still may be putting themselves at risk because of the high number of exposures).

42. *Morbidity and Mortality Weekly Report, Results from the National Adolescent Student Health Survey*, 261 JAMA 2025, 2025-30 (1989) (finding a 21% rate of multiple partners among adolescents).

43. Richard A. Winett & Eileen S. Anderson, *HIV Prevention in Youth: A Framework for Research and Action*, 16 ADVANCED CLINICAL CHILD PSYCHOL. 1, 2 (1994).

44. Toon W. Taris & Gün R. Semin, *Does Adolescents' Sexual Behaviour Affect their Sexual Attitudes?*, 5 INT'L J. ADOLESCENTS & YOUTH 139, 155 (1995) (explaining a longitudinal study finding that sexually experienced adolescents are unlikely to inquire about their partners' sexual pasts).

45. Mary L. Keller, *Why Don't Young Adults Protect Themselves Against Sexual Transmission of HIV? Possible Answers to a Complex Question*, 5 AIDS EDUC. & PREVENTION 220, 221 (1993) (citing research indicating that the incidence of high-risk sexual behavior is rising).

46. The Centers for Disease Control And Prevention (CDC) reports a major increase in the incidence of gonorrhea among 10 to 14 year olds (41% among males and 51.2% among females) between 1981 and 1991. *Centers for Disease Control, Special Focus: Surveillance for Sexually Transmitted Diseases*, 42 MORBIDITY & MORTALITY WKLY. REP. No. SS-3, at 1, 4 (Aug. 13, 1993) [hereinafter *CDC: Special Focus*].

fifteen to nineteen-year-olds, do not fare well either. In fact, they hold the record for the highest rates of several STDs.[47] Additionally, the rather large number of teenagers (over one million) who become pregnant every year, and the high percentage of those pregnancies which are unintended (five out of six among fifteen to nineteen year olds), reflect the high rate of unprotected sexual activity.[48]

Surprisingly, adolescents with knowledge of the factors that increase or reduce the chance of HIV infection do not appear to change their behavior based on that information. This fact holds true for both high-risk and non-high-risk youth. Several surveys reveal accurate and widespread knowledge of the major determinants of HIV infection with only some confusion about the modes by which HIV is typically *not* transmitted.[49] Unusually, this knowledge has failed to have an impact on sexual behavior, risky behavior, or changes in those behaviors.[50] For example, although adolescents understand the risk of sexu-

47. *CDC: Special Focus, supra* note 46, at 11.

48. HOUSE SELECT COMM. ON CHILDREN, YOUTH, AND FAMILIES, 1991, RISKY BUSINESS OF ADOLESCENCE: HOW TO HELP TEENS STAY SAFE, 102d Cong., 1st Sess. 22 (1992) [hereinafter RISKY BUSINESS—1991 CONGRESSIONAL HEARINGS] (statement of Lloyd J. Kolbe, Ph.D.) (citing health statistics for 15 to 19-year-olds); AIDS: THE SECOND DECADE, *supra* note 33, at 86 (1990) (citing similar statistics).

49. National surveys conducted in the early 1990s reveal highly accurate knowledge. *See* Joseph A. Catania, et al., *Towards an Understanding of Risk Behavior: An AIDS Risk Reduction Model (ARRM)*, 17 HEALTH EDUC. Q. 53, 57-58 (1990). *See generally* D. Michael Anderson & Gregory M. Christenson, *Ethnic Breakdown of AIDS-Related Knowledge and Attitudes From the National Adolescent Student Health Survey*, 22 J. HEALTH EDUC. 30 (1991); Laura Kann et al., *Establishing a System of Complementary School-Based Surveys to Annually Assess HIV-Related Knowledge, Beliefs, and Behaviors Among Adolescents*, 59 J. SCH. HEALTH 55 (1991).

50. The research is overwhelmingly conclusive. *See* Daniel D. Adame et al., *Southern College Freshman Students: A Survey of Knowledge, Attitudes, and Beliefs About AIDS*, 17 J. SEX EDUC. & THERAPY, 196, 198 (1991); John E. Anderson et al., *HIV/AIDS Knowledge and Sexual Behavior Among High School Students*, 22 FAM. PLANNING PERSP. 252, 254 (1990) (reporting that although HIV/AIDS education is increasing in schools, many students still have misconceptions about HIV/AIDS that could put them at risk); Marshall H. Becker, & Jill G. Joseph, *AIDS and Behaviorial Change to Reduce Risk: A Review*, 78 AM. J. PUB. HEALTH 394, 405-07 (1988); Judith Boswell et al., *A Comparison of HIV-Related Knowledge, Attitudes, and Behaviors Among Adolescents Living in Rural and Urban Areas of a Southern State*, 23 J. HEALTH EDUC. 238, 242 (1991); Ralph J. DiClemente et al., *College Students' Knowledge and Attitudes About AIDS and Changes in HIV Preventive Behaviors*, 2 AIDS EDUC. & PREVENTION 201, 210 (1990) (discussing the lack of preventive action when adolescents have knowledge about HIV-preventive behavior); Reginald Fennell, *Knowledge, Attitudes, and Beliefs of Students Regarding AIDS: A Review*, 21 HEALTH EDUC. 20, 25 (1990); Jeffrey D. Fisher et al., *Impact of Perceived Social Norms on Adolescents' AIDS-Risk Behavior and Prevention*, ADOLESCENTS & AIDS 117, 118 (Ralph J. DiClemente ed., 1992); Steven E. Keller et al., *HIV-Relevant Sexual Behavior Among a Healthy Inner-City Heterosexual Adolescent Population in an Endemic Area of HIV*, 12 J. ADOLESCENTS HEALTH 44, 46-47 (1991); Douglas Kirby, *School Based Prevention Programs: Design, Evaluation, and*

ally transmitted diseases, including HIV infection, most adolescents have not changed their behavior by consistently using condoms.[51]

D. Policymakers Have Failed to Develop Comprehensive Prevention Programs

Not surprisingly, researchers report that prevention of risky sexual behavior among adolescents involves complex social-psychological issues which evidently have yet to be fully understood.[52] The continued, widespread failure of sex education programs illustrates the complexities of this situation. Psychologists are able to offer several reasons for the failure and the limited usefulness of existing programs. These include the failure to address skills in using reproductive information,[53] the use of instructors who lack credibility,[54] the difficulty of

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Effectiveness, in ADOLESCENTS & AIDS 159, 164 (Ralph J. DiClemente ed., 1992); Karen L. Kotloff et al., *A Voluntary Serosurvey and Behavioral Risk Assessment for Human Immunodeficiency Virus Infection Among College Students*, 18 SEXUALLY TRANSMITTED DISEASES 223, 225 (1991); Mary Rotherman-Borus & Cheryl Kopman, *Sexual Risk Behavior, AIDS Knowledge, and Beliefs About AIDS Among Predominantly Minority Gay and Bisexual Male Adolescents*, 3 AIDS EDUC. & PREVENTION 305, 310 (1991); Mary-Ann Shafer & Cherrie B. Boyer, *Psychosocial and Behavioral Factors Associated With Risk of Sexually Transmitted Diseases, Including Human Immunodeficiency Virus Infection, Among Urban High School Students*, 119 J. PEDIATRICS 826, 831 (1991); Michael R. Stevenson & Deborah M. Stevenson, *Beliefs About AIDS Among Entering College Students*, 16 J. SEX EDUC. & THERAPY 201, 204 (1990) (discussing the results of a study among high school students regarding their knowledge about STDs and AIDS). *But see* Elizabeth Goodman & Alwyn Cohall, *Acquired Immunodeficiency Syndrome and Adolescents: Knowledge, Attitudes, Beliefs, and Behaviors in a New York City Adolescent Minority Population*, 84 PEDIATRICS 36, 41 (1989) (reporting that 39% of adolescents in survey had changed their behavior in the last six months due to their concern about AIDS).

51. Winett & Anderson, *supra* note 43, at 5 (reviewing available literature, concluding same and further noting that up to 75% of sexually active teens are at risk of HIV infection because of inconsistent condom use). *See also* Larry K. Brown et al., *Predictors of Condom Use in Sexually Active Adolescents*, 13 J. ADOLESCENT HEALTH 651, 652-53 (1992) (reporting that less than 30% of sexually active teens consistently use condoms).

52. Research reveals that adolescence is marked by a sense of invulnerability, difficulty of thinking abstractly in self relating matters, propensity to use denial as a coping mechanism and a heavy reliance on peers. For thorough examinations of the adolescent period, see ADOLESCENCE AND ITS SOCIAL WORLD (Sandy Jackson & Hector Rodriguez-Tom'e eds., 1993); ADOLESCENCE IN THE 1990S: RISK AND OPPORTUNITY (Ruby Takanishi ed., 1993); NANCY J. COBB, ADOLESCENCE: CONTINUITY, CHANGE, AND DIVERSITY (1992); AARON H. ESMAN, ADOLESCENCE AND CULTURE (1990); DOUGLAS KIMMEL, ADOLESCENCE: A DEVELOPMENTAL TRANSITION (1995); LINDA NIELSEN, ADOLESCENCE: A CONTEMPORARY VIEW (1991); LAURENCE STEINBERG, ADOLESCENCE (1993).

53. *See infra* note 86.

54. Researchers report that adults tend not to be perceived as credible and that peers are the predominant source of information and influence about sexual behavior. *See*

protecting against largely invisible risks,[55] the inherent nature of romantic relationships,[56] and the challenge of inhibiting pleasurable behavior.[57]

AIDS and Teenagers—1987 Congressional Hearings, *supra* note 13, at 223 (statement of Gary B. Melton, Ph.D.).

55. Given the lengthy incubation period for HIV, if an adolescent has AIDS, that individual will almost always have contracted the illness through events outside their control (e.g., transfusions). Commentators note that if we wish to increase adolescents' avoidance of behavior that increases the risk of HIV infection, a first step is to make the risk cognitively available (i.e. "concrete and salient in terms of adolescents' everyday experience"). *See AIDS and Teenagers—1987 Congressional Hearings*, *supra* note 13, at 216 (statement of Gary B. Melton, Ph.D.). Research regarding the progression of the disease, however, remains sketchy. *See* James J. Goedert et al., *A Prospective Study of Human Immunodeficiency Virus Type I Infection and the Development of AIDS in Subjects with Hemophilia*, 321 NEW ENG. J. MED. 1141, 1141 (1990) (noting that among seropositive hemophiliac patients, adolescents remain asymptomatic significantly longer than do adults); AIDS: THE SECOND DECADE, *supra* note 33, at 149 n.5 (1990) (citing Personal Communication from Karen Hein, Adolescent AIDS Program, Montefiore Medical Center, Bronx, N.Y., as noting that progression may be more rapid in adolescents infected through sexual activity or drug use).

56. Use of contraception requires mastery of several psychological challenges: identification of oneself as sexually active (which could be easy to deny when sexual intercourse is infrequent); acceptance of erotic feelings; overcoming negative reactions of salespeople when purchasing contraceptives; overcoming fear of being perceived as "experienced" because of preparation for intercourse; interruption of the "spontaneity" of romantic love-making; and the need to believe that using contraception will make a difference. As the National Research Counsel panel concluded, substantial changes in sexual behavior among adolescents may require significant social changes in order to enhance the life options of disadvantaged youth. ROBERT HAYES, RISKING THE FUTURE: ADOLESCENT SEXUALITY, PREGNANCY, AND CHILDBEARING 266 (1987).

It is important to emphasize that few researchers actually have examined the experience of adolescent romantic relationships; for a notable exception, see Roger J.R. Levesque, *The Romantic Experience of Adolescents in Satisfying Love Relationships*, 22 J. YOUTH & ADOLESCENCE 219, 220-21 (1993). Likewise, few have examined the actual experience of sexual activity. Eminent researchers recently summarized the problem:

> Today's concern over teenage sexual behavior and childbearing is often couched in terms of societal and individual cost of teenage parenthood . . . but ignores the teenager's experience, perceptions, and social settings. Little is known about the teenager's construction of sexuality: how they experience the emergence of sexual desire and their strategies for managing it; how they receive and process information about sexuality; how they negotiate sexual relationships in the face of potential sexual arousal; and how their sexual experiences relate to and effect other features of their development.

Jean Brooks-Gunn & Frank Furstenburg, *Coming of Age in the Era of AIDS: Puberty, Sexuality, and Contraception*, 68 MILLBANK Q. 59, 59 (Supp. 1 1990).

