

This chapter will help us to understand TYC Youth. This is one of the most important chapters of this training manual because it will hopefully shape your understanding of youth in our care.

## Neurological Development

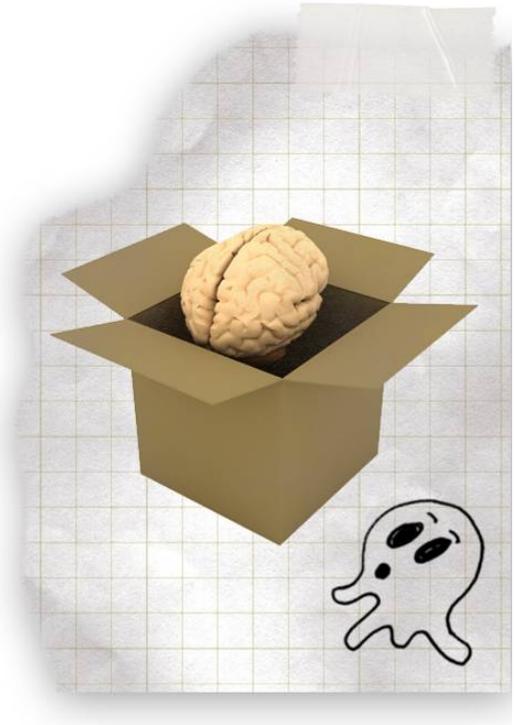
Neurological changes occur in the brain during the teenage years. The teenage brain is “under construction.” The frontal cortex is the part of the brain responsible for judgment, planning and strategizing. Adolescents have less activity in the frontal lobes and more in the amygdala than adults.

Studies Indicate that Teenagers:

- Are more likely to have an emotional response rather than a thinking response
- May not always exhibit planning, judgment and goal-directed behavior
- Engage in more risk-taking behaviors

### *Tips for Volunteers*

- Work with youth on problem-solving skills and “new thinking” so they learn how to think through issues and make better decisions.
- Ask the youth about a tool called “thinking report” which helps them pay attention to their thinking, attitudes, values and beliefs.
- Teach and role model coping skills such as controlling anger, managing stress, expressing feelings appropriately, etc.
- Listen attentively, validate feelings and demonstrate empathy.
- Build rapport and trust with the youth to make it more likely that they will talk through their feelings with you instead of lashing out at you.
- Remember that change doesn’t happen over night. Recognize and praise positive behaviors that youth demonstrate so they will be encouraged to keep trying.



## Physical Development

Physical changes during the adolescent years are dramatic with teens growing inches seemingly overnight, their bodies re-shaping and voices changing all at once.

## Sexual Development

During puberty, changing hormonal levels play a role in activating the development of secondary sex characteristics. These include:

1. Growth of pubic hair
2. Menarche (first menstrual period for girls) or penis growth (for boys)
3. Voice changes (for boys)
4. Growth of underarm hair
5. Facial hair growth (for boys)
6. Increased production of oil, increased sweat gland activity, and the beginning of acne.

## **Psychological Development**

Adolescence is a complex stage of development that requires the guidance and support of caring adults. Youth may be trying to “find themselves” by exploring different groups.

In Fiscal Year 2009, **43%** of new TYC arrivals were admitted **gang members**.

Research has found that children who have experienced abuse and neglect are more likely to have psychological and emotional problems.

In Fiscal Year 2009, **38%** of new TYC arrivals had a **history of abuse or neglect**.



