Hard Time, Healing Hands

...oping Primary Health Care Services for Incarcerated Youth

MATERNAL AND CHILD HEALTH BUREAU

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Hard Time, Healing Hands

Developing Primary Health Care Services for Incarcerated Youth

EDITED BY

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AND

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Contents

Foreword

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CHILDREN AND ADOLESCENTS IN the juvenile justice system in this country do not often benefit from the health services that they need. The morbidities affecting older children and adolescents, especially minority youth, often go unaddressed when these youth are incarcerated in juvenile correctional institutions. The reasons for this neglect are many. Standards for health care services in correctional settings for these young people have been developed but have not been widely adopted. Health services too often are provided on a limited basis or by clinicians with limited training in correctional health and adolescent medicine. Furthermore, services are not sensitive to the ethnic and cultural concerns of the population and financing of needed health care is problematic for many jurisdictions. With respect to the latter issue, incarcerated juve niles are frequently excluded from publicly financed care because of their incarceration.

For the last half decade, the Maternal and Child Health Bureau (MCHB) has devoted considerable time and resources to addressing the special needs of children in the juvenile justice system through a series of national and regional conferences and publications. The bureau established funding priorities for demonstration projects to (1) improve the health of black male children and adolescents—overrepresented among incarcerated youth—and (2) to improve the health status of minority youth who

are in contact with the juvenile justice system. All of these activities have served to create partnerships between providers of public health services and juvenile corrections.

This publication, *Hard Time, Healing Hands: Developing Primary Health Care Services for Incarcerated Youth,* seeks to further the partnership by providing guidance to both health care providers and youth corrections professionals in the delivery of enhanced physical and mental health services to incarcerated youth. Contributors to this volume have worked with the MCHBin the past to formulate its priorities and have been involved in developing model health programs for incarcerated youth.

Hard Time, Healing Hands reviews the health status and health care delivery issues as well as the training and legal aspects of providing care to this population. Youth with chronic illnesses and disabilities frequently find their way into the system, as well as young people who have been victimized by violence, homelessness, chronic mental health concerns, and the like. Any professional participating in the system of care for these youth needs to have a thorough understanding of the issues and be able to tailor services to address them. MCHB hopes that this publication will be useful in this regard.

Poverty, lack of economic opportunity, substance abuse, and violence contribute significantly to minority youth overrepresentation in the juvenile justice system, and this is discussed in some detail in this volume.

While each of the chapters are not exhaustive reviews, they do as a whole cover all of the important areas needed when enhanced health services are planned for incarcerated youth; MCHB believes that it will be a useful tool to local and state juvenile corrections agencies as well as public health agencies as they plan further services for this population. The bureau and its Child and Adolescent Primary Care Service Branch staff greatly appreciate the contributions of the editors, Drs. Linda S. Thompson and James A. Farrow, the efforts of the experts who wrote the chapters, and Paula Sheahan, Christopher Rigaux, Dan Halberstein, and Carol Adams, who produced this book.

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Overview

Linda S. Thompson, M.S.N., Dr.P.H.
James A. Farrow, M.D.

"Gold and Reimer reported that 88% of adolescents interviewed confessed to committing at least one chargeable offense within the three-year period prior to their interview."

JUVENILE DELINQUENCY, INCARceration, and institutional treatment have resulted in skyrocketing monetary and human costs. The expenses associated with property loss and institutional intervention and treatment are well documented. As incarceration rates rise, the education of more young people is interrupted, retarding their economic and personal development. Public policy discussions about the administration of juvenile justice rarely address the medical care of youth within our juvenile justice system. Improving public health intervention and treatment in the juvenile justice system may lower long-term costs and decrease educational interruption, offering a more humanitarian approach to juvenile justice.

In support of our thesis, we have reviewed the literature on selected risk factors for delinquency and incarceration. Our review focuses on three major areas: individual factors, social and contextual factors, and the developmental challenges of adolescence. The review of individual factors examines age, sex, race, academic performance, and health problems. Next, social and contextual factors such as socioeconomic status, family factors, and community and cultural factors are analyzed. Finally, the developmental challenges of adolescence are studied as risk factors for delinquent behavior. We conclude from our review that carefully targeted public health intervention

offers significant opportunities for improving the administration of juvenile justice.

Individual Factors

In 1990, almost 2 million children and adolescents were arrested in the United States—an increase of 10% since 1986.[1] The typical arrested suspect was male (88%), black or Hispanic (60%), and between the ages of 14 and 17 (80%).[2] The majority of these suspects were charged with property offenses (theft or vandalism) or with status offenses such as truancy, running away from home, or being beyond the control of their parents. Less than one-fifth of this population was held for crimes of violence (see Figure 1). Children are incarcerated in adult prisons in disturbing numbers (close to 2,000 each day in 1989) in spite of nearly 20 years of litigation to halt the practice.

Arrests statistics alone underestimate the prevalence of delinquency in the United States. Self-report surveys suggest that delin-

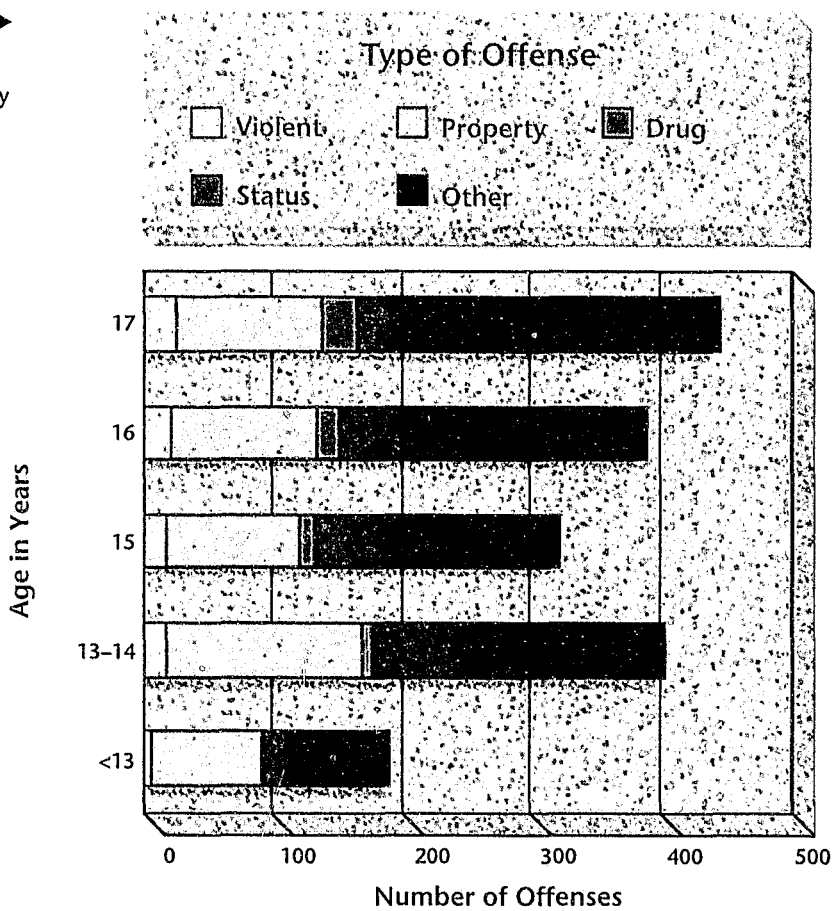

Figure 1
Juvenile Arrests by Selected Offense Categories by Age 1990 (N=1,754,542)

Source: Uniform Crime Report (1991)

quent behavior is quite common. For example, Gold and Reimer[3] reported that 88% of adolescents interviewed confessed to committing at least one chargeable offense within the three-year period prior to their interview. Investigations of official records, however, indicate that arrest statistics vary according to selected characteristics, including individual factors and social environment.[4] These characteristics are explored in the following sections.

Age

Several studies have investigated the relationship between age and delinquency.[3-6] These studies, which included cross-sectional as well as prospective and retrospective longitudinal methods, generally measured and defined delinquency by the prevalence of delinquent or criminal offenses. All suggested a dramatic peak in delinquency at 15 to 17 years of age for both males and females, independent of race, with a decline thereafter.

Elliott et al.[5] followed a nationally representative sample of over 1,700 juveniles ages 11–17, interviewing them every year for five years about offenses committed in the previous year. Restricting the analysis to ages with at least three estimates from different cohorts and averaging these estimates yielded a peak age of 15–17 for the prevalence of offenses.

The FBI's *Uniform Crime Reports 1990* (UCR)[1] data also support the finding of a peak in delinquency between 15 and 17 years of age. For example, in 1990, juvenile arrests were distributed among the age groups as follows: under 10 (2%), 10–12 (8%), 13–14 (23%), and 15–17 (66%). According to the FBI data, participation in criminal activity, particularly serious offenses, declines after age 18. A three-year average of UCR statistics from 1988 to 1990 reveals that property crime arrests peak at age 16 (4,000 arrests per 100,000 persons) and decrease by half at age 20, and that violent crime arrests peak at age 18 (700 arrests per 100,000 persons). Nonetheless, because UCR data are based only on arrest information and do not account for all criminal activity, the higher arrest rates for juveniles may reflect an increased chance of being caught due to youth and inexperience.

◀ property crime arrests peak at age 16 (4,000 arrests per 100,000 persons) and decrease by half at age 20 . . . violent crime arrests peak at age 18 (700 arrests per 100,000 persons).