57. Although this seemingly would not need a citation, the paucity of available citations is revealing; the variable is surprisingly absent from research. Research, which has included the positive motivations for engaging in sexual relationships, reveals that pleasurable behavior is the *strongest* predictor of casual sexual attitudes and behaviors. *See, e.g.*, Ruth A. Levinson et al., *Older Adolescents' Engagement in Casual Sex: Impact of Risk Perception and Psychosocial Motivations*, 24 J. YOUTH &

Despite this list of psychological obstacles, experts have yet to develop comprehensive programs which adequately deal with their effects. Although the research community has known that the HIV infection prevention approaches created for adult populations are ineffective for adolescents, it has yet to respond appropriately.[58] Thus, yet another peculiarity of the place of adolescents in the HIV-AIDS epidemic is the failure to attempt comprehensive methods of prevention despite the continued failure of existing preventive programs.

Experts also have failed to use basic psychological knowledge about adolescents in the effort to combat HIV-AIDS. For example, psychologists have known about the importance of adolescents' sense of egocentrism which does not respond well to scare tactics.[59] Researchers also understand the sexual nature of adolescence. Yet the most often proposed programs focus on scare tactics and insist on abstinence.[60] In addition, there is still little research dealing with the experience of

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ADOLESCENCE 349, 361 (1995) ("The strongest predictor of casual sex attitudes for both men and women focused on physical pleasure.").

58. For a series of suggestions, see Jean Brooks-Gunn et al., *Preventing HIV Infection and AIDS in Children and Adolescents: Behavioral Research and Intervention Strategies*, 43 AM. PSYCHOL. 958, 962-63 (1988). Currently, much of the research on adolescents with AIDS deals with youth who are hemophiliacs, who account for a very small number of HIV infections. *See, e.g.*, Sharmistha Bose, *Psychologic Adjustment of Human Immunodeficiency Virus-Infected School-Age Children*, 15 DEVELOPMENTAL & BEHAVIORAL PEDIATRICS S26, S26 (1994) (studying transfusion-infected children living in middle-class families).

Other research tends to focus on pediatric AIDS. *See* Felissa L. Cohen, *Research on Families and Pediatric Human Immunodeficiency Virus Disease: A Review and Needed Directions*, 15 DEVELOPMENTAL & BEHAVIORAL PEDIATRICS S34 (1994); Sandra Y. Lewis et al., *Living Beyond the Odds: A Psychosocial Perspective on Long-term Survivors of Pediatric Human Immunodeficiency Virus Infection*, 15 DEVELOPMENTAL & BEHAVIORAL PEDIATRICS S12 (1994); Laurie N. Sherwen & Mary Boland, *Overview of Psychosocial Research Concerning Pediatric Human Immunodeficiency Virus Infection*, 15 DEVELOPMENTAL & BEHAVIORAL PEDIATRICS S5 (1994).

Most researchers, however, tend to focus on adults; for a comprehensive literature review, see Seth C. Kalichman & Kathleen J. Sikkema, *Psychological Sequelae of HIV Infection and AIDS: Review of Empirical Findings*, 14 CLINICAL PSYCHOL. REV. 661 (1994).

59. Fear-based tactics have proven unsuccessful. *See* Levinson, *supra* note 57 at 360-61 (noting the limited impact of prevention programs that focus on fears and disease); Brian Magruder et al., *The Relationship Between AIDS-Related Information Sources and Homophobic Attitudes: A Comparison of Two Models*, 26 J. HOMOSEXUALITY 47, 64-67 (1993); Richard Seltzer, *AIDS, Homosexuality, Public Opinion, and Changing Correlates Over Time*, 26 J. HOMOSEXUALITY 85, 93-96 (1993). Indeed, research indicates that scare tactics actually lead to discrimination against people living with AIDS. *See, e.g.*, PLANT & PLANT, *supra* note 38, at 127 (noting how fear campaigns have been widely criticized by health professionals and AIDS specialists, and also reporting that fear campaigns have aroused alarm and resulted in a *lack* of sympathy for people with AIDS).

60. *See infra* note 123 and accompanying text.

living with HIV.[61] Instead, the focus remains on dying of AIDS, an experience which is not likely to be relevant to adolescents.[62] Thus, despite two decades of research aimed at understanding the impact and spread of HIV-AIDS, programs which deal directly with adolescents' issues are virtually nonexistent.

E. Adolescents Most at Risk are Ignored by Policies

Even though research has failed to directly address adolescents, it has sparked a growing interest in identifying adolescents "at risk." Advocates hope that this identification will allow for intervention in order to prevent or delay behaviors that increase the likelihood of transmitting HIV infection. These epidemiological efforts have proven quite successful. Indeed, early in the epidemic, experts recognized that several groups of adolescents were especially at risk; including gay adolescents,[63] runaways,[64] and underclass, delinquent youths.[65]

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61. Existing research is limited to "pop" accounts. *See, e.g.*, MARY KITTREDGE, TEENS WITH AIDS SPEAK OUT (1991); WHITE & CUNNINGHAM, *supra* note 3.

62. Anita Gates, *"Kids" Evokes Strong Reactions from Youths as Well as Parents*, N.Y. TIMES, Aug. 5, 1995, § 1, at 11 (reviewing a controversial film which attempted to portray how teenagers actually live with AIDS).

63. "Over 50% of persons with AIDS diagnosed between the ages of 20 and 24 are males reporting a homosexual contact that could have exposed them to HIV." *See* RISKY BUSINESS—1991 CONGRESSIONAL HEARINGS, *supra* note 48, at 18 (statement of William Gardner, Ph.D.).

64. About one million adolescents run away from home each year. NATIONAL NETWORK ON YOUTH AND RUNAWAY SERVICES, DECADE OF DENIAL 116 (1992) (estimating that as many as 1.3 to 2.0 million youth run away from home each year). [hereinafter DECADE OF DENIAL]. These youths are likely to become involved in drug use, drug trafficking, prostitution, and other risky behavior. *See supra* note 38. *See also* Mary J. Rotheram-Borus et al., *Preventing HIV among Runaways: Victims and Victimization, in* PREVENTING AIDS: THEORIES AND METHODS OF BEHAVIORAL INTERVENTIONS 175, 175 (Ralph J. DiClimente & John L. Peterson eds., 1994) (noting that "runaways and homeless youth are an understudied and underserved population at increased risk of Human Immunodeficiency Virus (HIV) infection"); Gregory D. Zimet et al., *Sexual Behavior, Drug Use, and AIDS Knowledge Among Midwestern Runaways*, 26 YOUTH & SOC'Y 450, 457-60 (noting the importance of not generalizing behaviors and finding that runaways in Cleveland may have lower levels of health-compromising behaviors and drug use than those in New York City, Los Angeles and San Francisco). *See generally* MARK-DAVID JANU ET AL., ADOLESCENT RUNAWAYS: CAUSES AND CONSEQUENCES (1987) (evaluating an influential study of adolescent runaways).

65. HIV infection is increasingly prevalent in areas of concentrated poverty within the inner cities, particularly among minority groups suffering from coincidental epidemics of intravenous drug use and other STDs. *See* RISKY BUSINESS—1991 CONGRESSIONAL HEARINGS, *supra* note 48, at 17 (statement of William Gardner, Ph.D.). It is important, however, to avoid mislabeling minority youths as a group at high risk of becoming infected with HIV. Because many minority youths do live in areas of concentrated poverty in inner cities, they are at high risk for exposure to HIV due to where they live and not due to their race. *See AIDS and Teenagers—1987 Congressional*

This finding, and its use or lack thereof, reveals the failure of current HIV-AIDS policies. These youth are the most difficult to reach through traditional school or public health interventions.[66] Yet, inadequate approaches to prevention prevail[67] as some policymakers continue to foil innovative efforts.[68] Thus, a most unfortunate aspect of the HIV-AIDS crisis is that adolescents at greatest risk are even more disenfranchised than other adolescents: they are stigmatized, alienated, or simply ignored.

Other aspects of adolescents' encounters with HIV-AIDS reflect the tendency to stigmatize and ignore those with the disease. Research highlights the increasing likelihood that adolescents are less likely to develop AIDS than they are likely to be orphaned by it. Estimates project that by the year 2000, over 80,000 youths will be left without mothers due to their deaths from HIV-AIDS related causes.[69]

Hearings, *supra* note 13, at 18 (statement of William Gardner, Ph.D.). Again, it is critical to note that the prevalence of risk-taking among minority youths varies greatly across subgroups within this population. *See* RISKY BUSINESS—1991 CONGRESSIONAL HEARINGS, *supra* note 48, at 18 (statement of William Gardner, Ph.D.) (noting, for example, that a well kept secret is that alcohol use and even other drug use is less prevalent among blacks than whites among high school seniors).

66. Roger C. Katz et al., *Knowledge and Attitudes About AIDS: A Comparison of Public High School Students, Incarcerated Delinquents, and Emotionally Disturbed Adolescents*, 24 J. YOUTH & ADOLESCENTS 117, 129-30 (1995) (finding an especially urgent need to reach delinquent and emotionally disturbed youth who require more comprehensive intervention); Vered Slonim-Nevo et al., *Educational Options and AIDS-Related Behaviors Among Troubled Adolescents*, 20 J. PEDIATRIC PSYCHOL. 41, 57-59 (1995) (finding that educational aspirations predict AIDS-related knowledge, attitude, and behaviors). *See also* Tracy A. Lieu et al., *Race, Ethnicity, and Access to Ambulatory Care among U.S. Adolescents*, 83 AM. J. PUB. HEALTH 960, 963-64 (1993) (finding that minority adolescents are particularly vulnerable to lack of health care access, even after adjusting for health insurance, family income, need, and other factors).

Even when minority youth are reached through sex-education programs, the programs do not necessarily have the intended impact. *See* Deborah Holtzman et al., *Changes in HIV-Related Information Sources, Instruction, Knowledge, and Behaviors Among U.S. High School Students, 1989 and 1990*, 84 AM. J. PUB. HEALTH 388, 391-92 (1994) (noting that the increased instruction relating to HIV was linked to significant decrease in sexual activity for white females, but not other groups).

67. Michael Hennessy, *Adolescent Syndromes of Risk for HIV Infection*, 18 EVALUATION REV. 312, 329 (1994) (concluding that it is "difficult to identify particular sources of optimism in regard to either the short- or long-term efficacy of the general public health approach being taken in the area of adolescent HIV infection"); RISKY BUSINESS—1991 CONGRESSIONAL HEARINGS, *supra* note 48, at 19 (statement of William Gardner, Ph.D.) "[P]revention of risky behaviors related to HIV infection among adolescents is not working." *Id.* For a theoretical discussion of needed reforms, *see* June A. Flora & Carl E. Thoresen, *Reducing the Risk of AIDS in Adolescents*, 43 AM. PSYCHOL. 965, 965-69 (1988). For a historical examination of research and methods which show promise, *see* Winett & Anderson, *supra* note 43, at 25-40.

68. *See infra* note 92 (discussing efforts to curb condom distribution in schools).

69. David Michaels & Carol Levine, *Estimates of the Number of Motherless Youth*

Research indicates that these adolescents, who account for at least half of the AIDS-orphans,[70] face unique challenges.[71] Yet, adolescents' concerns essentially remain ignored.[72] Moreover, when the needs of orphaned adolescents are actually addressed, they are treated indiscriminately from those of young children.[73]

With the inability to prevent the spread of HIV infection to the adolescent population, the lack of adequate research, and seeming inability to reach youth, the question no longer centers on whether policymakers should focus on and intervene with youth. Instead, the question is how policymakers can best intervene. With increasing exigency, some researchers and policymakers have turned their attention to preventing HIV infection in youth and dealing with youth directly and indirectly affected by AIDS. The attention has resulted in identifiable progress, to which we now turn.

Orphaned by AIDS in the United States, 268 JAMA 3456, 3458 (1992). The report startled the world by stating that, in 1991, 22% of all children and adolescents whose mothers had died lost their mothers to AIDS. *Id.* The report was even more startling in that more than 80% of the youth were offspring of African-American or Hispanic women. *Id.*

70. Mireya Navarro, *Left Behind by AIDS*, N.Y. TIMES, May 6, 1992, at B1 (estimating that half the children who have lost a parent to AIDS are teenagers).