# COMMON MENTAL HEALTH DISORDERS AMONG JUVENILE OFFENDERS

| DISORDERS                                    | SIGNS & SYMPTOMS   |
|--|--|
| <b>Depression</b>                            | <ul style="list-style-type: none"> <li>• Mood Disorder</li> <li>• Often characterized by sadness, misery or despair beyond what would be considered normal</li> <li>• Sometimes manifests as anger, irritation or opposition in youth</li> <li>• Must have lasted at least 2 weeks and is often accompanied by additional symptoms such as sleep disturbance, appetite disturbance, lack of concentration, loss of interest or pleasure in activities</li> <li>• Youth may appear withdrawn, or express feelings of worthlessness or hopelessness</li> </ul> |
| <b>Bipolar</b>                               | <ul style="list-style-type: none"> <li>• Mood Disorder</li> <li>• Characterized by drastic and sudden mood swings from depressed to energetic, euphoric or agitated</li> <li>• May have times when they are quite or withdrawn then suddenly become very talkative, agitated or engage in reckless behavior</li> </ul>   |
| <b>Dysthymia</b>                             | <ul style="list-style-type: none"> <li>• Mood Disorder</li> <li>• Characterized by a mildly depressed personality all of the time</li> <li>• Mild form of depression, but can progress to Depression</li> <li>• More common than Depression or Bipolar among juvenile offenders</li> </ul>   |
| <b>Post Traumatic Stress Disorder (PTSD)</b> | <ul style="list-style-type: none"> <li>• Anxiety Disorder</li> <li>• Most common Anxiety Disorder among juvenile offenders</li> <li>• Results from experiencing/witnessing an event(s) which caused them to be in fear of their lives or someone else's life accompanied by intense horror and/or helplessness</li> <li>• May experience nightmares or memories which remind them of the event</li> <li>• May become emotionally detached or numb to protect against feelings</li> <li>• May exhibit explosive anger or get very anxious</li> </ul>          |

# COMMON MENTAL HEALTH DISORDERS AMONG JUVENILE OFFENDERS

| DISORDERS  | SIGNS & SYMPTOMS  |
|--|---|
| <b>Psychosis</b>                                       | <ul style="list-style-type: none"> <li>• Characterized by breaks with reality</li> <li>• May have hallucinations, such as seeing, hearing or feeling things that are not really there</li> <li>• May have delusions which are strongly held beliefs held by others to be bizarre and inconsistent with reality</li> <li>• May exhibit bizarre behavior, difficulty with social interactions and impairments with daily living activities</li> </ul> |
| <b>Attention-Deficit/Hyperactivity Disorder (ADHD)</b> | <ul style="list-style-type: none"> <li>• Characterized by inattention or hyperactivity or both</li> <li>• Includes difficulty paying attention and concentrating</li> <li>• May exhibit impulsivity or have difficulty sitting still in class or group</li> <li>• May exhibit difficulty with complex verbal instructions</li> <li>• May interrupt conversations or blurt out in class</li> </ul>   |
| <b>Conduct Disorder</b>                                | <ul style="list-style-type: none"> <li>• Characterized by behavior that violates rules or rights of others</li> <li>• Very common diagnosis among TYC youth</li> <li>• May exhibit aggression to people and/or animals</li> <li>• May engage in destruction of property</li> <li>• May engage in lying, stealing or other forms of deceit</li> </ul>  |
| <b>Learning Disorders</b>                              | <ul style="list-style-type: none"> <li>• Characterized by performance on standardized academic tests which is significantly below the expected performance based on the youth's IQ</li> <li>• May exhibit a learning disorder with any IQ</li> <li>• May exhibit a learning disorder in any or a combination of the following areas—math, reading, or written expression</li> </ul>   |

[http://www.aacap.org/cs/root/facts\\_for\\_families/conduct\\_disorder](http://www.aacap.org/cs/root/facts_for_families/conduct_disorder)

[http://www.aacap.org/cs/root/facts\\_for\\_families/posttraumatic\\_stress\\_disorder\\_ptsd](http://www.aacap.org/cs/root/facts_for_families/posttraumatic_stress_disorder_ptsd)

*Supervising Juvenile Offenders with Mental Health Disorders*, video, American Correctional Association, 1999

Many TYC youth are prescribed psychotropic medications. Psychotropic medications alter the brain's function to affect behavior, mood and perception.

***Common Psychotropic Medications and Psychiatric Conditions:***

- Antidepressants (ex. depression, anxiety disorders, obsessive compulsive disorder)
- Anti-anxiety medications (ex. anxiety disorders)
- Stimulants (ex. Attention Deficit Disorder—ADD, Attention Deficit Hyperactivity Disorder—ADHD)
- Mood Stabilizers (ex. Bipolar Disorder)
- Anti psychotics (ex. Schizophrenia)

These medications are prescribed to manage a condition, so it is important that the youth and families understand the purpose of the medication and how it is to be administered.

## **Volunteers Responding Appropriately**

### ***Be Observant***

Staff and volunteers who work directly with the youth are the best source of information. Be sure to share your observations and concerns with dorm staff.

### ***Maintain Open Communication with Team Members***

It is important to share issues/concerns with the caseworkers, correctional staff, and Multi-Disciplinary Team (MDT) whose job it is to identify strategies and interventions for youth who are having difficulties.