Data from both *Uniform Crime Reports 1990* and studies based on self-reports indicate that the frequency of relatively minor acts such as drinking, smoking marijuana, and petty theft increases from late childhood through adolescence, subsiding after early adulthood. More serious delinquent activities

such as robbery, vandalism, and assault accelerate during adolescence and decline thereafter.[1,7] Over 80% of those surveyed admit to committing one or more minor delinquent acts between the ages of 11 and 17.[3] When delinquency is defined broadly—the commission of either a delinquent or a status offense—the overlap between adolescence and juvenile delinquency is pronounced. Examination of the relationship between adolescence and delinquent behavior may enhance our understanding of adolescence in general and of adolescent problem behavior in particular.[7-9]

Sex

▶ **the incidence and prevalence of both delinquent and status offenses committed by juveniles are greater among males than females, regardless of race.**

Farrington's review of the literature on gender variations in delinquency rates[10] shows that the incidence and prevalence of both delinquent and status offenses committed by juveniles are greater among males than females, independent of race. This gender variation holds true for every age group, not just for adolescents. However, the ratio of males to females arrested or referred to juvenile courts is declining; there has been an upsurge in arrests of female juveniles.

In *Uniform Crime Reports 1990*, males outnumber females in every category except prostitution and running away from home.[1] Tracy, Wolfgang, and Figlio[11] investigated 13,000 males and 14,000 females born in 1958 and surveyed at age 18. They recorded a male to female ratio of 4.2:1 for all delinquencies, 8.8:1 for nonviolent offenses, and 14:1 for violent offenses. The offenses with the widest gender disparity were vehicle theft, burglary, robbery, homicide, and aggravated assault.

UCR data indicate that though overall arrest rates increased for both male and female juveniles from 1986 to 1990, the increase was greater for females (24%) than for males (18%). The decrease in the gender ratio for juvenile delinquency has been accompanied by a shift in female offenders toward more aggressive and hostile acts. Girls are still more likely than boys to be held in custody for status offenses. Twenty percent of the girls arrested in 1990 were detained as status offenders, compared to only 4.5% of the boys.

Researchers have probed the relationship between gender and the different prevalence rates for aggressive crime among male and female adolescents. One possibility is a biological distinction affecting male and female aggressive behaviors. Maccoby and

Jacklin[12] argue that males are more aggressive than females in all human societies for which evidence is available. Furthermore, similar gender variations in aggressiveness are found in subhuman primates. The authors suggest that aggression in males is related to levels of sex hormones such as testosterone.

A second explanation reflects the different socialization processes for boys and girls that are reinforced by parents and society. Parents tend to place more restrictions on girls while allowing boys greater freedom, even in delinquent behavior. Girls are encouraged to "follow the rules"; boys are permitted to bend them. In addition, since girls are more likely than boys to spend time shopping, it is not surprising that shoplifting is more common among females. Boys, who have more interest in cars and weapons and more knowledge about how to use them, are more likely to commit car thefts and robberies.[10]

◀ Parents tend to place more restrictions on girls while allowing boys greater freedom, even in delinquent behavior.

Several explanations have been given for the changing nature of female juvenile offenses as well as for the declining gender ratio. The most direct explanation is that the involvement of female youth in delinquent activities has actually risen. Another explanation is that police and juvenile justice professionals are more willing to process female offenders officially, rather than handling their cases informally as had been done in the past. This would be especially true in the case of the increase in larceny-theft.[13] Both theories may be accurate, and both may reflect the shifting norms for women's roles, their rights, and how they are perceived in American society.

Race

Studies citing official crime statistics have found arrest rates among blacks well above those for whites.[1,4,11,14] The main difference in arrest rates for blacks and whites has consistently been for more serious offenses, especially those involving violence.[15] However, data reported by Lewis, Feldman, and Barrengos[16] suggest that white adolescents committing violent acts are more likely than black adolescents to be hospitalized for their problems, whereas blacks are more likely to be incarcerated.

◀ white adolescents committing violent acts are more likely . . . to be hospitalized for their problems, whereas blacks are more likely to be incarcerated.

Self-report studies have also examined racial variations in delinquency rates. These studies have tended to show negligible differences between the delinquency rates of black and white youth,[17] leading many professionals and advocates to suggest that race differences exist in the processing of juveniles by

police and official agencies.[14,18,19] A recent analysis conducted by Mauer[14] indicates that the high incarceration rate among minorities is a direct result of the "get tough" sentencing policies of justice officials and the impact of the "war on drugs." Mauer argues strongly for a shift in focus to prevention and rehabilitation.

Academic Performance

A substantial body of empirical research links academic difficulty with an increased risk of delinquency.[20-28] The exact nature of the link is unclear. Some researchers suggest that limited academic ability results in poor general adaptation, in turn increasing delinquency risk.[22,23] Others suggest that learning disabilities are mislabeled by school officials as disciplinary problems.[28] Nonetheless, researchers agree that ratings of academic competence, aspirations, and attitudes are significantly related to delinquent behavior.[24,25]

A substantial body of empirical research links academic difficulty with an increased risk of delinquency.

Bachman, O'Malley, and Johnston[22] found a consistent association between low educational attainment and self-reports of both aggression and serious delinquency. These associations were as strong in the seventh to ninth grades as they were later, indicating that the link was well established fairly early in schooling and did not increase in strength later. Similarly, West and Farrington[23] discovered that self-reported delinquents tended to score relatively low on tests of verbal and nonverbal intelligence and on tests of educational attainment. Once again, associations were evident early in schooling.

Elliott, Huzinga, and Ageton[24] investigated the interrelationships between educational aspiration, academic capability, and self-reported delinquent behavior. They concluded that neither academic capability nor level of aspiration alone were related to delinquent behavior; rather, delinquent behavior was related to the combination of either very low or very high educational aspirations and certain academic skill levels. Further clarification of the mechanisms that promote or diminish such attitudes and aspirations may require consideration of the school as a social environment.

Elliott and Voss[25] investigated the relationship between social difficulties in school and delinquent behavior. They report that social problems in school are associated with delinquent behavior rather than with poor attendance or academic difficulties. Further, when youth experiencing social difficulties drop out of school, their problems with delinquency are frequently reduced.

Children with learning disabilities, including disorders such as minimal brain dysfunction, dyslexia, developmental aphasia, and attention deficit disorders, are at risk for becoming juvenile offenders during adolescence. According to a juvenile and family court-sponsored report, learning disabilities were associated with delinquent adjudication among boys in three urban areas. Further, the associations remained after controlling for age, ethnicity, and socioeconomic status.[28] The authors suggest that learning disorders may result in academic difficulties which are mislabeled by school officials as behavioral problems. Thus, a learning disabled child is more likely to develop maladaptive behavior patterns, resulting in antisocial activity, a precursor of delinquency. The authors argue strongly for careful clinical evaluations of children to establish appropriate treatment and intervention programs.

Health Problems

Several investigators have identified increased health problems among delinquents.[29–40] Most early investigations showed that physical ailments and defects were more frequent among delinquents than nondelinquents.[30] Scott[31] found that ill health was associated with delinquency and, within a delinquent group, with maladjustment. Similarly, Wadsworth[32] found that delinquents were more likely than nondelinquents to have been admitted to a hospital during their first five years of life.

◀ ill health was associated with delinquency, and, within a delinquent group, with maladjustment.

Lewis and Shanok[33] compared the medical records of 109 randomly selected delinquents with those of nondelinquents matched for age, sex, and race. They found that delinquents had more accidents and injuries and more hospital admissions. A comparison within the delinquent group showed that this excess (primarily injuries in the first four years) occurred mainly in those with criminal fathers.[34] A parallel comparison[35] between incarcerated and nonincarcerated delinquents (84 of each) showed that the former had experienced more head and face injuries and more physical abuse; they had also experienced more perinatal difficulties. Incarcerated delinquents who were especially violent had more of these problems.

Lewis[36] also conducted a nonconcurrent prospective study of 33 incarcerated males, 9 of whom later committed murder. By looking at all available neuropsychological records predating the murder, she found that all nine had manifested extreme

violence as children and adolescents, and had a first-degree relative who had experienced psychiatric hospitalization or demonstrable psychosis. Almost all had been severely abused or had directly witnessed violence, and had major neurological impairment (i.e., grand mal seizures and/or head injuries). Lewis suggests that severe central nervous system dysfunction with vulnerability to paranoid psychotic thinking leads to quick and brutal actions when threats occur.

Farrow[37] investigated the health concerns of juvenile offenders in a short-term detention facility. He found a high percentage of chronic health conditions, most notably asthma (12%) and allergies (25%). Untreated skin disease (acne, dermatitis, and eczema) were common. Trauma and chronic bone and joint problems ranged from 20% to 55%, respectively. Sexually transmitted diseases (most commonly urethritis) were found in 22% of those tested. Interestingly, 17% of the males receiving health screening on admission were found to have delayed puberty and small stature. This percentage is twice that found in nondelinquent boys of the same age. The significance of this finding is unclear, but it may contribute to general poor self-esteem and acting-out behavior. Other pubertal disorders, such as male gynecomastia, were common. The majority of detainees used cigarettes, alcohol, and other illicit substances. Many detainees had been sexually victimized.[37] In this study, the great majority of delinquent youth reported that they had not been seen by a dentist or had a general physical exam within the past two years. Prior to incarceration, only 22 percent of the males had been taught testicular self-examination, and only 63 percent of the females had been taught breast self-examination.