71. *See* Barbara H. Draimin et al., The Mental Health Needs of Well Adolescents in Families with AIDS (1992) (unpublished D.S.W. dissertation, City University of New York) (describing the exponential increase in the number of adolescents living in families with AIDS and the difficulties facing adolescents, such as poverty, parental drug use, and the need to care for parents who become progressively ill with this highly stigmatized disease).

72. For example, despite the need to acknowledge adolescents' needs when they are faced with losing their parents, legal commentators who have examined the issue have focused their work on re-examining parental rights. *See* James M. Smith, *Legal Issues Confronting Families Affected by HIV*, 24 J. MARSHALL L. REV. 543, 549-55 (1991) (detailing guardianship, custody, and visitation issues for children with HIV-infected parents); Aline C. Barrett & Michelle A. Flint, Comment, *The Effect of AIDS on Child Custody Determinations*, 23 GONZ. L. REV. 167, 171-84 (1987-88) (describing parental rights in context of custody issues); Nancy B. Mahon, Note, *Public Hysteria, Private Conflict: Child Custody and Visitation Disputes Involving an HIV Infected Parent*, 63 N.Y.U. L. REV. 1092 (1988) (examining custody disputes involving HIV-positive parents); Amy R. Pearce, Note, *Visitation Rights of an AIDS Infected Parent*, 27 J. FAM. L. 715 (1988-89) (focusing on HIV-infected parents); Susan L. Waysdorf, *Families in the AIDS Crisis: Access, Equality, Empowerment, and the Role of Kinship Caregivers*, 3 TEX. J. WOMEN & L. 145 (1994) (focusing on the need to provide kinship care).

Other commentators have contented themselves by simply detailing the content of existing laws. *See* Josephine Gittler & Sharon Rennert, *HIV Infection Among Women and Children and Antidiscrimination Laws: An Overview*, 77 IOWA L. REV. 1313 (1992).

73. In fact, in a major orphan study, children and adolescents are lumped together into one category. Michaels & Levine, *supra* note 69, at 3458. *See generally* Theresa Cameron, *Children Orphaned by AIDS: Providing Homes for a Most Vulnerable Population*, 9 AIDS & PUB. POL'Y J. 29, 30 (1994); FORGOTTEN CHILDREN OF THE AIDS EPIDEMIC (Shelley Geballe et al. eds., 1995).

III. ADDRESSING ADOLESCENTS' NEEDS: UNUSUAL PROGRESS, USUAL INADEQUACIES

Nearly two decades into the HIV-AIDS epidemic, adolescents have become a group worthy of unique concern. Although the discussion lacks a distinguishable group of commentators and policymakers concerned with the impact of the epidemic on adolescents, there have been considerable attempts to address the needs of children and adolescents as a group. Those concerned about this group of "children" have quickly turned the concern into rights issues. Primary among these concerns were issues involving children's rights in schools and health settings.[74] A largely unacknowledged, dramatic transformation of both for a resulted from this focus.

A. HIV-AIDS, Adolescents and Public Schools

Public schools have been the most visible and contentious battleground for recognizing HIV-infected adolescents' rights. Early battles centered around the admittance of HIV-infected youth into public schools.[75] Given the tenor of public reactions and fears of AIDS,[76] courts' reactions were startling.

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74. These especially focused on sexuality education, condom distribution in schools, and the right to obtain health services. *See infra* notes 75-110.

75. *See generally* Marsha B. Liss, *The Schooling of Children With AIDS: The Development of Policies, in* CHILDREN, ADOLESCENTS & AIDS 93 (Jeffrey M. Seibert & Roberta A. Olson eds., 1989) (discussing how school placement decisions are made for HIV infected children based on public opinion, court decisions, and school administrators). For reviews of early cases, see Lawrence O. Gostin, *The AIDS Litigation Project: A National Review of Court and Human Rights Commission Decisions, Part I: The Social Impact of AIDS,* 263 JAMA 1961 (1990); Lawrence O. Gostin, *The AIDS Litigation Project: A National Review of Court and Human Rights Commission Decisions, Part II: Discrimination,* 263 JAMA 2086 (1990).

76. Gregory M. Herek & Eric K. Glunt, *An Epidemic of Stigma: Public Reactions to AIDS,* 43 AM. PSYCHOLOGIST 886, 887-90 (1988) (describing social and psychological processes contributing to AIDS-related stigma and offering suggestions for eradicating stigma through public policy and individual education).

Several states have enacted new legislation in reaction to public fear of AIDS. *See, e.g.,* FLA. STAT. ANN. § 384.24 (West 1993) (prohibiting a person infected with HIV from having sexual intercourse without informing his or her partner of the infection); IDAHO CODE § 39-601 (1995) (prohibiting an AIDS carrier from knowingly or willfully exposing another to AIDS or HIV).

Other states use existing criminal laws. *See, e.g.,* Brock v. State, 555 So. 2d 285, 289 (Ala. Crim. App. 1989) (affirming conviction of defendant with AIDS for first-degree assault for biting a corrections officer); State v. Haines, 545 N.E.2d 834, 841 (Ind. Ct. App. 1989) (affirming jury conviction of defendant with AIDS for attempted murder for spitting and spattering blood at paramedics); Weeks v. State, 834 S.W.2d 559, 566 (Tex. Ct. App. 1992) (imposing life sentence on HIV-positive defendant after attempted murder conviction for spitting on a prison guard); Zule v. State, 802 S.W.2d 28, 35 (Tex. Ct. App. 1990) (affirming conviction of defendant with AIDS for aggravated

Courts systematically rejected attempts to exclude youth with HIV-AIDS from schools.[77] Just as startling was the tendency of some

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sexual assault for infecting victim with AIDS).

Several commentators have noted the criminalization of AIDS. *See generally* Michael L. Closen et al., *Criminalization of an Epidemic: HIV-AIDS and Criminal Exposure Laws*, 46 ARK. L. REV. 921 (1994) (discussing both traditional criminal and HIV-specific statutes addressing HIV-AIDS issues); J. Kelly Strader, *Criminalization as a Policy Response to a Public Health Crisis*, 27 J. MARSHALL L. REV. 435, 439-45(1994) (listing several possible rationales for criminalizing the HIV epidemic, but concluding that criminalization is not the solution); Stephen V. Kenney, Comment, *Criminalizing HIV Transmission: Lessons from History and a Model for the Future*, 8 J. CONTEMP. HEALTH L. & POL'Y 245 (1992) (proposing that legislation criminalizing the intentional spread of HIV must consider problems from past similar provisions, such as those for syphalis, and that even the most narrowly-tailored provisions may be counter-productive in the struggle to control transmission); Thomas W. Tierney, Note, *Criminalizing the Sexual Transmission of HIV: An International Analysis*, 15 HASTINGS INT'L & COMP. L. REV. 475 (1992) (proposing an HIV-specific statute as the best means for a penalty, rather than current criminal laws).

The fear of AIDS has also given rise to civil sanctions. However, civil sanctions do not mandate as much constitutional protection as criminal sanctions. *See* Robinson v. California, 370 U.S. 660, 683-84 (1962) (Clark, J., dissenting) (stating that civil commitment is not subject to the constraints of the Eighth Amendment's prohibition against cruel and unusual punishment). The result is that some states have turned to quarantine, commitment, and preventive detention. *See, e.g.*, COLO. REV. STAT. ANN. § 25-4-1406(2)(c) (West Supp. 1995) (authorizing public health officials to order persons infected with HIV whose behavior endangers others to cease and desist, and in the event that they violate those orders, to apply restrictions necessary to stop them); IDAHO CODE § 39-604 (1995) (classifying AIDS & HIV infection as diseases subject to quarantine). *See generally* John A. Gleason, Comment, *Quarantine: An Unreasonable Solution to the AIDS Dilemma*, 55 U. CIN. L. REV. 217 (1986) (discussing the legal issues that might arise upon a mandatory quarantine of AIDS victims); Wendy E. Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53 (1985) (exploring the historical evolution of the law of quarantine and analyzing its applicability to the AIDS epidemic); Kathleen M. Sullivan & Martha A. Field, *AIDS and the Coercive Power of the State*, 23 HARV. C.R.-C.L. L. REV. 139 (1988) (responding to those who advocate coercive police power as a means to combat AIDS).

An intriguing aspect of the AIDS epidemic is the fear of allowing children with AIDS to attend school. ROBERTA WEINER, AIDS: IMPACT ON THE SCHOOLS 29 (1986). This fear is based on the theory that AIDS infected children will spread the disease to others. *Id.* *See also* Verla S. Neslund et al., *The Role of the CDC in the Development of AIDS Recommendations and Guidelines*, 15 LAW, MED. & HEALTH CARE 73, 76 (1987) (discussing the Centers for Disease Control's role in developing guidelines and recommendations to prevent further spread of HIV and AIDS).

77. Initially some schools responded to the AIDS epidemic by automatically excluding children with AIDS from the classroom. However, these automatic exclusion policies were found to be violative of federal and constitutional law. *See, e.g.*, District 27 Community Sch. Bd. v. Board of Educ., 502 N.Y.S.2d 325 (N.Y. 1986) (considering for the first time factual and legal issues surrounding AIDS in the classroom setting); Danny R. Veilleux, Annotation, *AIDS Infection As Affecting Right to Attend Public School*, 60 A.L.R. 4th 15 (1988 & Supp. 1995) (discussing state and federal cases that have considered the right of a student with the AIDS virus to attend public school).

Early challenges to school exclusion policies were based on the Rehabilitation Act of

schools to take an activist role in educating and enlightening the public about AIDS. Landmark cases in which school boards and commissioners defended the right of AIDS infected children to attend schools reflect this tendency.[78] In addition, and just as remarkably, courts

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1973, 29 U.S.C.A. § 701-96(i) (West 1985 & Supp. 1995), which the Supreme Court interpreted to be fully applicable to individuals who suffer from a contagious disease in School Bd. of Nassau County v. Arline, 480 U.S. 273, 289 (1987), thus opening the way for lower courts to find protection under the Act for persons suffering from AIDS. *See* Robert P. Wasson, Jr., *AIDS Discrimination Under Federal, State, and Local Law After Arline*, 15 FLA. ST. U. L. REV. 221, 234-54 (1987). For more recent cases, see Doe v. Attorney Gen. of United States, 723 F. Supp. 452, 454 (recognizing that AIDS is a "handicap" for purposes of the Rehabilitation Act), *aff'd in part, vacated in part on other grounds*, 941 F.2d 780 (N.D. Cal. 1989); Thomas v. Atascadero Unified Sch. Dist., 662 F. Supp. 376, 381 (C.D. Cal. 1987) (finding that "handicapped persons" included child with AIDS within the meaning of the Rehabilitation Act); Glanz v. Verinck, 756 F. Supp. 632, 635 (D. Mass. 1991) (finding HIV-positive status to be a "handicap" within the meaning of the Rehabilitation Act). *See generally* KERN ALEXANDER & M. DAVID ALEXANDER, AMERICAN PUBLIC SCHOOL LAW 402 (3d ed. 1992) (concluding that the Rehabilitation Act now protects children with AIDS or HIV from exclusion from schools); Frank D. Aquila, *AIDS and "AFRAIDS" in Our Schools: Whither Our Children?*, 69 DENV. U. L. REV. 315 (1992) (examining the impact of AIDS on schools and on the lives of school children); Matthew J. Welker, *The Impact of AIDS Upon Public Schools: A Problem for Jurisprudence*, 33 EDUC. L. REP. 603 (1986) (discussing the possible impact of AIDS upon public school education in light of compelling individual and state interests); Leah Hammett, Comment, *Protecting Children with AIDS Against Arbitrary Exclusion from School*, 74 CAL. L. REV. 1373, 1398-1400 (1986) (proposing a federal statute which would enable states to establish administrative boards of physicians to decide whether to permit a child with AIDS to attend school); Lisa J. Sotto, Comment, *Undoing a Lesson of Fear in the Classroom: The Legal Recourse of AIDS-Linked Children*, 135 U. PA. L. REV. 193 (1986) (arguing that children facing AIDS-related discrimination are protected by federal anti-discrimination laws as well as by the Federal Constitution, and that school officials are thereby prohibited from excluding an AIDS-linked child from the regular classroom); Deborah L. Titus, Note, *AIDS as a Handicap Under the Federal Rehabilitation Act of 1973*, 43 WASH. & LEE L. REV. 1515, 1533-35 (1986) (detailing protections from discrimination under the Rehabilitation Act); Susan A. Winchell, Note, *Discrimination in the Public Schools: Dick and Jane Have AIDS*, 29 WM. & MARY L. REV. 881 (1988) (discussing the rights of AIDS infected children under the Equal Protection Clause).

