Vaccination in Juvenile Correctional Facilities: State Practices, Hepatitis B, and the Impact on Anticipated Sexually Transmitted Infection Vaccines

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SYNOPSIS

Objectives. Juvenile correctional facilities are an ideal setting to provide preventive vaccines to adolescents who are at risk. In many instances of incarceration, facilities overcome the need for parental consent by making young people wards of the state and the state providing consent. The authors investigated current state practices for administering hepatitis B vaccine to incarcerated adolescents. These may impact the delivery of anticipated sexually transmitted infection (STI) vaccines to incarcerated adolescents.

Methods. From June to August 2004, interviews were conducted with state Immunization Program Managers by telephone about hepatitis B vaccination and consent policies in juvenile correctional facilities.

Results. Forty-five states were able to provide information about hepatitis B immunization in publicly funded juvenile correctional facilities. Forty-one of the 45 states offered hepatitis B vaccine to adolescents who were sentenced and thereby considered to be wards of the state. Of those 41 states, 20 also made hepatitis B vaccine easily accessible to detained adolescents (no parental consent required). Those 20 states considered detained adolescents as wards of the state ($n=13$), or allowed them to self-consent for the vaccine ($n=7$).

Conclusions. Most states offer hepatitis B vaccination to sentenced adolescents in correctional facilities. Just over half of these states also vaccinate detained adolescents. Juvenile correctional facilities have experience administering vaccines, and this might allow for expansion of vaccination services when new STI vaccines become available. Still, there are major barriers to universal vaccination of incarcerated adolescents, including the issue of consent.

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Licensed preventive vaccines have existed for two sexually transmitted diseases: hepatitis A and B. However, vaccines for other sexually transmitted infections (STIs) are currently in development. The U.S. Food and Drug Administration recently licensed a vaccine against human papillomavirus (HPV) in June of 2006, and potential vaccines against herpes simplex virus (HSV-2) and human immunodeficiency virus (HIV) are in development. Other anticipated STI vaccines include chlamydia (CT) and gonorrhea (GC).^{1,2} Current state practices regarding hepatitis B vaccination may provide the infrastructure for anticipated STI vaccine administration.

Adolescents in juvenile correctional facilities are a population at risk for STIs in that many have engaged in behaviors such as sexual intercourse and alcohol and illicit drug use.³ In one study, 75% of incarcerated adolescents reported three or more sex partners, 25% reported never using condoms, and 19% had a current diagnosis of at least one STI.⁴ As compared with their peers who have not been in correctional facilities, detained youth have been shown to have STI incidence rates that are twice as high.⁴

Juvenile correctional facilities may house detained and sentenced or committed adolescents. Detained adolescents may be “held awaiting a court hearing, adjudication, disposition or placement elsewhere,” whereas adolescents sentenced, or committed, “include those placed in the facility as part of a court ordered disposition.”⁵ Individuals younger than 21 years of age may pass through these sites. States detain adolescents from days to weeks, whereas they sentence adolescents for longer periods of time. When a minor resides in a juvenile correctional facility, the minor may become a “ward of the state,” meaning that the state has the authority to make decisions on behalf of the minor. Some state laws, however, maintain the parents’ authority to make decisions for minors in correctional facilities.

Though history and research demonstrate that vaccination is a safe and effective means to prevent the spread of hepatitis B,⁶ the issue of obtaining consent complicates the vaccination of adolescents. In a 1997 study, Gordon et al. addressed state-by-state informed consent requirements for adolescent immunization and found that parental consent was required in 43 of 50 states.⁷ However, all states allow adolescents to self-consent for testing for and treatment of STIs.⁸ At the time of the Gordon et al. study, nine states allowed adolescents to self-consent for hepatitis B vaccination in specific settings, which included sexually transmitted disease clinics and family planning clinics.⁷

Adolescents who are at risk for STIs are one popula-

tion that should receive preventive STI vaccines, and correctional facilities provide a setting for administering vaccines to at-risk, hard-to-reach adolescents as part of their routine medical care. We interviewed state immunization program managers about hepatitis B vaccination and consent policies in juvenile correctional facilities to determine whether they routinely offer this preventive vaccine to detained and sentenced adolescents.