▶ the great majority of delinquent youth...had not been seen by a dentist or had a general physical exam within the past two years.

Studies of HIV seropositivity among incarcerated populations cite infection rates varying from less than 1% to close to 20%.[36,39] These differences may be explained in part by regional variations (e.g., in drug use) and ethnicity. In a recent study,[40] incarcerated youth reported several behaviors that are risk factors for HIV infection: having three or more sex partners (35.6%), engaging in homosexual behavior (2%), having anal sex with a male or female (19.3%), and having sex with an intravenous drug user (14.4%).

Socioeconomic Status

Current studies indicate that racial differences in delinquency are better understood if viewed within a larger socioeconomic framework. Therefore, it is important to look at research addressing the relationship between social class and juvenile delinquency.

Studies indicate that youth with low socioeconomic status (SES) have higher arrest rates, are referred more often to juvenile court, and are placed in correctional institutions more frequently than adolescents and young adults from higher-income areas.[41] However, it is not clear that juvenile justice statistics accurately represent the delinquency rates of various socioeconomic groups. Higher arrest rates among low-income youth, when viewed independently of race, age, and gender, may indeed represent a greater level of delinquent activity; or the correlation may be an artifact. Certain studies have shown that middle class delinquency occurs as frequently as delinquency of the lower class but is hidden.[42] The problems and needs of upper- and middle-income juvenile offenders are more likely to be handled informally by police and parents and thus bypass the juvenile justice system.[39]

◀ Higher arrest rates among low-income youth, when viewed independently of race, age, and gender, may indeed represent a greater level of delinquent activity; or the correlation may be an artifact.

Researchers do agree, however, that there are distinctions between the types of offenses committed by adolescents of different socioeconomic classes. Chilton[42] reported that while adolescents from low-income areas are overrepresented in offenses involving personal gain or personal injury to others, those from high-income areas are more likely to come to court for property offenses that do not lead to personal gain, or for violation of drinking, driving, and curfew laws.

The disproportionate number of blacks who live in poverty, as well as differences in the handling of cases according to the race and social background of juvenile offenders, make it difficult to determine the precise relationship between race, social class, and juvenile delinquency. The trends are apparent: Adolescents who are black or have a low socioeconomic status have higher arrest and incarceration rates.

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Family Factors

The family structure and relationships experienced by adolescents may predict subsequent delinquent activities. A num-

ber of studies indicate that the following factors are strong determinants of juvenile delinquency: poor parent-child communication; lack of attachment between parents and children; erratic, strict, or lenient discipline; marital disharmony; and lack of supervision and control over children's behavior.[20,21,43-46] Moreover, the presence of more than one of these negative family factors increases the probability that a youth will become a juvenile offender.[20,21]

"broken" or single-parent homes do not contribute to juvenile delinquency. . . . Instead, unhappiness resulting from family tension. . . has a stronger relationship.

Contrary to popular belief, "broken" or single-parent homes do not contribute to juvenile delinquency.[43] Instead, unhappiness resulting from family tension in either broken or intact homes has a stronger relationship to juvenile delinquency. Also, consistency of punishment and not the type or amount of discipline is a determining factor in later delinquency, an observation borne out by other studies as well.[43,45]

Abused and neglected children have a higher likelihood of arrests for juvenile delinquency, adult criminality, and violent criminal behavior than do matched controls. Widom[47] identified a large sample of official child abuse and neglect cases from 20 years before and matched them with a control group of nonabused children to determine the extent to which each subsequently engaged in juvenile and adult criminal and violent behavior. In comparison to controls, abused and neglected children had more arrests as juveniles (26% vs. 17%), more arrests as adults (29% vs. 21%), and more arrests for any violent offenses (11% vs. 8%). These results remained after controlling for age, sex, and race. Widom suggests that prevention programs and intervention strategies aimed at buffering at-risk children play a potentially important role in the reduction of further violent criminal behavior.

Glueck and Glueck[30] report a relationship between hostile, rejecting fathers and delinquent behavior. According to research conducted by Audry,[46] juvenile offenders, in contrast to adolescents in a nondelinquent control group, tend to believe that they were not loved or appreciated by their parents.

Community and Cultural Factors

One of the most important community socialization models is based on Edwin Sutherland's differential association theory.[48] Proposed in the 1930s, the theory remains widely accepted as an explanation of how social interactions and associations during adolescence can lead to delinquent behavior. Sutherland conclud-

ed that social attitudes and behaviors are formed through social contact. Some individuals and groups an adolescent interacts with may accept asocial behavior; others may not. The adolescent's choice of a delinquent versus nondelinquent path depends largely on the ratio of delinquent to nondelinquent associations, the duration and intensity of the relationships, and the frequency of contact.[46] Consequently, juvenile delinquency rates are expected to be high in communities and neighborhoods where criminal and asocial influences are prevalent.

Loftin[49] argues that serious crime and violence are subcultural and may spread explosively in a vulnerable population. Using data on homicides in Detroit from 1964 to 1974, Loftin demonstrates that violent crime increased with gun ownership. He suggests that large numbers of individuals arm themselves due to anxiety about the ability of sanctioned institutions to provide protection. Furthermore, personal violence spreads because offenders and victims are part of social communication networks through which assaultive violence flows. Studies conducted on incarcerated males support the subcultural hypothesis.[50–52] They suggest that violent offenders share a common lifestyle and beliefs about crime (e.g., that crime is exciting and regular work boring).

◀ [Loftin argues] offenders and victims are part of... communication networks through which assaultive violence flows.

Interpersonal aggression in children correlated highly with later juvenile delinquency in a number of studies evaluating teacher and peer ratings as well as self-reports.[53] Furthermore, overt antisocial and aggressive behavior at age five predicts delinquency, including chronic and violent delinquency.[54] By kindergarten, more than 60% of eventual chronic offenders are already distinguishable from the other children by their aggressive behaviors (e.g., showing disrespect, acting defiantly, and being disruptive). Other data reveal that 9 out of 10 individuals committing violent offenses by age 26 were rated as highly aggressive at ages 10–13.[55]

Developmental Challenges of Adolescence

Certain behaviors, phases, and transitions associated with adolescence also characterize juvenile delinquency: the separation from parents, the increase in peer influence, and the intense preoccupation with maintaining self-esteem within the context of a group setting. Each of these factors, as well as the all-encompassing challenge of adolescence—to develop a sense

of self while making the difficult transition from childhood to adulthood—play a role in juvenile offenses.[7]

The separation from parents and the simultaneous increase in the importance of peers profoundly influence juvenile delinquency. These phenomena often combine to produce a disdain for authority figures and societal norms, leading in most adolescents to the formation of cliques and peer groups. Peer groups not only represent outlets where adolescents may test their newfound independence from their parents, but also encourage adolescents to challenge the mores of the adult world. "To some extent, every adolescent peer group teaches its members some kind of deviance, since variance from the standards of parents, teachers, and the adult establishment is integral to establishing an independent identity."[7]

Youth gang activities are deviant manifestations of the healthy and constructive outlets that adolescent peer groups normally provide. Statistics suggest that 60–90% of offenses committed by juveniles result from group influence.[56] Most juvenile delinquent acts are committed by groups of youth.[56]

Youth offenses reflect the need for peer approval, independence from parental control, and attention, all part of the adolescent's attempt to form an adult identity. Half of the referrals to juvenile court are for property crimes such as burglary, motor vehicle theft, arson, and vandalism; 20% are for status offenses such as truancy and drinking alcohol.[1] According to a Rand Corporation study,[57] juvenile offenders indicate that the reasons for committing illegal acts include thrill-seeking, peer influence, attention-getting, and status improvement.

Because of the experimental nature of adolescence, as well as its relatively short and defined duration, juvenile delinquent activities are anticipated and to some degree tolerated by adults. Delinquent behaviors diminish with the resolution of certain identity conflicts and the fulfillment of adult roles and responsibilities. Mulvey and LaRosa[58] found that factors contributing to decreased involvement in delinquency included the onset of a heterosexual relationship, vocational opportunity, and decreased involvement with deviant peers. If asocial behaviors continue beyond adolescence, acceptance and reinforcement by peers and adults diminish. The tolerated range of delinquent behaviors narrows, and the delinquent identity is no longer useful for raising young adults' self-esteem.[7]

▶ factors contributing to decreased...delinquency include the onset of a heterosexual relationship, vocational opportunity, and decreased involvement with deviant peers.

Conclusions

This review of the literature suggests that juvenile delinquency and its impact on the health and well-being of America's children are significant national problems. The negative consequences of delinquent behavior for youth as well as for society are reason enough to intensify efforts to minimize the problem.

Health professionals must therefore focus more attention on the health needs and problems of alienated and troubled youth. Successful interventions should lead to a significant lowering of the financial and social costs of juvenile delinquency. Each year billions of dollars are spent to repair the tangible consequences of such acts as vandalism and shoplifting. Additional billions are invested in responding to the legal, correctional, educational, and psychological needs of those youth whose behavior warrants intervention. Other costs, less easily calculated, are equally real: the morbidity and mortality associated with crime, the exacerbation of preexisting health problems, and the mutilation that may result from incarceration.