More recently, the American with Disabilities Act (ADA), Pub. L. No. 101-336, 104 Stat 328 (codified at 42 U.S.C. §§ 12101-213 (1990)), reaffirmed the inclusion of HIV-AIDS as a handicap and extended protections to the private sector. *See* E. Anne Benaroya, *The ADA and AIDS: How Will Public Law No. 101-336 Affect This New Minority?*, 39 FED. B. NEWS & J. 91, 94 (1992); William G. Buss, *Human Immunodeficiency Virus, the Legal Meaning of "Handicap," and Implications for Public Education Under Federal Law at the Dawn of the Age of the ADA*, 77 IOWA L. REV. 1389, 1445 (1992).

78. *See, e.g.*, Board of Educ. v. Cooperman, 523 A.2d 655, 662 (N.J. 1987) (upholding state commissioner's decision to overrule local school boards' exclusion of students with AIDS); District 27 Community Sch. Bd. v. Board of Educ., 502 N.Y.S.2d 325, 341-42 (N.Y. 1986) (holding that New York Board of Education had the right not to exclude HIV infected children from regular classrooms). *See also* Frederick A.O. Schwarz, Jr. & Frederick P. Schaffer, *AIDS in the Classroom*, 14 HOFSTRA L. REV. 163 (1985)

took seriously the need to protect students with AIDS and respected the concern for their privacy in pursuing education.[79]

In addition to these achievements which have benefited children as well as adolescents, adolescents particularly have benefited from changes in sex education curriculum. Historically, in terms of determining the particular content of education, adolescents have had no legal influence: courts leave the substance of education to school officials. With minor exceptions,[80] courts entrust school officials with the power to determine the content of sex education classes.[81] In addition,

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(discussing the *District 27* case and its implications in the education setting and authored by the attorneys representing the Board of Education).

79. A student's right to privacy derives from statutory and constitutional grounds. For legislative provisions, see the Family Education Rights and Privacy Act (FERPA), passed in August, 1974, as an amendment to the Omnibus Education Bill, 20 U.S.C. § 1232(g) (1995), and privacy provisions within the 1978 General Educational Provisions Act (GEPA), 20 U.S.C. § 1232(h) (1995), and the Education of All Handicapped Children Act of 1975 (EAHCA), 20 U.S.C. §§ 1414-20 (1995).

The extent to which these statutes explicitly protect adolescents, however, is questionable. For example, the FERPA grants parental power; adolescents only benefit through parents or if they are 18 years of age. 20 U.S.C. § 1232g (1995). For constitutional analyses, see Child v. Spillane, 875 F.2d 314, 314 (4th Cir. 1989) (affirming a student's constitutional right to privacy in school records).

The need for vigilant efforts to maintain privacy is underscored by cases in which privacy was not protected. Ryan White's case from Kokomo, Indiana accurately reflects the hazard of disclosure and difficulties that ensue. *See* James Barron, *AIDS Sufferer's Return to Classes is Cut Short*, N.Y. TIMES, Feb. 22, 1986, at A6; *Indiana Judge Allows AIDS Victim Back in School*, N.Y. TIMES, Apr. 11, 1986, at A14. The more notorious case, though, is that of three brothers from Arcadia, Florida. In that instance, their home was intentionally set on fire, and the residents forced the family out of the community. *See Family in AIDS Case Quits Florida Town After House Burns*, N.Y. TIMES, Aug. 30, 1987, at A1; JON NORDHEIMER, *To Neighbors of Shunned Family, AIDS Fear Outweighs Sympathy*, N.Y. TIMES, Aug. 31, 1987, at A1.

80. Courts increasingly invalidate efforts by school officials to promote only one viewpoint and attempts to exclude controversial matters from school curricula. Board of Educ. v. Sobol, 613 N.Y.S.2d 792, 795 (N.Y. Spec. Term 1993) (ruling that school board resolution, requiring all AIDS prevention education to devote "substantially" more time and attention to abstinence than to other methods of prevention, was violative of state regulations that protect academic freedom and state power to protect health by giving students accurate and effective health education).

81. The general rule is that school officials have almost unlimited discretionary authority in controlling courses and materials in the curriculum. *See* James A. Whitson, *Sexuality and Censorship in the Curriculum: Beyond Formalistic Legal Analysis, in* SEXUALITY AND THE CURRICULUM: THE POLITICS AND PRACTICES OF SEXUALITY EDUCATION 59, 64 (James T. Sears ed., 1992) (further noting that courts upholding school officials power to control curriculum includes "censorship authority with which the judges personally might disagree"). Courts have generally supported state and local school authorities in cases dealing with sex education programs. *See, e.g.*, Mercer v. Michigan State Bd. of Educ., 379 F. Supp. 580, 587 (E.D. Mich.) *aff'd mem.*, 419 U.S. 1081 (1974) (dismissing claim by a teacher and physician who argued that state law prohibiting instruction on birth control in the public school was unconstitutional);

school officials have considerable discretion to regulate extra-curricular activities, including prohibiting behavior which could be construed as (improperly) sexual in nature.[82]

Given the general lack of students' rights,[83] surprisingly, for the first time in history, schools are publicly discussing the long taboo topic of sexuality. Indeed, schools are addressing sexual topics at levels of specificity and at early ages considered inappropriate only a generation ago. These developments toward providing youth with more appropriate sex education are nothing short of phenomenal.[84] The remarkable nature of these developments reach even new dimensions when juxtaposed against the previous failure to recognize adolescent sexuality.[85] Yet, the veil of sexual silence has not begun to lift because of a legal revolution in adolescents' rights. Instead, the transformation has occurred because the AIDS crisis has legitimized the discussion of topics which school districts historically ignored.

Smith v. Ricci, 446 A.2d 501, 508 (N.J.) (upholding regulation by State Board of Education requiring local districts to provide a family-life education program, including sex education), *appeal denied*, 459 U.S. 962, 962 (1982); Ware v. Valley Stream H.S. Dist., 545 N.Y.S.2d 316, 320 (N.Y. App. Div. 1989) (upholding state commissioner's requirement that all elementary and secondary students receive education on AIDS).

82. The Supreme Court validated this general rule in 1988. *See* Hazelwood Sch. Dist. v. Kuhlmeier, 484 U.S. 260, 276 (1988) (upholding a high school principal's decision to prevent publication of portions of the school newspaper); *see also* Bethel Sch. Dist. No. 403 v. Fraser, 478 U.S. 675, 686 (1986) (allowing school to regulate sexually explicit language through its "disruptive conduct rule").

83. *See, e.g.*, Vernonia Sch. Dist. v. Acton, 115 S. Ct. 2386, 2397 (1995) (allowing random, suspicionless drug tests because students were high school athletes); Tinker v. Des Moines Indep. Community Sch. Dist., 393 U.S. 503, 513-14 (1969) (allowing students to wear black armbands as a First Amendment protected political process, but noting that students' First Amendment protections are not coterminous with those of adults).

84. For a brief history of sex education, see JOHN D'EMILIO & ESTELLE B. FREEDMAN, INTIMATE MATTERS: A HISTORY OF SEXUALITY IN AMERICA (1988).

85. *See generally* FLOYD M. MARTINSON, THE SEXUAL LIFE OF CHILDREN (1994). Five years into the HIV-AIDS epidemic, "over half of the states have mandated HIV-AIDS education in their schools and most others strongly recommend it." Jonathan G. Silin, *School-Based HIV/AIDS Education, in* SEXUALITY AND THE CURRICULUM: THE POLITICS AND PRACTICES OF SEXUALITY EDUCATION 267, 267 (James T. Sears ed., 1992). Just as remarkable are the results of national polls revealing "that an overwhelming majority of Americans—themselves ill-informed about the topic—favor sexuality education, including AIDS education endorsing the value of condoms for prevention . . . ." James T. Sears, *Dilemmas and Possibilities of Sexuality Education: Reproducing the Body Politic, in* SEXUALITY AND THE CURRICULUM: THE POLITICS AND PRACTICES OF SEXUALITY EDUCATION 7, 7 (James T. Sears ed., 1992) [hereinafter Sears, *Dilemmas and Possibilities*]. Indeed, "three-fourths favor integrating sexuality education into the elementary school curriculum." *Id. See also* Jeanne Brooks-Gunn & Frank Furstenberg, *Adolescent Sexual Behavior*, 44 AM. PSYCHOLOGIST 249, 255 (1989) (citing Harris poll indicating that virtually all parents want AIDS education in the schools).

Despite noticeable progress in sex education, these controversial reforms remain largely half-hearted and inadequate, if not misguided. Although revolutionary, it would be naive and erroneous to equate progress with success. The content of sex education classes remains limited in scope: these classes tend to avoid discussions of explicit sexual practices and controversial moral issues.[86] Also, programs tend to reach adolescents at points which are admittedly too late,[87] deny access to preventive measures,[88] and ignore the experiences of adolescents who do not fit predetermined profiles of normalcy.[89] Similarly, it seems that some schools which had made considerable progress are now retreating.[90]

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86. Reviews of programs consistently find that "topics least discussed are homosexuality, birth control, abortion, and masturbation and other safer sex practices." Sears, *Dilemmas and Possibilities*, *supra* note 85, at 9. The most common topics are "anatomy and physiology, sexuality transmitted diseases, and sexual decision making (issues relating to dating, marriage, and parenthood) with particular emphasis on abstinence." *Id.* This results in a hidden curriculum, which reinforces "proper" sexuality; one which is adult and which has grave consequences for those adolescents who play with fire. Silin, *supra* note 85, at 268 (arguing that sexuality education and values clarification classes aim to persuade the student to adopt the adult perspective of saying no to sexual activity).

87. Research indicates that adolescents do not receive sex education until after they have already initiated sexual activity. DECADE OF DENIAL, *supra* note 64, at 78-79. Although timing of the initiation into sexual activity varies by demographics, the trend is consistent. *Id.* In urban samples, for example, research reveals that, by ninth-grade, over 90% of the boys and 50% of the girls were sexually active. Laurie S. Zabin et al., *Evaluation of a Pregnancy Prevention Program for Urban Teenagers*, 18 FAM. PLAN. PERSP. 119, 121-23 (1986) (study of nearly 1700 inner-city students). In rural areas, research reveals that, in eighth grade, nearly two-thirds of the boys and four out of ten girls had engaged in sexual intercourse. Cheryl S. Alexander et al., *Early Sexual Activity Among Adolescents in Small Towns and Rural Areas: Race and Gender Patterns*, 21 FAM. PLAN. PERSP. 261, 261-66 (1989) (study of 758 eighth-graders from three rural counties). *See also* Sandra L. Hofferth et al., *Premarital Sexual Activity Among U.S. Teenage Women Over the Past Three Decades*, 19 FAM. PLAN. PERSP. 46, 49 (1987) (discussing a National Survey of Family Growth which reported that 23.1% of women stated that they had had intercourse by their 16th birthday, and 4% stated they had intercourse by their 14th birthday).

88. The most controversial preventive measure has been access to condoms. *See infra* note 92.

89. The unfortunate result is that the experiences of minorities are ignored. *See, e.g.*, Janie V. Ward & Jill M. Taylor, *Sexuality Education for Immigrant and Minority Students*, *in* SEXUALITY AND THE CURRICULUM: THE POLITICS AND PRACTICES OF SEXUALITY EDUCATION 183, 183-98 (James T. Sears ed., 1992) (arguing that sexuality education fails to serve the needs of minorities and offering suggestions for reform).

90. *See New York's Watered-Down AIDS Curriculum Doesn't Please Critics*, 10 AIDS POL'Y & L. 9, 10 (1995) (citing reaction that the new curriculum "was one more step toward the dismantling of AIDS education in New York" and noting the power of the new school board which ousted former school Chancellor Joseph A. Fernandez, a strong supporter of progressive sex education).

In the context of education, then, it is critical to recognize the immense power of school officials.[91] Progress in recognizing adolescents' needs has resulted mainly from the work of activist school officials combating parental and community sentiments.[92]

91. *See, e.g.*, Levesque, *International Children's Rights*, *supra* note 18, at 208 (noting that "[m]uch like the good-faith parental standard, the Court also has adopted a differential approach to determinations of the rights of children by school administrators" and that "discretion is left to [those] acting *parens patriae* and, barring the extreme of abuse and neglect, no one is in the position to second guess such discretion").