METHODS

We conducted telephone interviews with state Immunization Program Managers⁹ from June to August 2004. Immunization Program Managers either answered our queries themselves, or directed us to medical directors in adolescent correctional facilities or to state hepatitis B coordinators. We asked our contacts the following questions about their states:

1. Is the hepatitis B vaccine available to adolescents in public correctional facilities?
2. If the vaccine is available, who is able to give consent for an adolescent to receive it?
3. Is there a difference in the consenting protocol for detained adolescents vs. sentenced adolescents?

The interviewer recorded and grouped each informant’s response in Microsoft Excel according to whether hepatitis B vaccine was available in juvenile correctional facilities. The interviewer further classified states that reported that the vaccine was available based on their consent policies. We tallied the number of states in each category and calculated percentages of states with particular vaccination policies.

RESULTS

The stipulations for vaccinating adolescents in correctional facilities differed from state to state. Some states required parental consent for both detained and sentenced adolescents; some made the adolescents wards of the state so that the court or superintendent of the correctional facility had authority to consent for their medical care; others allowed adolescents to self-consent.

Forty-five states were able to provide information about hepatitis B immunization in publicly funded juvenile correctional facilities (Table 1). Forty-one of the 45 states surveyed (91%) offered hepatitis B vaccine in at least some of their juvenile correctional facilities. Twenty-six of the 45 states (58%) offered the vaccine to both detained and sentenced adolescents; 20 (44%)

Table 1. Hepatitis B vaccination offered in publicly funded juvenile correctional facilities (as reported by Immunization Program Managers, Medical Directors, or State Hepatitis B Coordinators)

<i>Offered to detained and sentenced adolescents</i> n=26	<i>Offered to sentenced adolescents only</i> n=15	<i>Not offered</i> n=4
AL	AZ	MS
AK	AR	ND
CA	CT	TN
CO	HI	WV
DE	ID	
FL	IL	
GA	MI	
IN	MN	
IA	NE	
KS	NH	
KY	NY	
LA	OH	
MD	OK	
MT	PA	
NV	WI	
NJ		
NM		
NC		
OR		
RI		
SC		
TX		
UT		
VT		
VA		
WA		

of these 45 states made hepatitis B vaccine accessible without parental consent and allowed for either state or self-consent. In 13 of the 20 states, both detained and sentenced adolescents became wards of the state, so that the state could consent for their vaccination. In the remaining seven of the 20 states, adolescents could self-consent for vaccination (Table 2). Fifteen states (33%) offered only hepatitis B vaccine to sentenced adolescents. Fourteen of these 15 states did not consider detained adolescents as wards of the state. Four states (9%) did not offer the vaccine to either sentenced or detained adolescents.

DISCUSSION

Most adolescents with a sentence to serve time in a U.S. correctional facility are offered preventive vaccination against hepatitis B. Previous studies show that the prevalence of HIV-related risk behaviors and STIs among incarcerated adolescents is high.^{3,4} Therefore,

stays at juvenile correctional facilities provide prime opportunities to vaccinate these young people against infectious diseases such as hepatitis B.

Vaccination is safe and effective at preventing hepatitis B infection. The vaccine schedule is in a three-dose series (baseline, one month, and four months) for maximal effectiveness. Following an initial shot, 31% of those vaccinated develop antibodies. After a second dose, 77% have developed antibodies, and 96% have developed antibodies once the series is completed.⁶ There is an abundant supply of this vaccine, and federal funding for hepatitis B vaccine for eligible adolescents up to 18 years of age has been available since 1993 through the Vaccines for Children (VFC) program.¹⁰ Children who are wards of the state are automatically eligible for hepatitis B vaccine through the VFC program, and states purchase and supply the vaccine directly to juvenile correctional facilities at no cost to the facilities (Personal communication, Rhode Island Department of Health, Immunization Program, Dec 16, 2005).