Serious delinquent behavior during adolescence may reduce an individual's educational and vocational opportunities. Children unnecessarily placed outside of their homes may be relegated to a lifetime of institutional care and dependency or activity in the criminal economy. Because of the detrimental physical, social, and psychological impact of youth incarceration, advocates have argued strongly for the design of new, community-based programs.

There is no simple cure for delinquency. The scope and complexity of the problem make it difficult to identify causes and to develop appropriate prevention programs. Nevertheless, child health professionals must understand the health problems and needs of incarcerated and delinquent youth. More importantly, health professionals must apply public health models to this neglected population of youth. We hope that planned and coordinated programs will reduce the negative outcomes experienced by delinquent youth. Below we offer a set of recommendations that may serve as a guide for health professionals designing programs for high-risk youth.

Recommendations

1. **Apply the public health prevention model.** Health care professionals should assist juvenile justice officials in applying

public health approaches to the problem of delinquency. Programs should be based on a continuum ranging from primary prevention to rehabilitation and treatment. Intervention approaches should target children in preschool and early elementary grades to have the greatest impact on later school achievement and social behavior. Children should be taught social problem-solving skills as a way of coping with peer influence and risky behaviors. Role-playing, peer instruction, and media analysis may assist in teaching these skills.

2. **Reform juvenile justice sentencing policies.** Juvenile justice agencies should create service facilities and programs that emphasize community-based concepts. Institutional treatment of children is extremely costly in both human and economic terms. Therefore, programs should design a comprehensive system that responds to the needs of troubled children and families. These programs should target families at risk for having a child removed and provide intensive in-home services that include home visitation and monitoring and parent education and support. Individualized treatment and rehabilitation plans should be designed for offenders.

3. **Develop multidisciplinary approaches that coordinate services between agencies providing services to children.** Programs should address the different types of predictors—individual, behavioral, and socioenvironmental—linked to juvenile delinquency. While it may not be financially and logistically possible to set up programs to meet all the needs of each risk group (e.g., children with conduct or learning disorders, those with family problems, or those from neighborhoods where delinquency is prevalent), every effort should be made to meet the special requirements of each group. In addition, a variety of programs should function concurrently since many of the risk factors are interrelated and can exist simultaneously.

   Communities should design and implement integrated youth correctional programs with health, mental health, and social services, and with educational and vocational programs. These services should be well planned and coordinated to promote collaboration and change in the system. In addition, policymakers should determine outcome performance measures to evaluate and ensure agency accountability.

4. **Establish programs that target children with conduct and learning disorders for special school accommodations.** Conduct and learning disorders appear in early childhood and often predict later delinquency. Therefore, screening and treatment programs for these problems should be established in elementary school. Due to significant differences in the causes and treatments of conduct versus learning disorders, greater care must be taken in the school system to classify the different disorders and treat them separately. Health care professionals should assist school personnel in clinical evaluations of children to establish appropriate treatment and learning accommodations.

   Learning disorders should be subdivided, with identification of those categories associated with aggression and hence juvenile delinquency. For example, only certain children with attention deficit disorder are hyperactive, and only certain children with hyperactivity are truly aggressive. Multidisciplinary treatment approaches may involve a combination of medication and social and behavioral modifications. Improper treatment or classification limits the effectiveness of any intervention measure.

5. **Target high-risk families for family preservation approaches.** Several approaches may be taken to prevent or reduce parent-child interactions that are delinquency risk factors (e.g., parental rejection or erratic discipline). One method is the establishment of parent training programs organized by health departments, school systems, or other community organizations. Parenting concepts to be taught include: communicating effectively with children, providing opportunities and appropriate rewards for involvement in family tasks, and developing consistent discipline practices. Crisis intervention techniques should also be taught. Experimental evidence indicates that delinquency referrals are reduced when both parents and children are trained in communication, contingency contracting, and negotiation skills. This training also appears to reduce delinquency referrals of younger siblings.

6. **Develop school-based health programs.** Health care professionals should collaborate more with educators to increase

awareness of health deficits of children with special needs. They should assist teachers with identifying health problems and with securing appropriate referral and treatment. Further, health personnel should suggest special accommodations to enhance children's ability to learn and achieve. Schools should offer health education and behavior courses to emphasize health promotion and the prevention of negative health outcomes, including substance abuse, injuries, nutrition disorders, and problems related to sexuality.

We recommend targeted school-based health programs that provide an array of services, including health, mental health, outreach, and case management. These programs should also provide consultation services to teachers regarding the health needs and concerns of children.

7. **Address deficiencies in the social environment.** Positive role models and social influences must be fostered to offset delinquent peer behavior which may affect children, particularly those living in low-income urban areas. Responsible adults should be empowered to provide supportive services to one or more children. Approaches may vary from individual case management and mentoring to small group meetings.

   Prevention programs based on the differential association theory attempt to decrease contact with delinquent peers by encouraging participation in conventional groups and activities. This goal may be achieved through the development and expansion of after-school and summer programs for children. Ideally, these programs should involve constructive and creative group activities such as those engaged in at youth and recreation centers. In addition, these programs may provide youth with work experience and prepare them to enter the labor force. Youth who participate in such programs will have less free time to fill and less motivation to get into trouble. They will also have a positive substitute for the delinquent activities promoted by peers.

8. **Improve institutional physical and mental health programs.** Many existing medical and mental health problems can be addressed when children enter secure detention facilities. Standards of care exist and should be met through working relationships between the juvenile justice system, correctional facilities, and public health services.

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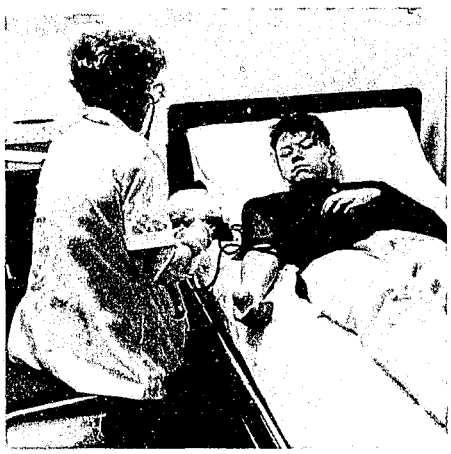
Health Status and Health Care Issues



Linda S. Thompson, M.S.N., Dr.P.H.

"Children held in adult jails have routinely been beaten, raped, and murdered.... The federal Juvenile Justice Act of 1974 mandated the removal of minors from adult jails.... Unfortunately, almost 2,000 children were still held in adult jails each day in the United States in 1989."

UNFORTUNATELY, THE HEALTH needs and status of incarcerated youth have received limited public policy and programmatic attention. This chapter will address a number of critical health status issues for the incarcerated youth population. First, data on the population will be provided. Next, health problems of incarcerated youth, health services available in juvenile justice facilities, and issues confronting health care professionals in correctional settings will be described. Finally, recommendations for improving the quality of health care services for incarcerated youth will be given.

In 1990, almost 2 million children and adolescents were arrested in the United States—an increase of 10% since 1986.[1] This increase in youth arrests may be explained in part by improved reporting, but it also relates to increases in gang activities and drug-related activities which result in the incarceration of higher numbers of underprivileged and minority youth. Changes in social conditions in the past two decades have produced a growing subculture of alienated and disaffected youth such as runaways, throwaways, juvenile prostitutes, and homeless and street youth. The children who enter the juvenile justice system are often those with chaotic family backgrounds and histories of multiple problems.[2] Their families are often poor, with medical care by necessity low on their list of financial priorities. Such

social conditions, coupled with insufficient health education in schools, places incarcerated youth at increased risk for health problems.

In the past two decades, health care professionals and youth advocates have increased national attention to problems in health care for incarcerated youth.[3-9] This attention has resulted in new models of health care delivery, new standards of practice, and a certification process for health care in correctional facilities.[6,7] However, the overall quality of health care within juvenile justice facilities remains deficient.[10,11]

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Health care professionals in correctional settings frequently confront a variety of complex issues, some unique to their correctional environments. These issues include limited funding for comprehensive health care screening and treatment, limited coordination of aftercare services, demoralized and undertrained health care staff, and institutional practices that harm the health and well-being of children though they may further correctional objectives.

Description of Incarcerated Youth Population

Although the adolescent population in the United States has declined over the last decade, the number of cases handled by juvenile courts has increased. In 1989, the average daily population of juveniles in public correctional facilities was 56,123, an increase of 14% since 1985.[12] The decline in the number of adolescents in the country, coupled with an increase in the number of those incarcerated, has produced an increase in the number of juveniles held in custody (185 per 100,000 in 1985 vs. 221 per 100,000 in 1989). Focusing on incarceration statistics underestimates the prevalence of delinquency in the United States. For example, in a national survey of more than 800 youth ages 13–16 years, 88% confessed to committing at least one chargeable offense within a three-year period prior to their interviews.[13] Longitudinal investigations suggest that 29% of whites and 50% of blacks have police records for nontraffic offenses by age 18.[14] Selected populations of youth have even greater offense rates. These populations include youth with learning and developmental disabilities, youth who are adolescent parents, youth who abuse drugs or alcohol, and youth who have been physically or sexually abused.[15-18] Children in correctional facilities are predominantly males (88%), minorities (60%), and those between the ages of 14 to 17 years, with an average age of 15.4 years.[12]

Department of Justice data[12] suggest that 95% of juveniles are in custody for legal offenses, distributed as follows: Property offenses (41%), offenses against persons (25.5%), offenses related to the use of drugs and alcohol (13.5%), and other offenses (28.4%). (The percentages add up to more than 100% because some juveniles have committed more than one type of offense.) The other 5% of juvenile offenders are in custody due to status offenses such as running away from home, truancy, or incorrigibility; abuse or neglect; or voluntary admission. The number of youth held for drug-related offenses increased by nearly 150% from 1985 to 1989.