92. *See supra* notes 78-79 and accompanying text. In general, courts remain sympathetic to parents' claims that they have a constitutional right to exclude their children from being exposed in school to materials the parents find offensive. The primary example of parental activism has been the increased litigation resulting from efforts to distribute condoms in schools. The general result of this challenge has been to give veto power to parents. *See, e.g.*, Alfonso v. Fernandez, 606 N.Y.S.2d 259, 268 (N.Y. App. Div. 1993) (finding parental involvement provisions to be a prerequisite to a constitutionally valid condom distribution program); *see also* Larry Witham, *Lawsuits Grow as Schools Pass Out Condoms*, WASH. TIMES, May 24, 1992, at A3 (discussing the controversy over school distribution of condoms).

It is important to note, however, that communities differ dramatically in their acceptance of activist methods. *See* Henry Chu, *Free Condoms Now Just a Fact of Life at High Schools*, L.A. TIMES, July 6, 1993, at B1 (noting prevalence of condom distribution in L.A. schools); Anna Quindlen, *Public and Private Parental Rites*, N.Y. TIMES, Sept. 25, 1991, at A23 (condemning opposition to school programs which make condoms available to students); *see generally* SARAH E. SAMUELS & MARK D. SMITH, CONDOMS IN THE SCHOOLS 1-25 (1993) (commenting on several surveys regarding condom availability programs); Karl J. Sanders, Comment, *Kids and Condoms: Constitutional Challenges to the Distribution of Condoms in Public Schools*, 61 U. CIN. L. REV. 1479 (1993) (discussing the viability of future challenges to the distribution of condoms in public schools).

Another general rule is that courts have limited power to combat strong community sentiments and foster social change. *See generally* GERALD N. ROSENBERG, HOLLOW HOPE: CAN COURTS BRING ABOUT SOCIAL CHANGE? (1991) (discussing whether and under what conditions courts can produce significant social reform in the context of civil rights and women's rights). The limited role of the courts in the context of HIV-AIDS and students is best seen in the relative inability of courts to combat discriminatory behavior against infected students. *See supra* note 78. As it stands, the law has the potential to reduce stigmatizing effects in two ways. First, it can target the stigma by offering recourse against illegal discrimination. Second, it may do so by limiting who gains access to HIV-related information. Both of these approaches are fraught with limitations and loopholes. For example, legal remedies may be inadequate to protect against discrimination because the harmful effects of such discrimination must be shown before a court will act. *See supra* notes 77 and 79 and accompanying text. Likewise, litigation takes a long time, is expensive and stressful, and forces the disclosure of information about the litigants. *But see* Robert Roden, Comment, *Educating Through the Law: The Los Angeles AIDS Discrimination Ordinance*, 33 UCLA L. REV. 1410, 1429-40 (1986) (examining the nation's first AIDS anti-discrimination ordinance and proposing that such efforts are effective in transforming community perceptions).

B. Adolescents' Position in Health Settings

In addition to the legal issues involving schools, the law also affects an adolescent's position in the health field. The primary and most controversial issue in health settings has been whether adolescents should have the right, independent of parental or other outside interference, to consent to be tested.[93] The law generally requires parental consent when health care is provided to minor children.[94] The epidemic, however, reminds us that this basic requirement has numerous exceptions.[95] These exceptions are directly relevant in determining the extent to which adolescents, who are minors, can consent to their own HIV testing.

In certain specific circumstances, states offer exceptions to a minor's inability to consent to medical services.[96] States are increasingly adding HIV testing to the list of exceptions. Some states explicitly authorize minors to consent to HIV testing.[97] Other states take the

93. Despite diverse health needs of adolescents in terms of the HIV epidemic, reform has focused on minors' consent to testing. *See, e.g.*, Mary J. Rotheram-Borus & Cheryl Koopman, *Adolescents, in* CHILDREN AND AIDS 45, 48-52 (Margaret L. Stuber ed., 1992).

94. The Supreme Court has struggled with the need to balance parental rights and minors' rights in the area of minors seeking abortions without parental consent. *See* Hodgson v. Minnesota, 497 U.S. 417, 457 (1990) (holding two-parent notification constitutional when a judicial bypass of the notification accompanies the requirement); Ohio v. Akron Ctr. for Reprod. Health, 497 U.S. 502, 520 (1990) (holding parental/judicial consent requirement constitutional). Bellotti v. Baird, 443 U.S. 622, 634 (1979), enumerated the reasons for limiting the rights of minors: the peculiar vulnerability of children; the inability of children to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing. These cases, however, do clearly find that the state may not require parental consent without some type of alternative for the minor seeking an abortion.

95. *See, e.g.*, GITTLER, *supra* note 13, at 4 (recognizing four exceptions to parental consent including emergency situations, specific health problems, exceptions related to the status of certain minors, and exceptions arising out of the jurisdiction of juvenile and family courts).

96. *See generally id.* (recognizing an exception to parental consent if the minor has a specific health problem).

97. ARIZ. REV. STAT. ANN. §§ 36-661(2) and 36-663 (1995) (written informed consent required for HIV test and capacity to consent determined without regard to age); CAL. HEALTH & SAFETY CODE §§ 199.22 and 199.27(a) (West Supp. 1995) (written consent needed for HIV test; minors under age 12 deemed incompetent to consent); COLO. REV. STAT. ANN. § 25-4-1405(6) (West Supp. 1995) (minor may be examined for HIV infection without parental consent); DEL. CODE ANN. tit. 16, § 1202(f) (1994) (minors 12 and older may give consent for HIV testing); FLA. STAT. ANN. § 384.30 (West Supp. 1995) (consent of a parent or guardian not required for examination of a sexually transmitted disease); IOWA CODE ANN. § 141.22(6) (West Supp. 1995) (stating that a minor may apply and give consent for screening for AIDS); MICH. COMP. LAWS ANN. § 333.5127 (West Supp. 1995) (stating that a minor may consent to medical care, treatment or services for HIV); MONT. CODE ANN. § 50-16-1007(9) (1993) (stating that

capacity to consent further and directly authorize minors to consent to treatment for AIDS or HIV infection.[98] This progress recognizes the necessity of reaching adolescents.

Although the progress is remarkable in its attempt to consider the needs of adolescents, the effort arguably remains largely symbolic. Prior to these express allowances, adolescents had several ways to circumvent the existing restrictions. Indeed, most states allow minors to be tested for STDs and, in other provisions, define HIV as an STD.[99] In instances in which there are no direct provisions allowing

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minors may consent for HIV-related test without parental consent); N.M. STAT. ANN. § 24-2B-3 (1994) (stating that minor has capacity to give consent for HIV test); N.Y. PUB. HEALTH LAW §§ 2780(5) and 2781(1) (McKinney Supp. 1995) (written informed consent required; capacity to consent determined without regard to age); N.C. GEN. STAT. § 130A-148(h) (1994) (unemancipated minor may be tested for HIV without parental consent when parent or guardian has refused to consent to such testing and there is reasonable suspicion that the minor has AIDS or HIV); OHIO REV. CODE ANN. § 3701.242(B) (Baldwin Supp. 1995) (minor may give consent for an HIV test); WIS. STAT. ANN. § 252.15(2)(4)(a) (West Supp. 1994) (consent of minor age 14 or older required for HIV test).

98. COLO. REV. STAT. ANN § 25-4-1405(6) (West Supp. 1995) (stating that minor may be examined and treated for HIV infection without consent of a parent); IOWA CODE ANN. § 141.22(6) (West Supp. 1991) (stating that minor may apply and give consent for screening or treatment for AIDS); MICH. COMP. LAWS ANN. § 333.5127 (West Supp. 1995) (stating that minor may consent to medical or surgical care, treatment, or services for HIV).

99. They do so by allowing minors to obtain treatment for certain sexually transmitted diseases and classify HIV as a sexually transmitted disease. *See, e.g.*, ALA. ADMIN. CODE r. 420-4-1-.03 (Supp. 1995) (classifying HIV as an STD); ALA. CODE § 22-11A-19 (Supp. 1994) (authorizing minors to consent to STD care); FLA. STAT. ANN. § 384.23 (West 1993) (including HIV in the definition of STDs); FLA. STAT. ANN. § 384.30 (West 1993) (authorizing minors to consent to confidential treatment for STDs); ILL. COMP. STAT. ANN. ch. 410, § 210/4-5 (West 1995) (permitting minors age 12 or older to consent to venereal disease (VD) diagnosis and treatment); ILL. COMP. STAT. ANN. ch. 410, § 325/3 (West 1995) (classifying HIV as an STD); KY. REV. STAT. ANN. § 214.185(2) (Michie Supp. 1994) (giving minors ability to consent to diagnosis and treatment of VD); KY. REV. STAT. ANN. § 214.410(2) (Michie Supp. 1994) (defining STD to include AIDS and HIV); MONT. CODE. ANN. § 50-18-101 (1993) (defining HIV as an STD); MONT. CODE ANN. § 50-16-1007(9) (1993) (authorizing minors to consent to care for STD); WASH. REV. CODE ANN. § 70.24.017(13) (West 1995) (defining STD to include HIV and AIDS); WASH. REV. CODE ANN. § 70.24.110 (West 1995) (authorizing minors age 14 and older to consent to diagnosis and treatment of STDs); WYO. STAT. ANN. § 35-4-130(b) (Michie 1994) (including AIDS as a reportable STD); WYO. STAT. ANN. § 35-4-131 (Michie 1994) (authorizing minors to consent to examination and treatment for VD).

Likewise, other states simply give authority to minors to seek treatment for sexually transmitted diseases. *See, e.g.*, MISS. CODE. ANN. § 41-41-13 (1995) (permitting minors to obtain treatment for VD without parental consent); NEV. REV. STAT. ANN. § 129.060 (Michie 1993) (authorizing minors to consent to examination and treatment for STD); S.C. CODE ANN. § 20-7-290 (Law. Co-op. Supp. 1994) (permitting minors to receive, without parental consent, health services the provider deems necessary to maintain the well-being of the minor); TENN. CODE. ANN. § 68-10-104(c) (1992) (authorizing minors

adolescents to be tested, an adolescent's special status often provides an exception.[100] For example, adolescents living apart from their parents may give consent regarding their own health care, a liberty that emancipated and independent minors traditionally have enjoyed.[101] Even adolescents still living with their parents may consent to their own care through the court-conceived "mature" minor doctrine.[102] Likewise, juvenile courts and child welfare agency personnel hold considerable power to consent to medical services for children under their care.[103]

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to be examined, diagnosed, and treated for STD without parental consent); VT. STAT. ANN. tit. 18, § 4226 (1983) (authorizing minors age 12 and older to consent to VD treatment).

100. For example, the mental health setting already recognizes that parental consent is often precluded where minors need mental health assistance, especially with at-risk minors. *See* John M. Shields & Alf Johnson, *Collision Between Law and Ethics: Consent for Treatment with Adolescents*, 20 BULL. AM. ACAD. PSYCHIATRY & L. 309, 309 (1992).

101. Usual indicia of emancipation and independence are marriage, induction into the armed services, living in a home away from parents, and economic independence. These principles have a long history. *See* Francis C. Cady, *Emancipation of Minors*, 12 CONN. L. REV. 62, 62-91 (1979); Sanford N. Katz et al., *Emancipating Our Children—Coming of Legal Age in America*, 7 FAM. L.Q. 211, 211-30 (1973); Shields & Johnson, *supra* note 100, at 315. In examining these issues, it is important to note that the minor's capacity to make decisions is not the guiding principle, it is the independence from parents which determines emancipation. *See generally* GITTLER, *supra* note 13. For a recent review of emancipation statutes with specific references to health care issues, *see id.* at 4-7. For an empirical analysis of emancipation, see Carol Sanger & Eleanor Willemsen, *Minor Changes: Emancipating Children in Modern Times*, 25 U. MICH. J.L. REF. 239 (1992).

102. This exception rejects the presumption of adolescent incompetency and the lack of capacity due to chronological age. Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 715-19 (1993). The exception allows for individualized determinations of the actual decision-making capacity of minors. *Id.* The most notable application has been in the context of minors' rights to family planning services and abortions. *See, e.g.*, Planned Parenthood v. Casey, 505 U.S. 833 (1992) (upholding parental notification with judicial bypass).