### ***LEAPS: Listen, Empathize, Ask, Paraphrase, and Summarize***

Every interaction you have carries the chance to build rapport and trust with the youth. Use active listening and show empathy.

### ***Be Fair, Firm, and Consistent***

The rules of behavior should be consistent and predictable. Youth should be clear about what is or isn't considered acceptable behavior.

### ***Be a Role Model***

Maintain a professional presence and interact with the youth in a way which models appropriate social skills. Dress, speak, and carry yourself in a professional manner. Almost every interaction you have with the youth is a "teachable moment" because they learn from the things you say and do.

## Abuse and Dependence

Youth are screened at intake for substance abuse and dependency. Those that are dependent may receive specialized chemical dependency treatment while at TYC.

**80%** of TYC youth have **substance abuse histories**. Research has established the link between substance use and criminal behavior, suggesting that chemical dependency, if left untreated, places youth committed to TYC at risk of future criminal behavior.

Commonly abused prescription drugs include:

- Pain killers
- Anxiety medications
- Sleep medications
- ADHD medications
- Weight loss medications



## Suicide Prevention

### ***Communication, Trust, and Rapport***

A listening skill known as reflection shows the youth you are trying to understand them, not judge them. This is important when it comes to suicide prevention—and youth, in general. By reflecting back what the youth says, you won't be perceived as judgmental, mean, intimidating, angry, etc. Professional boundaries encourage trust, rapport, and open communication between staff and youth. Your level of professionalism affects the trust and rapport you will have with the youth.

For example, you tell a youth, “Stop whining all the time. You're getting on my nerves.” If no trust and rapport are built between the youth and the volunteer, that statement could be very damaging. Imagine that statement being said to a youth who is suicidal and already thinking, “Everyone is better off without me.”

We must realize the power of our words—in both good ways and bad ways.

A volunteer's interaction with TYC youth is limited and you may not know what is “normal” and “abnormal” behavior for each youth. Staff, particularly dorm staff, have a much better understanding of what is “normal” and what is “abnormal” for the youth. If you believe a youth is acting abnormally or different than usual, ask the staff questions.

In one case, a youth who overdosed on pills was discovered only because staff thought the youth looked a little “out of it” while sitting on the couch. The youth recovered. It could have been easy to overlook had the staff not known how the youth normally acted.

It is also easy to overlook a youth sitting off in a corner or crying more than usual. Check on these youth. Communicate with them. It is your job, and it may be what saves a life.



### **Two BIG “DON’Ts”**

1. DON’T assume the youth is manipulating or just trying to get attention by claiming to be suicidal.
2. DON’T say anything that may discourage a youth from admitting that they want to hurt themselves.

Never jump to conclusions and label youth. It is too easy to blame and label youth as manipulators.

NEVER try to call their bluff by saying “If she was going to kill herself, she’d have done it by now. She just wants attention.”

That is a gamble you can not afford to lose.

The point is to keep the youth safe, not discourage them from getting help. Any inconvenience experienced by staff when a youth is placed on suicide alert is far better than the pain and horror of experiencing the death of a youth.

Open communication will make it easier for you to ask the youth, “Are you thinking about hurting yourself?”

### ***Risk Factors, Signs, and Symptoms***

“Always be alert!” The youth we serve now live in an environment conducive to suicidal ideation and attempts. Another thing to remember: Most youth just want the HURT to stop. During the crises, they don't think about suicide as *death or being permanent*; they do not have the ability to think clearly about other options.

## Risk Factors for Youth in a Facility

Signs and symptoms in a youth at risk in a facility are not that uncommon. It is important for you to apply what you already know about suicide and suicide prevention; use all of that knowledge in helping our youth at risk.

**Suicide is the third leading cause of death among all youth.**

We know that suicide risk increases in correctional environments when compared to living in the free world or even in residential treatment centers.

### What is so different about being in a facility?

- Schedules, told when to eat, sleep, go to bathroom etc.
- Confined to room overnight.
- Correctional environment – bare walls, loud talking and movement, echoes, etc.
- Forced to deal with a lot of strangers with a lot of power.
- Feelings of hopelessness will be here forever; no way out. Not much freedom of movement, expression etc.
- Forced to go to school and deal with issues they could avoid on the outside.
- Poor coping and social skills by history with loss of traditional ways of coping.
- Personal & family issues, including separation from family, friends, girlfriends and boyfriends, gang members or other associates with whom they had fun.
- Most have used drugs or alcohol to avoid development of problem solving skills with peers or family.