Gender variations in offense categories reflect the fact that boys account for nearly 90% of delinquency cases resulting in admissions to facilities. Girls account for almost 50% of juveniles held for status offenses. Since 1977, the percentage of youth incarcerated for status offenses has decreased by 50%.[12]

Studies suggest that 40% of children referred to juvenile court are repeat offenders. Sex, age, and type of offense are related to the risk of recidivism. The rate of repeat offenses is greatest for the following groups: youth offenders who commit more serious crimes (e.g., burglary, motor vehicle theft, or robbery), males, and those who are younger at the time of their first offense.[19]

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It is widely believed that holding juveniles with the adult population is extremely damaging to their health. Children held in adults jails have routinely been beaten, raped, and murdered.[20] Further, the reported suicide rate for juveniles in adult jails was 6 per 100,000 admissions in 1989, as compared to 2.2 per 100,000 in juvenile facilities.[12] The federal Juvenile Justice and Delinquency Prevention Act of 1974 mandated the removal of minors from adult jails and the separation of status offenders from delinquent youth in juvenile detention facilities.[21] Unfortunately, almost 2,000 children were still held in adult jails each day in the United States in 1989.[12]

Children held in correctional facilities tend to have little or no connection to traditional sources of medical services in the community. Therefore, correctional health care may be their first or only major source of health services. Health services are most likely to be provided to young people who are committed to a training school on a long-term basis (the average stay is eight months). It is more difficult to deliver comprehensive

diagnostic and treatment services within shorter periods. Youth confined to short-term detention centers while awaiting adjudication or placement have an average stay of 23 days.[12] Though these short stays are appropriate according to correctional policies, they afford less opportunity for correctional health care.

Health Problems of Incarcerated Youth

Although adolescence is generally a time of vigorous health, the health problems that do occur among adolescents often go untreated.[22-25] They frequently result from increased risky behavior or emotional distress.[26-28] Because adolescence is a time of experimentation, much adolescent health research has focused on outcomes associated with experimental behavior. Pregnancy, sexually transmitted diseases, and motor vehicle injuries related to the use of alcohol or other drugs are examples of health problems that result directly from normal adolescent experimentation. Since adolescents are less likely than adults to smoke, drink, or be sexually active, some researchers believe that inexperience is the factor that accounts for adolescents' increased vulnerability.[29] Inexperience with adult roles and behaviors, coupled with changes in cognitive processing, may lead adolescents to make poor judgments and behave unwisely.[30] Adolescents may engage in health-impairing behaviors (e.g., eating disorders, substance abuse, and withdrawal from supportive relationships with family and peers). Adolescence is also a period of significant mental health problems (e.g., serious anxiety, depression, and suicidal thoughts).

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For a variety of reasons, youth who enter the juvenile justice system are more likely than their peers to suffer from health problems.[4,31] Medical problems were diagnosed in 46% of the 47,288 adolescents examined in New York City's single youth detention facility over an 11-year period. Dental problems were diagnosed in 90% of these adolescents.

In an early investigation conducted by the American Medical Association, incarcerated youth had higher than average rates of many health problems, including seizure disorders (2.9%), respiratory problems including asthma (8%), obesity and other nutritional disorders (5.1%), orthopedic problems (4.1%), skin problems excluding acne (25%), and dental problems (26.6%).[5] Similar findings were reported in a more recent investigation of offenders in a short-term detention facility.[32]

Thompson[33] investigated the sick-call visits of youth offenders within a large training school for boys between March 1986 and February 1987. An average of 5.9 visits per person were made to the infirmary by 1,334 males, with a range of 1–40 and a standard deviation of 6.3. The most frequent reasons for visiting the infirmary were injury (70%) and abdominal pain (13%). In addition, youth were asked to self-report health problems within a 12-month period. Several psychosomatic or emotional problems were reported more frequently than others: recurrent headaches (16.7%), insomnia (16.9%), suicidal thoughts (13.3%), and suicide attempts (8.5%).[34]

Studies of human immunodeficiency virus (HIV) seropositivity among incarcerated populations reveal infection rates ranging from less than 1%[35] to close to 20%.[36] Differences in infection rates may be explained in part by regional variations in transmission rates, regional substance abuse patterns, and the ethnicity of the populations involved. In one investigation of behavioral risks for HIV infection, incarcerated youth reported several risk factors.[34] The risk factors included having three or more sex partners (35.6%), engaging in homosexual behavior (2%), having anal sex (19.3%), and having sex with an intravenous drug user (14.4%). In Farrow's investigation of youth offenders,[32] the majority of detainees used cigarettes, alcohol, and illicit substances. Many detainees had been sexually victimized.

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Several factors contribute to increased health problems among juvenile offenders. Confined juveniles as a group are more likely to engage in behaviors that compromise their health. Smoking and the use of alcohol and other drugs are typical adolescent behaviors that have been linked to increased risk of disease and shortened life expectancy.[37,38] Recent national surveys of youth in custody reveal that 63% report regular drug use; 32% were under the influence of alcohol when they committed their offense, and 39% were under the influence of another drug.[16,39] Youth in correctional facilities engage in sexual behavior at earlier ages than their peers, and they have more sexually transmitted diseases and increased early parenting.[18,40–42] Aggressive behavior has been associated with a higher risk of injury that results in disability or mortality.[43,44]

Confined youth offenders are much more likely to be from lower socioeconomic status families who have provided inadequate health care and supervision.[45,46] Confinement may exacer-

bate preexisting health problems or contribute to new ones. For example, juveniles may suffer injuries as a result of fights or self-mutilation. Staff attempts to control adolescents through handcuffs, other restraints, or excessive medication can lead to health problems, as can various forms of physical and psychological abuse common in detention and correctional facilities.[9,47]

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Since confined juveniles are wards of the state, the juvenile justice system has a duty to provide them with adequate health services. The provision of health care can present a problem for state officials because of limited financial resources as well as inadequate recognition of the extent of health problems among the incarcerated youth population.

In addition to their physical health problems, a large proportion of incarcerated youth have significant mental health problems. Data suggest a higher incidence of mental illness, emotional disturbance, and mental retardation among confined juveniles than among those in the general population.[48,49] In addition, studies of incarcerated youth indicate that they frequently suffer from major depression and report an unusually high rate of suicide attempts.[49-52] Learning disabilities and conduct disorders also appear to be significantly more prevalent than expected among incarcerated youth. The increased mental health problems among incarcerated youth may relate to organic or biological factors; ecological factors such as family, school, or peers; psychological factors; or an interaction of all three.[15-18,48-52]

Hyde, Mitchell, and Trupin[52] investigated mental health problems of youth admitted to a juvenile detention facility. They found that 23% of the children had a major depression. Manic symptoms were described by 14% of the children, delusions by 16%, hallucinations by 21%, and paranoid thoughts by 15%. One-third of the children reported histories of suicide attempts, and 37% described deliberate self-harm behavior of a nonsuicidal nature. Fifty-six deaths, including 24 suicides and 8 homicides, were reported among incarcerated youth in 1988. Clearly, suicide prevention must be a top priority for all juvenile detention and correctional facilities.

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of youth admitted to a juvenile detention facility.... 23% of the children had a major depression....One-third of the children reported histories of suicide attempts....Clearly, suicide prevention must be a top priority for all juvenile detention and correctional facilities.

There are fundamental questions about the appropriateness of placing youngsters with mental health problems in facilities that lack the capacity to respond effectively to their problems. Juveniles who are mentally ill, emotionally disturbed, or mentally retarded arrive too frequently in detention and correctional

facilities without identification or appropriate diagnosis of their problems. In other instances, youth are confined precisely because no alternative facilities are available.[48]

The Select Panel for the Promotion of Child Health recommends that juvenile offenders with mental health or mental retardation problems not be placed in secure detention or correctional settings that lack services to meet their special needs.[53] Detention and correctional facilities have a responsibility to meet the mental health needs of juveniles, just as they should meet the physical health needs of those in their care. A number of states are working to develop flexible and diverse alternatives to secure settings. Even so, there will continue to be some mentally ill, emotionally disturbed, or mentally retarded youth offenders who must be placed in secure settings.

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Health Services in Juvenile Justice Facilities

The health care problems of incarcerated youth signal the need for a comprehensive system of health care delivery within correctional facilities. This system of care should be coordinated by an adolescent health care professional and should include assessment, diagnosis, and treatment. There are currently wide variations in the system of health care delivery for incarcerated youth,[33] but the care generally falls into three categories: (1) an onsite, comprehensive care model involving a complete medical team of physicians and nurses; (2) an onsite, limited care model involving a small number of providers, primarily nurses and contractual physicians; and (3) an offsite model. In the offsite model, routine initial health screening and management of minor ailments are provided at the facility by non health care staff. Physical examinations, evaluations, and emergency treatments are usually performed offsite by physicians in the community.[33]

Despite two decades of increased public attention, regulatory effort, and scientific research, success in improving health care services within correctional facilities has remained elusive. A 1983 survey of services highlighted several problems.[10] First, one-fifth of the responding institutions were not providing regular sick call. Second, two-fifths of the institutions were not conducting a medical screening on admission. Third, one-fourth were not providing followup physical exams within the first week of confinement. Finally, half were not providing

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mental health care for youth. Similar fragmented services were reported in recent statewide[11] and national[33] surveys.