103. States wield considerable power to intervene into family relations through child abuse and neglect laws, most of which include the failure to provide medical/health care as neglect. *See, e.g.*, CAL. PENAL CODE § 11165.2(b) (West Supp. 1995) (defining general neglect as including negligent failure of the person having custody of the child to provide medical care). A critical aspect regarding intervention is that, once the child welfare system has intervened, the state is obligated to provide care for the minor. CAL. WELF. & INST. CODE §§ 362, 369 (West Supp. 1995) (providing that when a minor is adjudged dependent, the court may make any reasonable order for the care of the child). This protection has received the Supreme Court's imprimatur. *But see* DeShaney v. Winnebago County Dep't of Soc. Serv., 489 U.S. 189 (1989) (holding that while due process protects children deprived of liberty by state actors, the state had no affirmative, constitutional duty to protect children, or any citizens, from harm by private actors).

Given the extensive nature of the laws which allow minors to be tested, the concern for and focus on creating new laws that would allow adolescents to be tested would seem unwarranted. A closer look, however, reveals a host of barriers. Surprisingly, approximately half of adolescents who summon up the courage to be tested for HIV do not return for their results.[104]

A major reason for the failure of adolescents to return for their HIV results has been attributed to the lack of confidentiality.[105] Although this undoubtedly may be true, the most formidable barriers seem to be more practical in nature. For example, the cost of testing remains prohibitive for adolescents.[106] In addition, once tested, there is not necessarily effective treatment available.[107] Nor is there necessarily an assurance that the testee will learn about or obtain condoms in order to

104. Novello, *supra* note 28, at 5M (noting that 47% of adolescents do not return for results).

105. *See, e.g.*, Lawrence S. Freidman et al., *Survey of Attitudes, Knowledge, and Behavior Related to HIV Testing of Adolescents and Young Adults Enrolled in Alcohol and Drug Treatment*, 14 J. ADOLESCENT HEALTH 442, 444 (1993) (noting that 84% of subjects would agree to HIV testing if they were assured anonymity and confidentiality). Protection of confidentiality is a critical element in adolescents' willingness to seek health care for HIV. *Id.* A surprisingly high number of at-risk adolescents would agree to HIV testing if the test were anonymous and confidential. *Id.* Adolescents generally lack the level of privacy that is available to adults. Gary B. Melton, *Minors and Privacy: Are Legal and Psychological Concepts Compatible?*, 62 NEB. L. REV. 455, 455-93 (1983). Parents have control over their child's medical and educational records. *Id.* at 462. Likewise, the state, such as school or mental health professionals, often infringes on the privacy of adolescents' associations and personal effects. *Id.* at 487-88. *See also* IOWA CODE ANN. § 141.22(6) (West 1989 & Supp. 1995) (stating that a minor may apply and give consent for screening for AIDS and providing for parental notification in cases of positive HIV test results).

106. An AIDS test costs approximately $35, in addition to the cost of a patient's visit to the doctor. *Pre-Marital AIDS, Syphilis Testing Proposed*, DAYTON DAILY NEWS, Nov. 2, 1995, at 5B. *See, e.g.*, OHIO REV. CODE ANN. § 3701.242(B) (Baldwin 1995) (stating that a minor may give consent for an HIV test, but parents are not liable for costs of test provided without their consent).

107. Rotheram-Borus & Koopman, *supra* note 93, at 50-52 (noting the same and detailing considerations for not testing adolescents, such as the possibility of increasing suicide risks and increasing the chances that youths will not receive services). The unavailability of skilled health care providers continues to exclude teenagers from services. Unfortunately, the failure runs throughout all forms of care systems. *See generally* Roger J.R. Levesque, *The Failures of Foster Care Reform: Revolutionizing the Most Radical Blueprint*, 6 MD. J. CONTEMP. LEGAL ISSUES 1, 20-22 (1995); Samuel P. Whalen & Joan R. Wynn, *Enhancing Primary Services for Youth Through an Infrastructure of Social Services*, 10 J. ADOLESCENT RES. 88, 94 (1995) (noting that social services remain an underdeveloped resource); Stephen C. Young et al., *An Overview of Issues in Research on Consumer Satisfaction with Child and Adolescent Mental Health Services*, 4 J. CHILD & FAM. STUD. 219, 229-31 (1995) (illustrating the consumer dissatisfaction with adolescent health services).

prevent further infection of others.[108] Similarly, the youths who would engage in high-risk behaviors and endanger their own lives will likely not altruistically change their behaviors for others.[109] Simply put, the right to testing is rather hollow without the concomitant right to services and treatment.[110] Thus, instead of focusing on issues of testing, policymakers would benefit youth more by focusing on alternatives to caring for HIV-infected youth.

IV. TAKING ADOLESCENT JURISPRUDENCE SERIOUSLY

At a time when HIV-AIDS has advanced into the adolescent population,[111] the HIV-AIDS situation presents unique and important concerns. Despite controversies, the primary objective of policymakers' efforts must focus on preventing further acquisition of infections and ameliorating the conditions of those dealing with the affliction. To achieve this end, society, policymakers, and commentators must seriously reexamine the peculiar effects of HIV-AIDS on adolescents in light of the substantive features of a jurisprudence tailored to adolescents. Although the task remains rather formidable, reasonable steps toward further recognizing the legal personhood of adolescents could

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108. *See supra* note 92 (discussing condom distribution in schools).

109. Rotheram-Borus & Koopman, *supra* note 93, at 48.

> Those youths who are most likely to be seropositive due to their high-risk behaviors often have other characteristics that undermine the benefits of informing them of their serostatus. A decision to initiate testing assumes that if persons know their serostatus they will . . . be motivated to change their high-risk behaviors. Only under these circumstances is testing useful. Developmentally, adolescents are not characterized by such . . . behavior.

Id. Other research also indicates that wishful thinking and attempts to forget the disease are the most common way adolescents cope with sexually transmitted illnesses despite the acknowledgment that it is the least helpful mechanism. *See, e.g.*, Susan L. Rosenthal, et al., *Strategies for Coping with Sexually Transmitted Diseases by Adolescent Females*, 30 ADOLESCENCE 655, 663 (1995).

110. There is no general right to treatment. The major exception, of course, is if the adolescent is in the care of the state. *See supra* note 103; *see also* Levesque & Tomkins, *supra* note 19, at 96 n.33 (citing cases upholding the right to treatment for juveniles). This article also examines states' statutory obligations to provide treatment services as part of family preservation efforts. *Id.* at 106-16. *See generally* William A. Bradford, Jr. et al., *The AIDS Epidemic and Health Care Reform*, 27 J. MARSHALL L. REV. 279 (1994) (examining the issues associated with providing medical treatment for people with AIDS, including the demographics of HIV infection, possible protections under ADA, health care access with private payers, and the burden on Medicaid from uninsured HIV patients); Roy G. Spece, Jr., *AIDS: Due Process, Equal Protection, and the Right to Treatment*, 4 ISSUES L. & MED. 283 (1988) (advocating a taxonomy of equal protection and due process claims designed to promote a right to treatment, but which relate to basic necessities generally and medical treatment specifically, while characterizing claims by AIDS patients as general constitutional claims protecting everyone).

111. *See supra* part II.A.

be taken. These steps are only the beginning of a much needed adolescent jurisprudence.

This Part first advocates the removal of adolescence from the prevailing "rights-talk."[112] Next, it argues that adolescent jurisprudence should reflect adolescents' real-life concerns.[113] This Part concludes by asserting that adolescent jurisprudence must make more effective use of existing mandates.[114]

A. Removing Adolescence from the Prevailing "Rights-Talk"

A primary task of adolescent jurisprudence would be to remove adolescence from the prevailing "rights-talk,"[115] simply because adolescents ill-fit the dominant conception of rights.[116] Current rights-based systems are rooted in individualistic biases of the law and tend to presume individual autonomy and direct relationships with the state.[117] Rather than being legally autonomous agents, adolescents depend on their parents and state officials.[118] Current adolescents' rights-talk fails to properly address adolescent issues because it focuses on liberating adolescents from the hold of parents and states.[119]

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112. *See infra* part IV.A.

113. *See infra* part IV.B.

114. *See infra* part IV.C.

115. For an analysis of current rights discourse, see MARY A. GLENDON, RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE (1991).

116. Rights-talk for adolescents has proven to be both attractive and troublesome. *See* Levesque, *International Children's Rights, supra* note 18, at 228-32 (proposing that a critical factor leading to the demise of reforms aimed at assisting youth has been the success of the children's rights movement). For an informative critique of rights, see Linda C. McClain, *Rights and Irresponsibility*, 43 DUKE L.J. 989 (1994). For a thoughtful response to critics, see Cass R. Sunstein, *Rights and Their Critics*, 70 NOTRE DAME L. REV. 727 (1995).

117. This is a primary goal of the international children's rights movement: connecting the rights of children to the state, while still maintaining parental rights. *See* Levesque, *International Children's Rights, supra* note 18, at 239-40.

> Although the Convention [on the Rights of the Child] explicitly states that parental rights will be respected, asserting that their children have State-guaranteed rights necessarily weakens the parental role. Under the Convention, the United States' minimalist intervention approach would be replaced by a need for greater State supervision and the inevitable pressure to intervene in family matters.

Id. (footnote omitted).

118. *See, e.g.*, Levesque, *International Children's Rights, supra* note 18, at 208. "To summarize briefly the status of children's rights in the U.S., it seems fair to say what has emerged in the Court's treatment of children is a good faith parental or state official standard." *Id.*

119. *See, e.g.*, Martha Minow, *The Role of Families in Medical Decisions*, 1991 UTAH L. REV. 1, 23-24 n.108 (arguing for allowing a minor to make the decision for an abortion without parental or judicial intervention).

Thus, adolescent jurisprudence would profit from recognizing the vulnerability of adolescents and the role of parents and the state in ensuring that adolescents' rights are protected. The recognition of vulnerability, however, does not translate into placing emphasis on parental and states' rights. Instead, the recognition means that adolescents' needs and concerns are of paramount importance.[120]

B. Policies Should Reflect Adolescents' Concerns

Adolescent jurisprudence would encourage policies guided by adolescents' concerns. To do so, the approach necessarily would heed, first and foremost, the data reported by adolescents themselves. In terms of HIV-AIDS policies, efforts would focus more on the real world of adolescents.

In focusing on the real world of adolescents, policymakers must acknowledge research results indicating that contemporary adolescents in the United States begin sexual relations in their teens, and that a substantial number of youth begin having intercourse even before their teens.[121] This recognition would be highly controversial, but not improbable.[122] In the context of a deadly, sexually transmitted epidemic, policymakers can ill-afford to be side-tracked by wishful thinking that adolescents will follow suggested patterns of behavior.[123]

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120. Arguably, this is already the law. States have now universally adopted best interests standards to deal with children's issues. *See e.g.*, Wanda Uhlich, Note, *Best Interests of the Child: Considering the Effects of Passive Smoking When Making a Child Custody Adjudication*, 68 N.D. L. REV. 727, 755 (1992). Despite that recognition, current laws, state agencies, and courts disagree on the proper role of parents, society, and children in determining the substance of the child's interests. Levesque, *International Children's Rights, supra* note 18, at 193-94. A fruitful starting point for rethinking approaches would be to take seriously evolving international standards of children's rights. For example, the Convention of the Rights of the Child, which has been almost universally ratified by the world's nations, uses similar language. *See generally* Levesque, *International Children's Rights, supra* note 18, at 213-14 (providing citations to the substantive rights of children as identified by the Convention on the Rights of the Child, U.N. Doc. A/Res/44/23 (1989)).

121. *See supra* note 46.

122. The feasibility is suggested by the rapid transformation of educational systems. This transformation exemplifies the high number of parents committed to having explicit school based AIDS education and prevention programs, the activist role of educators, and the remarkable progress toward recognizing adolescents' needs. *See supra* note 81 and accompanying text.