### All of us have these common responsibilities:

- To help identify a youth with suicidal thoughts and/or behaviors
- To keep them safe until they receive help

Let's look at some of the **non-verbal cues** that may be communicated by youth with intent to harm themselves.



- History of prior attempts or family attempts at suicide. (This requires getting to know your youth)
- When a youth's behavior changes noticeably from quiet to loud, loud to very quiet, aggressive to passive or vice-versa, something is going on.

- Sometimes a suicidal person has come to a resolution about their dilemma. A period of calm and peace is present as they have decided to end their life.
- Changes in behavior after speaking with their family, visiting with their families or other significant events.
- A youth discontinuing psychotropic medications or checking them may be important non-verbal communication.
- Youth hoards checked medications prescribed for him/her or others.
- Giving away things that have had value, monetary or sentimental, to the youth, such as photos, letters, anything of significance or importance to the youth.
- Changes in behavior from what has been usual for them, such as losing interest in school or making phone calls home.
- Passive, withdrawn, or not socially involved as they were in the past or more irritable and aggressive than in the past.

**Direct care staff stop most suicides.  
So, use your best judgment in any single situation.  
Always be alert! Always get staff involved!**



### ***Risk Factors Becoming Motivators***

Most individuals in a suicidal crisis really do not want to die. They want the pain, the loneliness, the hopelessness or the anger to go away; they do not see any other way than dying. *Factors* that indicate a youth might be *motivated* to attempt suicide are called *Motivators*. Motivators contribute to the youth's belief, "Things are bad and not likely to get better."

Now here are some examples of motivators:

- Escape from intolerable situation
- Join a deceased loved one
- Attract attention
- Manipulate others
- Avoid punishment for a crime
- Control their time of death
- Punish their survivors

- End an irresolvable conflict
- Gain revenge
- Just end it all

## **Suicide Prevention Policy Review (GAP.91.88)**

GAP 91.88 –Suicide Prevention applies to all youth assigned to high restriction facilities operated by TYC.

GAP.91.87 contains the definitions for suicide alert terms. Both policies were revised in 2009 to better reflect national standards of care.

Let's discuss the procedures set forth in the policy.

Assessment is the first step. All youth are assessed for suicide risk upon:

- Admission to TYC
- Arrival to their placement from orientation and assessment
- Return to TYC custody (such as returning from bench warrant or revocation from parole)
- Concern that a youth is thinking about self-harm or suicide
- When youth are transferring among facilities

Transition to a new facility can be stressful. Youth do not know what to expect. They may be anxious and fearful. They don't know anyone and no one knows them. It is easy for these youth to fall through the cracks. We can't afford for that to happen when it comes to suicide risk. So, as matter of routine, we assess these youth right away.

### **There are two levels of assessment:**

**Suicide Risk Screening**—This screening may be conducted as part of an intake health screening by a nurse or it may be conducted by a trained designated staff upon notification that a youth may be at-risk for suicide. Policy requires the screening to be conducted within 1 hour of the youth's arrival/notification to determine whether the youth is potentially at-risk for suicide.

If the youth is found to be "potentially at-risk" for suicide, it means that the youth has either said something, done something, or there is other presenting evidence to suggest the youth is thinking about suicide or self-injury.

The screening helps determine the level of risk and how soon the youth needs to be assessed by a Mental Health Professional Health, known as an MHP.

**Suicide Risk Assessment**—a full assessment that can only be conducted by an MHP as follows:

- Within 4 hours after the screening if the youth *is* actively suicidal or has attempted suicide; or

- Within 24 hours after the screening if the youth *is not* actively suicidal, but is still considered at-risk for suicide.

According to nationally-recognized suicide prevention expert, Lindsay M. Hayes, suicide risk assessment is an on-going process, not a one-time event. Assessments occur as often as necessary to keep the youth safe from their admission to TYC through their discharge.

This is where *you* come in. **Staff and volunteers who work closely with the youth on the front lines will see the red flags before anyone else.**

**What does policy require me to do if a youth tells me he is having suicidal thoughts?**

1. Keep the youth in your direct line of sight to ensure his safety.
2. Talk to the youth and try to engage him in conversation.
3. Immediately let staff know of the situation.