Confined juveniles need complete medical evaluation and treatment plans. The treatment plans should be coordinated with community health services to assure continuity of health care after release. An initial medical screening by qualified health professionals is essential for several reasons. Screening may help identify seriously ill juveniles who should be transferred to hospitals or clinics rather than admitted to detention facilities. The examining professional may diagnose health problems requiring immediate or continuing treatment. Juveniles with infectious diseases may be identified. In the absence of appropriate treatment and followup, an adolescent's health problems may worsen after release, impairing adequate functioning in the community.

▶ Health care standards for juvenile correctional facilities were established by the American Medical Association in 1979 and subsequently revised by the National Commission on Correctional Health Care.

Health care standards for juvenile correctional facilities were established by the American Medical Association in 1979 and subsequently revised by the National Commission on Correctional Health Care.[6,7] The National Commission on Correctional Health Care and the American Correctional Association have accreditation procedures for juvenile correctional facilities.[8,54] The National Commission on Correctional Health Care has the most comprehensive set of standards. These standards were promulgated in 1992 by a coalition of more than 20 national health care organizations. The standards cover six aspects of health care in correctional institutions, including the administration of health services, personnel policies, the care and treatment of incarcerated children, the use of pharmaceuticals, the establishment and maintenance of health records, and medical legal issues, including informed consent and the right to refuse treatment. The American Correctional Association has a separate set of health standards for juvenile correctional facilities. It also has a set of certification standards for both adult and juvenile health care programs.

Health Care Professionals in Correctional Settings

Health care professionals working in correctional settings routinely face difficult and complex issues. Many of these issues arise from ethical questions, institutional policies, or funding constraints. Unfortunately, existing policies do not provide adequate guidance for health care concerns. An institution's ability

to attract and retain well-trained professionals is a major element in providing adequate health care. Sensitizing health care trainees to the health problems and needs of offenders is an important first step in attracting qualified personnel. One successful health care model pairs correctional facilities with academic medical training programs.

A major concern is that health care providers are asked too often to participate in practices that may adversely affect the health and well-being of youth. Such practices include the excessive use of disciplinary isolation and the misuse of mechanical or chemical restraints.[9,55,56] Participation in practices that may have adverse health consequences raises legal and ethical dilemmas.[9] In addition, medical personnel may be asked to perform body cavity searches to recover contraband goods or to obtain urine samples for drug screening.[8,57]

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Medical and legal experts have condemned the use of isolation and restraints for the punishment of children.[9,20] They argue that such practices potentially involve serious physical and mental abuse of children. Additionally, professional codes of conduct for health practitioners insist that health care providers actively resist administrative policies that are injurious to the health of inmates.[58,59] For example, the American Academy of Pediatrics condemns a number of common institutional practices defended by administrative staff on health grounds.[59] These institutional practices include: (1) isolation of children who are new admittees or who are returning to the institution from passes, pending examination to rule out infection; (2) standing orders to shave or delouse youngsters upon admission; (3) forcible pelvic or rectal examination for contraband search; and (4) use of psychotropic medications for behavioral control, without careful psychiatric evaluation and monitoring. Standard-setting bodies have argued strongly for a health care delivery system that minimizes ethical conflicts within correctional settings.[6-8] They suggest that health care services remain independent from correctional administration.

Physical or sexual abuse by institution staff or arresting law enforcement officials presents another problem for health personnel.[9] State child abuse statutes usually exclude injury caused by "reasonable and necessary" force used by law enforcement officers. Medical personnel who suspect excessive force are obliged to follow state legal requirements in reporting the inci-

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dent.[60] Health providers may also witness the effects of excessive measures used by facility staff to control behavior. These actions raise an ethical conflict for health providers who must meet the needs of adolescents while maintaining effective working relationships with facility staff and administrators.

Correctional staff who are not well informed regarding HIV infection and transmission may become unduly concerned about working with detained youth.[61,62] Health care professionals should assist correctional staff in designing appropriate policies and procedures to cope with the problem of HIV infection among incarcerated youth. They should assist with education and training programs for both workers and youth.

Responding to institutional or parental requests for experimental treatment may present problems for correctional health staff. Examples of experimental treatment include megavitamin therapy, hair analysis for diagnosis of trace mineral deficiency, aversion therapy, dietary therapy (e.g., antihypoglycemic diets), and pink paint on walls or elimination of fluorescent lights.[9] In one southern state, children in the state training school who attempted suicide were taken to the state mental hospital, stripped to their underwear, tied to the four corners of their beds, and given injections of B vitamins in a deliberately painful manner. The physician responsible for this "therapeutic" technique maintained that it was effective in modifying the children's behavior. Experimental therapies such as prolonged isolation or inappropriate use of restraints have been declared unconstitutional by federal courts.[63,64]

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In one southern state, children in the state training school who attempted suicide were taken to the state mental hospital, stripped to their underwear, tied to the four corners of their beds, and given injections of B vitamins in a deliberately painful manner. The physician responsible for this "therapeutic" technique maintained that it was effective in modifying [their] behavior.

Arranging aftercare health services for youth who leave facilities is frequently a problem. Many incarcerated youth lack a regular source of health care and are shuffled among various community placements. In addition, health care personnel are rarely consulted prior to an adolescent's release from a juvenile justice facility, and they find it difficult to arrange for medical evaluation and treatment following the adolescent's discharge.

Adapting health care practices to the security precautions of a restricted facility often presents problems for health care workers. For example, they may fail to understand the physical and emotional symptoms caused by the stress of living in such an environment. Health care professionals should understand that large numbers of youth in correctional facilities are housed in overcrowded facilities. The majority are nonviolent and experience

significant physical and emotional distress as a result of incarceration. Three states (Massachusetts, Utah, and Missouri) rely heavily on community-based programs and reserve incarceration for seriously violent or chronic offenders. Child health practitioners should educate policymakers about the need to place youth in environments that promote their health and preserve the family unit.[48]

Health care professionals may face problems in securing comprehensive health care services within a correctional facility and in justifying the need for them. Health care services in correctional facilities are generally financed in several ways: funds within the same budget pool as those for operating the institution, separate funds from the county or state health department, pilot program grants from the federal government, or reimbursement for services provided. Unfortunately, federal guidelines prohibit the use of federal Medicaid funds for health services provided within a correctional facility. Since youth in these facilities often come from low-income families, they frequently lack medical insurance or other financial resources to pay for health care. Therefore, health care providers within juvenile correctional facilities may not be reimbursed for services they provide.

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Discussion

Delinquent youth clearly represent an underserved population with many health care needs. Adolescents confined to correctional facilities should be protected as much as possible from developing physical and emotional problems that result from or are exacerbated by incarceration. Overcrowded and unsanitary living conditions are all too common. Maltreatment of youth with overuse of physical restraints, psychological intimidation, and unnecessary psychoactive medications still occurs. The majority of youth in correctional institutions are not perpetrators of violent or serious crimes. Many may be categorized as victims with underlying, undiagnosed, or untreated physical and emotional disorders.

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The majority of youth in correctional institutions are not perpetrators of violent or serious crimes. Many may be categorized as victims with underlying, undiagnosed, or untreated physical and emotional disorders.

Many incarcerated youth lack a regular source of comprehensive health care. A coherent plan to improve surveillance, prevention, diagnosis, and treatment of incarcerated youth is sorely needed. The hope is that these adolescents will become more productive and effective citizens through better health care.

Recommendations

Organizations of health professionals should become more involved in providing health care within detention and correctional facilities. Professionals should work to ensure that these facilities meet minimum standards of care established by the National Commission on Correctional Health Care. If deficiencies exist, health professionals should assist correctional facilities in identifying and coordinating health care services. A process should be designed to ensure that systemwide goals and performance measures include health status measures.

Health care professionals should become advocates for the health concerns of youth in correctional facilities and should ensure that medical practices are appropriate for adolescents and also comply with legal and ethical mandates.

Health care professionals should lobby elected and appointed officials to prohibit practices that may harm children physically and mentally. They should discourage the detention and incarceration of youth for mental illness. They should also discourage mechanical and chemical restraints, isolation for inappropriate reasons, experimental therapies not supported by scientific evidence, and the detention and incarceration of children and youth in adult jails.

Health care professionals should assume a greater role in analyzing the quality of health care services within juvenile justice facilities. Practitioners should assist juvenile justice staff in designing surveillance methods to assess the quality of health care programs.

Health care professionals should collaborate more with juvenile and correctional professionals to increase awareness of health care standards and practices. This collaboration should include the design and implementation of an integrated youth correctional program, including social, health, and mental health services and educational and vocational programs. A mechanism to alleviate "turf" issues and foster collaboration should be established.

Health care providers must interact with correctional professionals to establish a continuum of programs for youth offenders. These programs should range from primary prevention to rehabilitation and treatment. Individualized rehabilitative and treatment plans should be established for special groups of youth: first-time offenders, chronic and serious offenders, and youth in need of supervision.

Finally, health care professionals should work with elected officials to increase funding for health care for incarcerated youth. Flexible streams of funding should be designed to reduce eligibility barriers and simplify administration. Medicaid funding should be reviewed for possible legislative change.