123. The first congressional meetings to address adolescents and AIDS are illustrative. The response was simple. Then Surgeon General C. Everett Koop placed emphasis on encouraging teen abstinence from sex. *AIDS and Teenagers—1987 Congressional Hearings, supra* note 13, at 9-10 (statement of Surgeon General C. Everett Koop). This behavior would be encouraged through specially designed sex education courses that would "raise a whole generation of adolescents who will be abstinent until monogamous" and would "influence teens to become the proper kind of

In addition to acknowledging when adolescents begin having sex, adolescent jurisprudence would benefit from recognizing that the adolescent population is heterogeneous, comprised of adolescents from different racial, ethnic, and economic backgrounds.[124] This recognition would reflect the pluralistic nature of beliefs held by adolescents and the diversity of behaviors in which they engage. For example, recognizing diversity means offering intervention programs that reflect the diversity rather than attempting to impose a particular set of values on adolescents. Despite continued attempts to homogenize the manner used to address the HIV-AIDS epidemic,[125] research highlights the imprudence of believing that all adolescents share the same system of norms and values about sexual activity. Instead, adolescent jurisprudence would acknowledge that culturally specific concerns, beliefs and taboos, and language constraints influence individual behavior.[126] It would also be wise to recognize the "silent minorities," especially gay youth, who are at risk, but essentially ignored.[127]

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teens." *Id.* at 19 (statement of Surgeon General C. Everett Koop). The form of education that would lead to forming the "right kind of teens" was described by the Surgeon General as follows:

> We believe that: (1) the scope and content of AIDS education should be determined locally and should be consistent with parental values; (2) that information developed by the Federal government to educate young people about AIDS should encourage responsible sexual behavior—based on fidelity, commitment, and maturity, placing sexuality within the context of marriage; (3) any health information provided by the Federal government that might be used in schools should teach that children should not engage in sex before they are ready to marry.

Id. at 9-10 (statement of Surgeon General C. Everett Koop).

124. The transformations occurring in American cities on both coasts is a prime example. *See, e.g.*, Gary B. Melton, *Children, Families, and the Courts in the Twenty-First Century*, 66 S. CAL. L. REV. 1993, 2013-21 (1993) (detailing the rapid changes in ethnic diversity occurring in California).

125. The most prominent effort has been that of the school system. *See supra* note 78.

126. A good start would be to understand "adolescent language." For example, many adolescents interpret monogamy as one partner at a time, rather than one lifetime partner. FELISSA L. COHEN & JERRY D. DURHAM, WOMEN, CHILDREN AND HIV/AIDS 178 (1993).

127. Commentators have noted the tendency to ignore adolescent gay and bisexual males and have highlighted how current efforts to address the issue ironically nullify the potential for these youths "to form support networks needed to modify their behavior." Kevin Cranston, *MDiv, HIV Education for Gay, Lesbian, and Bisexual Youth: Personal Risk, Personal Power, and the Community of Conscience*, 22 J. HOMOSEXUALITY 247, 247 (1992). Several commentators, however, have recently described the need to address gay youths' situations. *See* Kelli K. Armstrong, *The Silent Minority Within a Minority: Focusing on the Needs of Gay Youth in Our Public Schools*, 24 GOLDEN GATE UNIV. L. REV. 67 (1994); Gilbert H. Herdt, *The Protection of Gay and Lesbian Youth*, 65 HARV. EDUC. REV. 315 (1995); Scott L. Hershberger & Anthony R. D'Augelli, *The*

In addition to recognizing the diversity of adolescents, adolescent jurisprudence must also recognize the diversity of situations in which adolescents find themselves. Regrettably, the reality of contemporary American society is that many young people live in situations which sometimes vary dramatically from the ideal family life epitomized by family policies.[128] Indeed, evidence indicates that those most at risk for HIV infection are those least buffered by a supportive family.[129] For example, abuse in the home continues to be an important moderating factor affecting increased risk-taking behaviors among adolescents, especially high risk behaviors such as drinking and sexual activity.[130]

The focus on overt abuses, however, should not detract attention from the continued decline in familial support systems.[131] Even families which are not marked by particularly abusive relations may place adolescents at risk. The situations in which young, gay males find themselves illustrates this problem.[132] For example, the acknowledgment of homosexuality often leads to family strife, including the rejection of adolescents due to their sexual orientation.[133] The effect of

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Impact of Victimization on the Mental Health and Suicidality of Lesbian, Gay, and Bisexual Youths, 31 DEVELOPMENTAL PSYCHOL. 65 (1995).

128. Despite the tenacity of the family ideal, few families conform. *See, e.g.*, Roger J.R. Levesque, *Targeting "Deadbeat" Dads: The Problem With the Direction of Welfare Reform*, 15 HAMLINE J. PUB. L. & POL'Y 1, 27 (1994).

> Despite the social and legal changes in conceptions of fatherhood and motherhood, there remains the ingrained notion of the nuclear family as the "family" prototype . . . . Despite commentators repeatedly noting that the notion of the norm as nuclear family should be debunked, the nuclear family constitutes a "reality" and forms the basis for [social] welfare policy.
>
> Because the legally constructed image of the family expresses what is appropriately considered family, it also constitutes the normal and defines the deviant . . . .
>
> Formal, legal, heterosexual marriage continues to dominate our discussions when we confront the possibilities of intimacy and family.

Id. (citations omitted).

129. *See supra* notes 63-66 and accompanying text.

130. Jeanne T. Hernandez et al., *The Effects of Child Abuse and Race on Risk-Taking in Male Adolescents*, 85 J. NAT'L MED. 593, 594-97 (1993).

131. JAN E. DIZARD & HOWARD GADLIN, THE MINIMAL FAMILY 172-73 (1990) (detailing increase in abuse, divorce, and adolescent problems in the 1980s). Also, families reported declining expectations of intimate family ties and reported that increasing perceptions of intimacy was threatening. *Id.* at 97.

132. Researchers report that many gay men acknowledge their homosexuality during adolescence and that gay and lesbian youth are "coming out" at an earlier age. *See* GILBERT HERDT & ANDREW BOXER, CHILDREN OF HORIZONS: HOW GAY AND LESBIAN TEENS ARE LEADING A NEW WAY OUT OF THE CLOSET 6 (1993).

133. For example, research indicated that approximately one-half of the parents of homosexual youth participating in the study rejected their children. Gary Remafedi,

rejection reverberates and often leads to situations in which high-risk sexual activities or substance abuse will likely occur.[134] The result is that young gay males are vulnerable to engaging in behavior which places them at risk for infection.

Given the important role of families in adolescents' lives, it is understandable that experts place much blame for the current HIV-AIDS epidemic on families.[135] Yet, even ideal families are not immune from placing adolescents at risk. The legal system's mythic presump-

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Male Homosexuality: The Adolescent's Perspective, 79 PEDIATRICS 326, 328 (1987). These youth have disproportionately high rates of multiple abuse histories, including neglect. MATTHEW P. MENDEL, THE MALE SURVIVOR: THE IMPACT OF SEXUAL ABUSE, 117-20 (1995) (briefly summarizing major studies noting same). Given the current state of knowledge, however, it would be important not to infer that abuse causes homosexuality. *See* Paul Cameron & Kirk Cameron, *Does Incest Cause Homosexuality*, 76 PSYCHOL. REP. 611, 616-17 (1995); Peter T. Dimock, *Adult Males Sexually Abused as Children*, 3 J. INTERPERSONAL VIOLENCE 203, 205 (1988); Lynda S. Doll et al., *Self-reported Childhood and Adolescent Sexual Abuse Among Adult Homosexual and Bisexual Men*, 16 CHILD ABUSE & NEGLECT 855, 861-63 (1992).

134. Mary J. Rotheram-Borus et al., *Prevalence, Course, and Predictors of Multiple Problem Behaviors Among Gay and Bisexual Male Adolescents*, 31 DEVELOPMENTAL PSYCHOL. 75, 81 (1995) (finding that stressful life events, especially coming out to family members and friends, lead gay youth to engage in high risk activities). This article also noted the "unexpected relation between sexual behavior and the other problem behaviors, emotional distress, and stress may indicate that gay youths may follow fundamentally different developmental pathways from heterosexual youths, particularly with respect to their sexual behavior." *Id.* at 83.

135. The series of hearings and reports of the Select Subcommittee on Children, Youth, and Families of the House of Representatives is illustrative. In its first hearing, the only point at which the subcommittee examined "causes," family breakdown was to blame. *See AIDS and Teenagers—1987 Congressional Hearings*, *supra* note 13, at 128 (statement of Clyde C. Holloway). "[T]he breakdown of the family in this country, in my opinion, has a great deal to do with all our problems with teenagers . . . this is a total breakdown in our environment today, and I blame it on the fact that we have no family life anymore in this country." *Id.* at 128-29 (statement of Clyde C. Holloway). *See also* the response by Dr. Mary-Ann Shafer:

> I have yet to see a teenager who, across the board, has had major problems where there's been an intact family and where there's a loving mother, a loving father and a basic economic support that they can lead an average kind of life. It's rare. Here and there we'll see problems but, in general, these individuals with strong families do function in general fairly well.

Id. at 129 (statement of Dr. Mary-Ann Shafer).

In other words, given an ideal situation, youth fare rather well. The 1990 hearings also reflect the focus on idealism and appropriate parental models. RISKY BUSINESS—1991 CONGRESSIONAL HEARINGS, *supra* note 48, at 120-21 (statement of Congressman Frank R. Wolf) (focusing on the need for parental leadership and the focus on abstinence).

In the Committee's final report, the majority did not focus on causes. The minority, however, focused its entire report on families. In the minority's view, "[t]he best way to guarantee that a child will not contract a STD, or AIDS . . . is to strengthen the family. To do less is to court failure." DECADE OF DENIAL—1992 CONGRESSIONAL HEARINGS, *supra* note 13, at 349-50.

tion that parents will act in the best interests of their children[136] runs counter to the experience of the mental health profession, which quite often sees parents making determinations based upon their own belief systems, preferences, and life-styles.[137] Similarly, the belief that parents guide their children's sexual activities persists, despite considerable evidence to the contrary.[138] Sex-talk still remains largely taboo in families.[139] However, even if families do discuss sexuality, research indicates that these discussions are not necessarily effective in influencing youths' risk behavior.[140]

In addition to recognizing the potential effects (and noneffects) of family life, adolescent jurisprudence would benefit from recognizing the limits of prevailing societal attitudes. A most pressing, yet ignored, area of intervention is the need for increased recognition of the various forms of sexual coercion.[141] The situation of sexual harassment in schools illustrates one example of this need. Despite numer-

136. Several have noted the current tendency of the legal system to view adolescents as part of an idealized middle-class model of the nuclear family, where parents ideally act in their children's best interests. *See supra* note 118.

137. Shields & Johnson, *supra* note 100, at 314.

138. *See, e.g.*, Brent B. Benda & Frederick A. DiBlasio, *An Integration of Theory: Adolescent Sexual Contacts*, 23 J. YOUTH & ADOLESCENCE 403 (1994); Jacqueline F. de Gaston et al., *A Closer Look at Adolescent Sexual Activity*, 24 J. YOUTH & ADOLESCENCE 465 (1995). The importance of peer influences is revealed in new research aimed at curbing high-risk sexual activity. *See, e.g.*, Michael R. Kauth et al., *HIV Sexual Risk Reduction Among College Women: Applying A Peer Influence Model*, 34 J. C. STUDENT DEV. 346 (1993); Robert W. Winslow et al., *Perceived Peer Norms, Casual Sex, and AIDS Risk Prevention*, 22 J. APPLIED SOC. PSYCHOL. 1809 (1992).

139. In the absence of widespread, effective sex education at home or in schools, the media has become the leading source of sex education in the United States today. At some level, though, this is a rather sad commentary, considering that American media is highly sexually suggestive and irresponsible. *See* MEDIA, CHILDREN, AND THE FAMILY: SOCIAL SCIENTIFIC, PSYCHODYNAMIC, AND CLINICAL PERSPECTIVES (Dolf Zillmann et al. eds., 1994); VICTOR C. STRASBURGER, ADOLESCENTS AND THE MEDIA: MEDICAL AND PSYCHOLOGICAL IMPACT 38-55 (1995).

140. "Fewer than half (47%) of sexually active teens surveyed reported having talked with their parents about sex and birth control." RISKY BUSINESS—1991 CONGRESSIONAL HEARINGS, *supra* note 48, at 6. Nearly 60% "of sexually active teens who have discussed both of these issues with their parents report consistent use of birth control . . . ." *Id.* That means, of course, that nearly half still do not protect themselves. Indeed, the result is but one example of a growing body of research indicating that, barring abuse or neglect, "the home environment has no lasting effects on [children's] psychological characteristics." Judith Rich Harris, *Where is the Child's Environment? A Group Socialization Theory of Development*, 102 PSYCHOL. REV. 458, 483 (1995). Although admittedly a broad conclusion, it does emphasize well the importance of peers and society in socializing the youngest members of society.