It's not enough to just "keep an eye" on the youth yourself without notifying the staff. Why is that not enough? There is no documentation of the observation, no accountability, no assurance of the youth's safety, no suicide screening or MHP involvement, etc. A trained designated staff will conduct the suicide risk screening within one hour after notification.

### ***More Risk Factors with Signs and Symptoms***

- Abrupt or Noticeable Changes
- Sudden mood swings - more than typical
- Excessive crying, sadness or gloom
- Difficulty in making conversations
- Difficulty in carrying out routine tasks
- Inability to concentrate
- Increased or decreased appetite
- Increased or decreased purging & bingeing
- Difficulty falling asleep in a youth *not having had this problem before*
- Difficulty staying asleep
- Early morning awakening (much earlier than usual with problems going back to sleep)
- Excessive sleeping
- Night time anxiety
- Acting out, aggressive behavior
- Quiet, passive behavior
- Going from one extreme to the other
- Explosive behavior
- Family history of suicide attempts
- previous attempt to commit suicide
- elaborate plan - not thought out well - went wrong – plan not good enough

**What if the plan is not well thought out? Does this indicate the youth does not intend to attempt?**

The youth's talking about the plan indicates that more thought is being given about the attempt.

Risk Factors can and usually stem from one or more the following areas:

- Family Problems
- Institutional Problems – Environmental
- Institutional Problems – Events
- Obsessed with Death Signs

**When are youth suicides most likely to happen?**

1. Any time youth observes staff not looking.
2. During room confinement
3. When all staff are not communicating youth's suicidal risk behaviors & status
4. When youth can predict the next security check
5. During shift change because staff are preoccupied
6. When monitoring by staff is not properly conducted
7. During low staff coverage days
8. At night

Report and document what you see, hear, or just “pick up on.” It's always better to be safe than sorry.

**Health-related risk factors that place youth at risk for committing suicide:**

- Substance Abuse/Addiction
- Alcohol/drugs – escape for their thoughts and feelings

**Depression is the most common issue** with our youth who have thoughts and feelings, leading to those of committing suicide. Youth respond in many different ways to depression.

- Withdrawal, isolation, loneliness, confusion
- Changes in mood, behavior, or daily routine
- Agitation, self-hatred, anxiety
- Self-abuse
- Suicidal ideation
- Threats, gestures
- Suicide attempts
- Thoughts about death
- Journaling
- Declining Interests
  - Declining interest in socialization
  - Failing in school or feels like a failure
  - Not interested in activities they once liked
  - Broken friendships
- Behavior Signals

Regardless of the cause, the factor, the illness, when a youth is considering suicide, what the youth really and only wants and needs is relief from the pain - a way out of feeling “this madness.”

**Behaviors you may notice when a youth makes the decision to commit suicide:**

- Exhibits severe depression traits or suddenly becomes happy.
- Engages in high risk behaviors.
- Talks about suicide.
- Refuses to commit to not harming self.
- Gives personal property away.
- Resolves to kill self – has a plan.
- Exhibits abnormal behavior.

**Methods most commonly used in facilities by youth are hanging, suffocation, ingestion, and self-injury.**

***Hanging - The Predominant Plan in Secure Care***

Materials Used

- Electrical cords
- Sheets
- Socks
- Bras & underwear
- Toilet paper ropes
- Torn clothing strips

Locations for hanging– (It doesn’t have to be from a high place.)

- a window grate, door knob, vents, or bed frame
- contemplation and searching for the method, material, and the right timing

**Your observation and documentation can lessen their opportunity to commit suicide.**

***How Staff are to Respond to a Youth Hanging***

It is very upsetting to encounter a youth who is hanging. However, it is not the time to panic. First and immediately, staff are expected to use their radios to call a **CODE BLUE**, as they would in any life-threatening situation. Designated staff responding to the CODE BLUE must bring the rescue kit to the location. The rescue kits are also on the dorms and includes the rescue tool that they use to cut the ligature. As in any life-threatening emergency, the Code Blue is initiated first and foremost. If staff are unable to conduct the cut-down procedure as trained and recommended, remember the goal is to free the youth's airway in the least amount of time. Use the best available means and methods to loosen and/or cut the ligature around the youth's neck as soon as possible.