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3 Training

Ronald A. Feinstein, M.D.

"Adolescents in custody may believe that any information they provide will be used against them in court. . . . The adolescent must believe that the interviewer is truly interested in his or her welfare and not functioning as a part of the criminal justice system."

MANY OF THE MAJOR HEALTH conditions affecting detained youth have become important public health issues. These conditions include violence-related injuries and deaths, sexually transmitted diseases (including AIDS), substance use and abuse, and unwanted or unintended pregnancies.[1] As pointed out by other contributors to this volume, these health conditions result in part from multifactorial problems involving families and communities. The most effective means of addressing these problems is through the development of health care delivery networks that focus on the causes of high-risk health behaviors rather than on the consequences of the behaviors. Success in the identification, treatment, and prevention of the health conditions of incarcerated youth requires that professionals and staff working in the juvenile justice and health care systems develop the unique skills necessary for dealing with this population.

Surveys of health professionals have shown that a majority lack knowledge and feel unprepared to handle adolescent issues and concerns.[2] A recent report published by the Maternal and Child Health Bureau (MCHB) states that health care workers lack experience in providing services for black male children and adolescents. In addition, MCHB states that most professionals are not properly prepared to do assessments and lack resources to

intervene if a problem is discovered. The report recommends improvements in the training of health professionals serving adolescents.[3]

In order for health professionals and policymakers to become more successful in reducing the unacceptably high morbidity and mortality rates among detained adolescents, they must acquire a more comprehensive understanding of adolescence itself. Specialized training is required if professionals and policymakers are to develop the unique skills and competencies necessary to provide services for adolescents. Preparation of professionals can best be accomplished through increased dissemination of information; innovative and improved linkages among appropriate programs, agencies, and organizations; and improved preparation of personnel in disciplines relevant to the provision of health care to adolescents in custody.

The purpose of this chapter is to provide the reader with information necessary to serve adolescents in custody. Programmatic issues to be discussed are:

1. Normal adolescent growth and development
2. Interviewing
3. Cultural sensitivity
4. Networking/linkages

Growth and Development

Recognition that adolescents form a unique group within the health care community has developed only over the past three decades. The transition from childhood to adulthood is no longer limited to the teenage years. In some instances it can last for 10 or 15 years. Adolescence is no longer perceived as a period when no significant health problems occur.[4] However, to understand what is abnormal in adolescence, one must first be knowledgeable about normal adolescent development.

Developmental components of adolescence include physical, cognitive, and psychosocial milestones. Maturation in all three areas occurs simultaneously but at different rates and times for different individuals. Changes in one area can have a considerable impact on other areas.

Physical[5]

Puberty is the stage of physical development at which an individual becomes capable of bearing or begetting children.

Historical records appear to document a trend for this process to occur at younger ages. It is the only period following birth during which an individual experiences an increase in growth rate, characterized by rapid increases in height and weight and the development of secondary sexual characteristics. Though the timing of these changes varies among individuals, a certain sequence of events normally occurs following initiation of the process. Assessment of pubertal maturation is most easily accomplished by physical evaluation of the configuration of pubic hair, breast tissue, and genitalia (Tanner staging or Sex Maturity Rating). The staging system involves the assignment of a number from 1 to 5, depending on the stage of maturation of the individual. Stage 1 indicates a childlike configuration and stage 5 an adult one.

Girls generally begin puberty about two years before boys do. Some girls begin this process as early as 8 years of age, while others may not begin until age 13. Almost 50% of girls begin puberty by 10 years of age. Changes usually take place over 3 years but can range from 1.5 to 4 years in duration and still be considered normal. The first sign of development in most girls is the appearance of a small amount of breast tissue. On average, menstruation occurs 2.5 years after breast budding and marks the conclusion of a girl's growth period. The mean age of menarche among American girls is approximately 12.5 years of age.

Pubertal stages in boys also follow established patterns. Ninety-five percent of boys begin puberty between 9.5 and 15.5 years of age, with half beginning by about 12.5 years. It then takes from 3 to 5 years to reach adult male status. The first sign of puberty in a boy is usually enlargement of his testicles. Boys become taller and more muscular than girls during this period. Boys do not develop sperm until they have completed the majority of their adult growth.

Tanner stages have many uses beyond the assessment of levels of pubertal development. Many laboratory values and physical complaints are uninterpretable without knowledge of an individual's stage of development. These include evaluations for possible anemia, primary amenorrhea, musculoskeletal complaints, or short stature. Thus, understanding the normal process of pubescence allows the initiation of appropriate care for the adolescent patient.

Tanner stages have many uses beyond the assessment of levels of pubertal development. Many laboratory values and physical complaints are uninterpretable without knowledge of an individual's [developmental] stage.

Cognitive[6]

Piaget provides us with the most commonly accepted theory of cognitive development: Adolescence is the period in which individuals are expected to make the transition from concrete to formal operational thought. During adolescence, the capacity for abstract thinking is developed. This provides individuals with the ability to generate hypotheses, consider contrary-to-fact situations, generate all possibilities from a specific situation, and approach a problem in a systematic fashion. It is believed that this transition begins as early as 12 years of age and exists in most adolescents by age 15 or 16. However, many young people and adults do not use abstract thinking effectively. It is not appropriate to expect individuals to think abstractly solely because they are physically mature. Researchers have not shown any correlation between the timing of cognitive development and the timing of physical development during adolescence. As a result, professionals must adjust their inquiries and explanations to take into account the level of cognitive development of each adolescent. This may require close-ended and directive questions and step-by-step explanations. The inability to think abstractly may account for the fact that many juvenile detainees do not consider the consequences of their actions.

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Psychosocial[7,8]

The development of an individual's capacity to function as an adult in society is the third important area of adolescent development. A framework for describing this type of development consists of four tasks that adolescents must complete before they are considered adults. These tasks are the achievement of:

1. Independence from parents and family
2. Realistic vocational goals
3. A mature sexual identity
4. A realistic self-image

It is almost impossible to predict an adolescent's level of psychosocial maturity in any of these areas based solely upon his or her chronological age or level of physical or cognitive development. It is most convenient to divide these tasks into early, middle, and late stages, as noted by Owens (see chapter 6, page 85).

To restate the concepts somewhat differently, early adolescents usually vacillate between wanting total independence and needing tremendous amounts of parental supervision and sup-

port. They generally have unrealistic vocational expectations and do not have a true understanding of their abilities. Early adolescents fantasize often about members of the opposite sex and begin to experiment with sexual behaviors. Their self-image is fragile, due largely to the numerous physical changes that occur at this time.

The middle adolescent becomes part of a peer group and prefers to spend time with friends rather than with parents or other family members. Adolescents begin to question their own and their parents' values and beliefs. They begin to have more realistic expectations about their futures, more socially acceptable interactions with the opposite sex, and more defined self-images. Middle adolescence is also the period during which problem behaviors usually begin to develop.

The late adolescent more equitably balances his or her peer group with parents and family. By this stage, adolescents are ready to strike out on their own and have chosen goals appropriate to their skills and abilities. Late adolescents are able to develop relationships in an adult fashion, and they have begun the process of self-acceptance.

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INTERVIEWING[9,10]

There are many differences between interviewing an adult and interviewing an adolescent. As discussed above, the interviewer must be knowledgeable about the unique developmental aspects of adolescence and be comfortable with the sensitive and controversial issues adolescents face in today's society. Interviewing the adolescent in custody usually presents added challenges because of the adolescent's suspicion that the information obtained will be used in court.

Attitudes

Prior to providing services to adolescents, individuals working with this population must reflect critically upon their own attitudes and beliefs. Professionals must be willing to set aside their own prejudices in order to provide services that are in the best interest of the adolescent. Open-mindedness is demonstrated by the willingness to discuss all topics and to consider all options available to the adolescent. Respect for the adolescent should be shown by a caring attitude and by interest in the adolescent's welfare. This should include commitment to the

adolescent's best interest without regard to his or her social background or financial status. Awareness of and consideration for the additional vulnerability of the adolescent in custody should be demonstrated. At all costs, the interviewer must not appear to be an agent of the court or to be judgmental, demeaning, or intolerant, to avoid replicating interactions youth might have had with custodial staff.

Skills

A major priority of the interviewer is to create an environment conducive to the provision of adolescent health services. When and where the interview is conducted is extremely important. Though it is recommended that the interview take place without a parent or other adult in the room, in some situations (e.g., detention centers) it is necessary to have someone else present. All too often, the adolescent in custody obtains services in an environment where privacy is lacking. This should be avoided if possible. All information pertinent to the interviewer's needs should be gathered. This information may include health status, family environment, financial status, and community support.

Inappropriate or insufficient information may be acquired because the adolescent does not understand the questions, is not ready to discuss sensitive issues, or is uncomfortable speaking in a certain environment. Adolescents in custody may believe that any information they provide will be used against them in court. The interviewer must make an effort to establish a trusting relationship with the adolescent; the adolescent must believe that the interviewer is truly interested in his or her welfare and not functioning as part of the juvenile justice system. Phone calls, noises, or interruptions by others asking questions are likely to make adolescents feel that they are of little importance. Ideally, the interview should take place in a quiet, relaxing environment that allows trust to develop.