141. The appearance of AIDS as a national health emergency has started to revolutionize the media's approach to teen sexuality. *See* STRASBURGER, *supra* note 139, at 38-55; *see also* Gates, *supra* note 62 (detailing the response to a film depicting teenagers with AIDS).

ous applicable statutes[142] and the high prevalence of sexual harassment in schools,[143] relatively few complaints are ever filed; fewer cases are heard, and even fewer are found actionable. This massive nonenforcement of sexual harassment is complex and embedded within our social and legal structures.

The lack of legal remedies is arguably a minor part of the problem.[144] Primary among reasons for nonenforcement is the failure of victims and society to recognize sexual maltreatment,[145] particularly the

142. Students are legally protected against sexual harassment by several federal and state statutes. The events may be actionable as child abuse, sexual assault, rape, pornography, criminal or civil libel, slander or defamation of character. *See generally* Roger J.R. Levesque, *Prosecuting Sex Crimes Against Children: Time For "Outrageous" Proposals?*, 19 L. & PSYCHOL. REV. 59 (1995) (briefly detailing the history of the legal recognition of child sexual maltreatment and the legal system's response).

143. A recent poll found that 85% of girls and 76% of boys reported experiencing "unwanted and unwelcome sexual behavior that interferes with their lives." THE AMERICAN ASSOCIATION OF UNIVERSITY WOMEN EDUCATION FOUNDATION, HOSTILE HALLWAYS: THE AAUW SURVEY ON SEXUAL HARASSMENT IN AMERICA'S SCHOOLS 7 (1993).

144. There are, however, signs of change. *See, e.g.*, Stoneking v. Bradford Area Sch. Dist., 882 F.2d 720, 731 (3d Cir. 1989) (finding public school officials violated student's Fourth Amendment right to "liberty" when they failed to protect her from sexual abuse by school employees), *cert. denied*, 493 U.S. 1044 (1990). For other cases in which courts have held that students may sue school districts for failing to act when teachers have sexually harassed them, see K.L. v. Southeast Delco Sch. Dist., 828 F. Supp. 1192 (E.D. Pa. 1993); C.M. v. Southeast Delco Sch. Dist., 828 F. Supp. 1179 (E.D. Pa. 1993). *See generally* Steven F. Huefner, Note, *Affirmative Duties in the Public Schools After DeShaney*, 90 COLUM. L. REV. 1940, 1941 (1990) (arguing that because schools have significant control over the educational environment, they must "offer some protection of students' liberty interests"); JoAnn Strauss, *Peer Sexual Harassment of High School Students: A Reasonable Student Standard and an Affirmative Duty Imposed on Educational Institutions*, 10 L. & INEQ. J. 163 (1992) (examining high school sexual harassment litigation and calling for prevention of peer sexual harassment through education); Jessica Lynch, Note, *A Matter of Trust: Institutional Employer Liability for Acts of Child Abuse by Employees*, 33 WM. & MARY L. REV. 1295 (1992) (addressing the legal response to child abuse at the institutional level).

145. A major problem is that some officials incorrectly view sexual harassment and touching as harmless adolescent behavior. Jane Gross, *Schools Are Newest Arenas for Sex-Harassment Issues*, N.Y. TIMES, Mar. 11, 1992, at B1 (noting how officials equate harassment as harmless adolescent exploration); *see also* Peter Kendall, *Sexual Harassment: Can it Happen in 3rd Grade?*, CHI. TRIB., Nov. 3, 1992, § 1, at 1, 6 (quoting school official as viewing sexual harassment as a normal "part of growing up"). The failure to view subtle coercive behavior as problematic is epitomized by the reaction to the "Spur Posse," a gang of high school athletes organized to have sex with as many girls as possible. *See* Seth Mydans, *High school gang accused of raping for 'points,'* N.Y. TIMES, March 20, 1993, at A6.

For other articles discussing this issue, see Jeff Horner, *A Student's Right to Protection From Violence and Sexual Abuse in the School Environment*, 36 S. TEX. L. REV. 45, 56 (1995) (concluding that while students are unlikely to recover damages from the school for actions against a student perpetrated by an employee or student, recovery is even less likely if the sexual harassment involves only students); Karen Bogart & Nan Stein, *Breaking the Silence: Sexual Harassment in Education*, 64 PEABODY J. EDUC. 146

various forms of adolescent sex offending.[146] Although society has made progress in recognizing sexually explicit adolescent coercion,[147] sexual harassment remains essentially unchallenged despite its tendency to occur in public and in full view of adults.[148] Adolescents would benefit, then, from what some aptly have called "a discourse of desire"[149] that publicizes overt problems in addition to subtle violence and victimization.

(1989); Adam A. Milani, *Harassing Speech in the Public Schools: The Validity of Schools' Regulation of Fighting Words and the Consequences if They Do Not*, 28 AKRON L. REV. 187, 215 (1995) (illustrating the civil liability for schools for failing to proscribe harassing speech); Karen M. Davis, Note, *Reading, Writing, and Sexual Harassment: Finding a Constitutional Remedy When Schools Fail to Address Peer Abuse*, 69 IND. L.J. 1123, 1123-27 (1994) (noting the failure of schools to adequately address peer abuse); Helena K. Dolan, Note, *The Fourth R—Respect: Combatting Peer Sexual Harassment in the Public Schools*, 63 FORDHAM L. REV. 215 (1994) (arguing that the special relationship between school officials and school children raises an affirmative duty for school officials to stop peer sexual harassment); Barbara L. Horwitz, Note, *The Duty of Schools to Protect Students From Sexual Harassment: How Much Recovery Will the Law Allow?*, 62 U. CIN. L. REV. 1165 (1994); Monica L. Sherer, Comment, *No Longer Just Child's Play: School Liability Under Title IX for Peer Sexual Harassment*, 141 U. PA. L. REV. 2119 (1993); Adam M. Greenfield, Note, *Annie Get Your Gun 'Cause Help Ain't Comin': The Need for Constitutional Protection from Peer Abuse in Public Schools*, 43 DUKE L.J. 588 (1993) (addressing the applicability of a § 1983 action for serious peer abuse).

146. There is a need to recognize the extent of sex offending and coercive sexual behavior. Very little research has examined subtle sexual coercion or the different forms of sexual harassment. *See* Kelly Corbett et al., *Sexual Harassment in High School*, 25 YOUTH & SOC'Y 93, 96-97 (1993); Carren Loredo et al., *Judgments and Definitions of Sexual Harassment by High School Students*, 32 SEX ROLES 29, 42-43 (1995); Bruce Roscoe et al., *Sexual Harassment: Early Adolescents' Self-Reports of Experiences and Acceptance*, 29 ADOLESCENCE 515, 518-19 (1994); Rick S. Zimmerman et al., *Adolescents' Perceived Ability to Say "No" to Unwanted Sex*, 10 J. ADOLESCENT RES. 383, 385-86 (1995).

147. Glen E. Davis & Harold Leitenberg, *Adolescent Sex Offenders*, 101 PSYCHOL. BULL. 417, 419 (1987) (reviewing empirical literature on sex offenses committed by adolescents).

148. *See, e.g.*, June Larkin, *Walking through Walls: The Sexual Harassment of High School Girls*, 6 GENDER & EDUC. 263, 264 (1994) (arguing that "[o]ne reason that sexual harassment has received so little attention in schools is the difficulty in disentangling harassing incidents from what have come to be accepted as typical male-female interactions."); Nan Stein, *Sexual Harassment in School: The Public Performance of Gendered Violence*, 65 HARV. EDUC. REV. 145, 149 (1995) (explaining that "[i]n schools, harassment often happens while many people watch.").

149. Michelle Fine, *Sexuality, Schooling, and Adolescent Females: The Missing Discourse of Desire*, 58 HARV. EDUC. REV. 29, 36 (1988) (arguing that "silencing a discourse of desire buttresses the icon of woman-as-victim"). For methods of including the missing discourse, see Sharon Thompson, *Putting a Big Thing into a Little Hole: Teenage Girls' Accounts of Sexual Initiation*, 27 J. SEX RES. 341 (1990).

Lastly, adolescent jurisprudence would benefit from focusing less on ensuring hollow rights and more on ensuring the proper provision of services. For example, the current excessive focus on giving adolescents the right to confidential HIV-testing ignores its limitations. A close examination of existing statutes reveals that adolescents have several alternatives to pursue if they want to be tested.[150] Indeed, these alternatives are rather numerous for youth at high risk; for at-risk youth tend already to be in the child welfare and juvenile court systems and thus have access to tests.[151] Therefore, efforts would be better placed on protecting adolescents from discrimination,[152] preventing arbitrary invasions of their privacy,[153] providing them with access to treatment,[154] sheltering them from victimization,[155] and ensuring reasonable efforts to prevent unnecessary removal from their families.[156]

C. Adolescent Jurisprudence Must Make More Effective Use of Existing Mandates

Contrary to popular perceptions (and arguably, to current practices), all of the above enumerated protections already exist. Adolescents are *legally* entitled to such protections. Thus, it is the proper implementation of these rights which continues to foil efforts to address adolescents' situations. Given the rather large legal armamentarium, adolescent jurisprudence would do well by making more effective use of existing mandates. Such an effort would move away from the current vision of rights aimed unrealistically at liberating adolescents,[157] and move toward adopting a vision of rights which recognizes the peculiar vulnerabilities and needs of adolescents. The effort would recognize those who wield immense power over adolescents' lives—parents and state officials—and aim to ensure that those who are responsible for adolescents' needs take those needs seriously.

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150. *See supra* notes 96-98 and accompanying text.

151. *See supra* notes 103, 110. Access to testing comes from being under the care of the state. *See supra* note 103. This form of access is rather significant, since high risk youth tend to be under state care. *See* Melton, *supra* note 124, at 2029-31 (1993).

152. *See supra* notes 76, 77, and 92 and accompanying text.

153. *See supra* note 79 and accompanying text.

154. *See supra* notes 96-98 and 105-09 and accompanying text.

155. *See supra* notes 129-33 and 142-49 and accompanying text.

156. *See supra* note 103 and accompanying text.

157. The major focus on children's rights has focused on a movement aimed toward liberating children. *See* Levesque, *International Children's Rights, supra* note 18.

V. CONCLUSION

All indicators point to the need to reconsider the current approach to adolescent HIV-AIDS. Whether adolescents have HIV, exhibit symptoms which qualify as AIDS, or have close relatives or friends who have HIV-AIDS, adolescents are facing the epidemic much more than realized.[158] In addition, adolescents have peculiar needs which currently are not being met,[159] even despite some dramatic improvements in providing education and health services.[160] The major obstacle is that, although dramatic, the improvements have remained constrained by the general inability to take seriously the need for an adolescent jurisprudence.

Quite surprisingly, a review of existing legal mandates reveals that a considerable amount of law protects adolescents and aims to ensure their rights. The increasing allowance of sex education in the schools and the ability of minors to consent to HIV testing indicates that lawmakers are beginning to understand the distinct needs of adolescents in the HIV-AIDS epidemic. However, despite the existence of these protections, there continues to be a considerable disjuncture between enumerated rights and practice. The result is that commentators continue to urge further reform as they play down the importance of existing rights. Although some reforms undoubtedly would be beneficial in some instances, ensuring that existing rights are protected would go a long way toward addressing adolescents' needs.

Lawmakers must realize that adolescents are neither children nor adults, and adolescent jurisprudence in the HIV-AIDS epidemic must reflect this distinction by incorporating adolescents' unique needs. To properly address adolescents' concerns, lawmakers must heed the voices of adolescents. Reformers must further recognize the power of parents and state officials to control adolescents' lives. Adolescents simply do not have the resources, personal nor financial, to have and exercise rights designed for autonomous adults. To ensure that adolescents' rights are respected, there must be an increased effort to inform those influencing adolescents' lives to respect adolescents' needs and to ensure that adolescents' perspectives are taken into account when decisions are being made on their behalf. It is only by considering adolescents' perspectives that their rights can be properly envisioned and ensured.

158. *See supra* notes 28-36 and accompanying text.

159. *See supra* part II.

160. *See supra* part III.