## Youth Confessions of Child Abuse

According to the Texas Family Code, TYC supervisors are required to report youth confessions of child abuse. If a TYC youth tells a volunteer that he has abused or neglected a child some time in the past before they were sent to TYC, then the volunteer must report it. The volunteer doesn't have to find if the confession of abuse is real or untrue – the volunteer just has to report it.

Again, a TYC volunteer who has cause to believe, based on information provided by a youth, that the youth is responsible for abusing or neglecting a child some time in the past when the youth was not in a TYC operated facility or contract care program, **must report that information, within 48 hours after the volunteer first receives it**, to the Community Relations Coordinator and youth's caseworker.

## HIV/AIDS and Blood Borne Pathogens

The students you will be working with have engaged in the two riskiest behaviors related to HIV infection - **drug use** and **sexual intercourse**.

It has been estimated that half of all new HIV infections in the United States are among people under age 25, and the majority of these young people are infected from engaging in sexual activity.

This data also shows that even though AIDS incidence is declining, there has **not** been a comparable decline in the number of newly diagnosed HIV cases among youth. Scientists believe that cases of HIV infection diagnosed among 13 - 24 year olds are indicative of overall trends in HIV incidence because they have more recently initiated high-risk behaviors.

### **Confidentiality**

**All HIV/AIDS information pertaining to any particular staff, volunteer, or youth is confidential.** You should not relate any information about the HIV/AIDS status of any individual to anyone else unless the individual has signed a release, specifically stating to whom the information may be released.



HIV/AIDS are reportable diseases. In accordance with the CDC Standards, **the institution contract physician must report any diagnosed cases** to the Texas Department of State Health Services.

To negligently or willfully release or disclose information, such as HIV/AIDS test results as it relates to an individual, to unauthorized persons is **a breach of confidentiality**; it is also a breach of confidentiality to negligently or willingly

allow HIV/AIDS test results OR any information pertaining to HIV/AIDS, as it relates to an individual, to become known by unauthorized persons.

### **Definition of Test Results**

A “test result” is any statement, indicating that an identifiable individual has or has not been tested for HIV infection, antibodies to HIV, or infection with any other probable causative agent or AIDS, including a statement or assertion that the individual is positive, negative, at risk or has or does not have a certain level of antigen or antibody.

### **Exceptions to Confidentiality**

1. A physician, nurse, or other health care professional with the legitimate need to know the test results to provide protection for the patient, others, and themselves.
2. Blood banks, hospitals, and laboratories under certain conditions.

**A breach of confidentiality is a criminal offense, Class A Misdemeanor, which can result in civil fines and/or penalties. Also, violations of the law in regard to testing, counseling, and confidentiality may result in civil liabilities.**

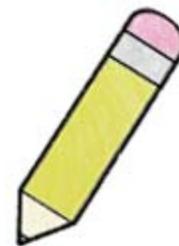
Criminal negligence is the criminal offense charged if a person releases HIV/AIDS test results (or other information regarding the individual tested) to unauthorized persons or to persons without a need to know.

So, in short, volunteers may not tell anyone about a youth who may have HIV/AIDS. It’s against the law.

### **Testing**

All youth are tested for HIV upon admission to TYC unless they refuse by signing a refusal form. HIV testing will not be performed routinely as a result of an assault by a youth, but may be requested or required if there has been potential exposure to a communicable disease.

If a youth in a TYC facility wants an HIV test conducted after admission, staff should **have the youth talk only to the facility's physician or head nurse**. If the youth is in a community placement, staff should refer the youth to the Department of Health & Human Services (DSHS) or its designated local authority.



The youth will receive pre-test counseling regarding HIV/AIDS and will then receive post-test counseling upon the arrival of the results.

A youth may voluntarily choose to discuss his HIV status with staff; however, staff should ensure that, by **referring the youth to the facility physician or head nurse**, accurate advice and counseling is provided for the youth.

Disclosure of a youth's HIV/AIDS status, obtained during counseling, would be a breach of confidentiality.

### ***Occupational Exposure***

An employee or volunteer with routine or direct contact with TYC youth in institutions or community settings may request the DSHS (or local health authority) to test a person who may have exposed them to any reportable disease in the course of the job performance. TYC youth may request this testing procedure for the same reasons.



A request under this section may be made **only if** the following apply:

1. The employee or volunteer is exposed in the course of performing normal duties and responsibilities.
2. The employee or volunteer has reason to believe that the exposure may have caused a risk of contracting a reportable disease.
3. The employee or volunteer submits a sworn affidavit, detailing the reason for the request for testing, to the DSHS authority.