It is notable that 42% of the states we surveyed exclude detained adolescents from hepatitis B vaccination programs. In these states, detained adolescents are not able to receive the preventive vaccine while incarcerated. In six states (13%), detained adolescents are offered vaccination, but vaccination requires parental consent. In 20 states (44%), detained adolescents are offered vaccination and do not need parental consent.

Despite the Centers for Disease Control and Prevention's 1991 recommendation that health care providers vaccinate high-risk adolescents for hepatitis B,¹¹ and some states' requirement of vaccination for school entrance, detained and sentenced adolescents may not have received hepatitis B vaccination due to a lack of routine health care utilization. Incarcerated adolescents report high rates of risk behaviors that are associated with increased likelihood of foregoing health care.⁴ Thus, to not vaccinate detained and sentenced adolescents against hepatitis B is to miss an opportunity that may not be recovered later. Medical clinics in correctional facilities have the ability to provide vaccination services to these adolescents who may not otherwise seek or have access to preventive health services.

In 2001, seven states had at least 1,000 detained adolescents in addition to those sentenced;⁵ of those, three (Florida, Georgia, and New Jersey) offered hepatitis B vaccination to detained minors, while four (California, Ohio, Texas, and Virginia) did not. Hepatitis vaccination programs in juvenile correctional facilities thus neglect a substantial portion of the nation's detained

Table 2. Methods of consent in the 26 states offering hepatitis B vaccination to all adolescents in correctional facilities (as reported by Immunization Program Managers, Medical Directors, or State Hepatitis B Coordinators)

<i>Least accessible</i> —————→ <i>Most accessible</i>			
<i>Parental consent needed for both detained and sentenced n=1 (4%)</i>	<i>Parental consent for detained; state consent for sentenced n=5 (19%)</i>	<i>State/superintendent of institution consents for both detained and sentenced n=13 (50%)</i>	<i>Self-consent for both detained and sentenced n=7 (27%)</i>
DE	CA KS MT TX VA	AK CO GA FL IA KY NV NJ NM RI SC UT VT	AL (age 14) IN (age 13) LA MD NC OR (age 15) WA (age 14)
N=6		N=20	

adolescents who would benefit from receiving even one dose of the vaccine.

One limitation to our study is that we assumed that states with more permissive consent procedures would have higher rates of hepatitis B vaccine delivery compared with states that required parental consent. However, the information about laws and protocols for hepatitis B vaccination in juvenile correctional facilities should be supplemented with statistics about the percentages of those adolescents who receive vaccination in each state. States that allowed adolescents to self-consent for vaccination might have rates of vaccination equivalent to or less than other states with more stringent consent requirements. Knowing these rates might lead us to look for other salient variables that interfere with adolescent hepatitis B vaccination.

Another limitation of this study is that we were not able to get all of our answers from State Immunization Program Managers. Querying facility medical directors may have been a more reliable way of assessing variations in common practices, as medical directors are more organizationally proximal to the people who enact immunization protocols than are State Immunization Program Managers.

Data was not available from five of 50 states (Maine, Massachusetts, Missouri, South Dakota, and Wyoming). We made several unsuccessful attempts at getting information from these states. Reasons for our inability to contact them included staff out on sick leave, lack of

responses to voicemails, and refusal to participate in the survey.

Most states report that they offer hepatitis B vaccination to sentenced adolescents in correctional facilities, but less than one half of those states report also offering vaccination to detained adolescents. In all states, the law permits adolescents to self-consent for testing and treatment for STIs. Hepatitis B vaccination is an STI preventive measure, and allowing self-consent for STI preventive vaccines seems a logical extension of these testing and treatment consent policies.

The Lifespan Institutional Review Board exempted our research study from its review per CFR 46.101(b), given that we examined a matter of public record. The study was conducted with support from the National Institute on Drug Abuse grants number 1K23DA00460 01A1 and T32DA13911; and the National Institutes of Health Center for AIDS Research grant number P30-AI42835.

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