DSHS will give the alleged source of exposure prompt and confidential written notice of the order for testing. DSHS will then arrange for the testing and inform the requesting employee or volunteer of the alleged source's test results. If the alleged source refuses to comply with the DSHS order, DSHS may then request that the state's attorney petition the district court for the alleged source's compliance by issuing a court order.

A volunteer who is exposed to a reportable disease while working with a TYC youth does **not** qualify for Workers' Compensation. A volunteer releases TYC from liability when you sign the Volunteer Agreement Form during orientation, with the understanding that there are inherent risks of volunteering with TYC youth.

### ***How Disease is Spread***

HIV is a blood borne and sexually transmitted virus. It is transmitted in three ways:

1. Through intimate sexual contact in which there is an exchange of infected semen or vaginal secretions.
2. Through injection of infected blood or blood products, i.e., needle sharing among drug users.
3. From an infected mother to their babies in the uterus before birth, during the birth process, or during breast feeding after the birth.



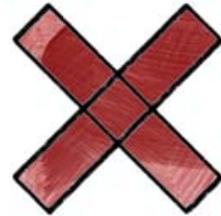
### **How Disease is NOT Spread**

1. HIV is not spread by saliva, sweat, or tears.
2. HIV is not spread by sharing eating utensils.
3. HIV is not spread in swimming pools.
4. HIV is not spread by casual contact, e.g. handshakes, hugs, etc.



### **Prevention**

1. Abstain from sex or use protection during sex.
2. Avoid having sex with those people who engage in high-risk behavior(s): multiple partners or strangers, or people you know engage in high risk behaviors.
3. Do not share needles.



Women at risk of HIV infection should postpone pregnancy and confer with a physician.

### **Acquired Immune Deficiency Syndrome (AIDS)**

AIDS is a serious disease caused by infection with HIV, which attacks the body's immune system and, over time (months to years), destroys the blood's virus- and bacteria-fighting white blood cells. The body then becomes less and less able to protect itself against any illness. The HIV+ person then becomes more susceptible to infections or cancers, attacking the body and possibly and more than likely, causing death.

### **Standard Precautions**

In 1996, the CDC revised the definition and recommendations for standard precautions. Today, standard precautions are the primary strategy used to reduce the risk of transmission of pathogens from moist body substances. Standard precautions apply to blood and secretions, except sweat - whether or not it contains visible blood - or mucous membranes.

Volunteers are advised to follow all procedures for safety at all times to reduce the risk of contracting an infectious disease.

- Avoid punctures by sharp objects. Always assume that every youth or area to be searched may have a potentially infectious, sharp object.
- Minimize your exposure to infectious germs. Wash your hands often; cover all skin breaks, rashes, etc., with clean, dry bandages; use disposable gloves if exposure to blood or bodily fluids is likely.
- Clean up blood spills (or spills that contain blood) as soon as possible; wear 2 pairs of disposable gloves; CPR masks; goggles; large disposable sheeting; use an approved disinfectant; properly dispose the gloves; wash hands thoroughly after removing gloves.
- Disinfect soiled clothing and equipment; wash clothing in machine as soon as possible and disinfect equipment, such as handcuffs, with appropriate disinfectant solution.

- Although there is no documented case of HIV, hepatitis B, or hepatitis C infection through administration of CPR, CPR masks (pocket) will be made available in all buildings and security vehicles, and employees will be trained in their use.

Volunteers are advised to follow these procedures and precautions at all times to reduce the spread of all contagious diseases.

Volunteers exposed to blood or other potentially infectious materials will have ready access to hand washing facilities. **Hand washing is the single most effective means of preventing the spread of infection.** If ready access to hand washing facilities is not feasible at the time of exposure, the volunteer will have access to one or more of the following temporary alternatives:

- Antiseptic cleanser to be used with a paper/cloth towel
- Alcohol swabs
- Hand sanitizer

If one of these alternatives is used, wash hands and/or other affected body parts with soap and running water as soon as possible.

Upon removal of personal protective gloves, volunteers will immediately wash their hands and any other potentially contaminated skin area with soap and water or a temporary alternative.

If exposure to skin or mucous membranes occurs, as soon as possible following contact, the volunteers should vigorously wash the area with soap and water or flush the area with water, as appropriate.