▶ **Many adolescents in custody are forced to receive services. It is not unusual for them to be uncooperative or verbally unresponsive.**

Many adolescents in custody are forced to receive services. It is not unusual for them to be uncooperative or verbally unresponsive. If the adolescent is silent or hostile during the interview, the contact should be terminated. The adolescent may be less angry or anxious and more cooperative at another time. It is important to remember that the hostility is rarely directed at the health provider. Practicing communication skills can be helpful. One of the most important and probably most neglected communication

skills is listening. A good listener is someone who knows when to be quiet, gives appropriate feedback, makes eye contact, and maintains a position that shows continued interest.

Confidentiality[11]

In order to establish a trusting relationship, the interviewer must communicate the concept of confidentiality to the adolescent. The principle of confidentiality protects the patient from the disclosure of certain confidences entrusted to a physician or other health care professional in the course of treatment. The privacy of adolescents—including confidentiality of their health records—must be respected except in cases where confidentiality could result in harm to others or in cases where there is suspected or proven child abuse. This confidential relationship extends to adolescents in custody.

◀ The privacy of adolescents—including confidentiality of their health records—must be respected.

Cultural Sensitivity

Racial differences are believed to have a tremendous impact on the provision of health care services. As noted by Ewing (see chapter 10, page 155) and others in this volume, racial and ethnic differences affect the expression of health concerns and provider responses to them. Unfortunately, little research has been done on the effect these differences have on the physician-patient relationship. Studies have shown that physicians spend more time with and provide more explanations to patients who seem more intelligent and better educated. It is known that people who share similar cultural patterns, values, experiences, and problems are more likely to feel comfortable with and understand one another. Research done on psychiatric patients has shown that black patients are accepted into psychotherapy less often than white patients, are assigned more often to inexperienced therapists, are seen for shorter periods of time and with less intensity, and are more likely to be given psychotherapeutic drugs.[12] Since the majority of health care providers serving adolescents in custody are white, and the majority of adolescents in custody are black, it is imperative that health care providers receive increased information and training about African American culture (see Bazemore and McKean, chapter 7, page 99).

◀ black patients are accepted into psychotherapy less often...are assigned more often to inexperienced therapists, are seen for shorter periods of time and with less intensity, and are more likely to be given psychotherapeutic drugs.

Though current beliefs about normal adolescent growth and development serve as a framework for understanding the gener-

al process of adolescence, they are in many ways inadequate for evaluating black adolescents in custody, particularly males. No black adolescent males or females were included in Tanner's studies on normal pubertal physical development. Although the sequence of changes is similar among different ethnic and racial populations of adolescents, there are significant differences in the timing of certain events. A provider unaware of these differences risks making inappropriate recommendations. Of greater concern than physiological differences is the possibility that the four psychosocial developmental tasks of adolescence will be inappropriate and irrelevant when applied to black male adolescents. For example, with the unemployment rate exceeding 50% for young black males, it may be unrealistic to base an assessment on the ability to find a job or to develop realistic vocational choices.

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Many white health care providers negatively stereotype African Americans. An example of this stereotyping is the belief that a female-headed household is accepted as normal within the black community and that single parenthood is encouraged within this community. Studies indicate that these conditions are not accepted norms within the African American community, and that when it is possible to control for social class, most of the differences between whites and blacks disappear. Providers working with the African American population must adapt the developmental tasks to be more realistic.

In the United States, minority adolescents must establish some form of racial, ethnic, or cultural identity during the normal process of growth and development. Research has shown that proactive guidance by parents to help children overcome racial barriers can lead to an increased sense of personal efficacy and improved academic performance.[14] However, in many areas in the United States, it is almost impossible to develop a positive black image and self-concept, due to the overwhelming feeling of hopelessness resulting from poverty and prejudice. Health care providers must recognize the existence of this hopelessness, obtain information to allow them to better understand it, and realize that it may be an important cause of health care problems among minority populations. If the health care provider is not sensitive to the process of racial identity formation as a source of stress, then an inappropriate evaluation and treatment program may be developed. Also, the development of effective preventive medicine and health promotion programs will be difficult.

NETWORKING/LINKAGES

Improving the health status of adolescents in custody requires the cooperation and involvement of individuals from a large number of disciplines and agencies. In most instances, these individuals are unfamiliar with one another's organizations and training. In order to provide health care services to adolescents in custody, professionals must develop the capacity to work as a team.

The development of an effective health services team requires that individuals become knowledgeable about team dynamics, including:

1. Team-building
2. Organization
3. Problem-solving
4. Conflict resolution

In order to build an effective team for adolescents in custody, representatives from all agencies involved with and interested in these youth should be included. Representatives from health care, justice, and social services are especially important. Additional members could include community leaders and Medicaid workers. Teams should develop realistic goals and objectives and the resources to accomplish tasks. Strategies should be adopted to encourage organizational development, well-defined goals, adaptability, and conflict resolution. An effective team must adapt to constant change.[15]

One means of improving the health care services provided to adolescents in detention facilities is the establishment of affiliations with training programs based in medical schools. Such relationships provide access to a wide range of disciplines and create opportunities for increased training and improved services.

RECOMMENDATIONS

Health care professionals and correctional staff are uniquely positioned to provide health care services to an underserved population. Health care and correctional systems can work together to develop an integrated network to improve the health status of the incarcerated youth population. In order to achieve this goal, there must be a concerted effort to improve training within both systems. All programs should strive to:

- Increase the amount of training in adolescent development that is provided to health professionals and correctional workers at all levels.
- Increase interview training, highlighting the specific challenges associated with racial and ethnic minorities.
- Increase the amount of information provided about African American history and culture at all levels of education.
- Improve the ability of individuals to develop networks and linkages throughout health care and correctional systems.
- Increase the amount of information provided to health care professionals about adolescents in custody.

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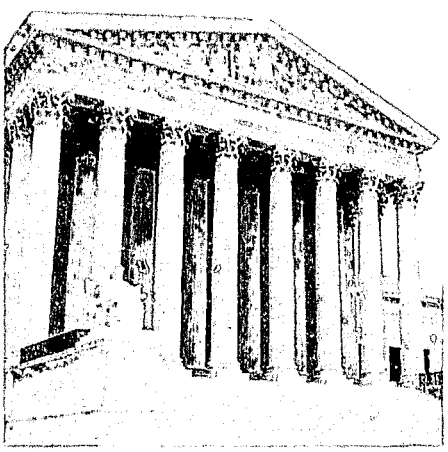
4

Legal Issues



Michael J. Dale, J.D.

"Concerns include liability for battery, invasion of the right to privacy, cruel and unusual punishment, [and] intentional infliction of emotional distress.... However... professional competence and reasonable policies and procedures... developed with the assistance of legal counsel, should assuage these fears."

FOR GOOD OR BAD, THE LAW HAS A direct and significant effect upon the health care provided to children who are incarcerated for violations of law. The federal and state constitutions and federal and state statutes each define and prescribe health care—medical, mental health, and dental care—to children held in America's correctional institutions. Effective and humane care for these children may be enhanced by an increased understanding of the legal and medical issues raised by a child's incarceration.

This chapter surveys the major legal issues confronting health care professionals who work with incarcerated youth. It begins by summarizing the various legal categories under which children are incarcerated. It then outlines the legal responsibilities of health care providers as defined by constitutional law, case law, statutes, and national professional standards. In this context, it focuses on sources of liability and theories of lawsuits. Thereafter, it surveys several of the major issues in the field, including questions of confidentiality and a child's consent to health care. This chapter concludes by asserting that health care providers should be concerned about and conversant with the legal issues affecting incarcerated youth, and that professionals ought not to be fearful of legal issues. With increased understanding, health care professionals should seek to provide the most

competent care available because it is the best means of avoiding unnecessary involvement in legal matters.

Categories of Incarcerated Youth

Four distinct legal categories of children are generally found in correctional institutions. They are children charged criminally as adults, juvenile delinquents, status offenders, and abused and neglected children. Understanding the child's legal status should help the health care provider give more individualized care. Furthermore, the child's legal status may affect the legal duty of the provider to the child. The largest percentage are children charged with or adjudicated to have committed acts of juvenile delinquency. It has been reported that each year approximately 700,000 adolescents are confined in public and private juvenile justice facilities.[1] Approximately 90% are in custody for delinquent offenses.

▶ Approximately 90% [of incarcerated youth] are in custody for delinquent offenses.... [acts] that if committed by an adult would be [crimes]....The states differ dramatically in how they treat juvenile delinquents.

Juvenile delinquency is defined as an act that if committed by an adult would be a crime. Virtually every state has specific statutes addressing juvenile delinquency, and in many states a separate court handles such matters. The states differ dramatically in how they treat juvenile delinquents. For example, the date at which a child becomes an adult for the purposes of adult criminal court adjudication varies significantly. The states differ as to what criminal charges will cause the child to be brought before an adult criminal court rather than a juvenile court. The states vary in how they handle children once they are convicted in adult courts. Some allow for the return of children to juvenile courts for dispositional purposes. Others require that children be sentenced and incarcerated in the adult criminal justice system.

The states also vary in their procedures for determining whether a child shall be dealt with in the adult system rather than in juvenile court. In some situations, charges will be filed against the child directly in the adult system. In other situations, governed solely by state law, the prosecutor may seek to transfer the child to adult court by means of a waiver petition. Waiver or transfer generally refers to a situation in which the prosecutor makes a motion asking the court to transfer the child to the adult court for adjudication based upon an assertion that treatment of the child in the juvenile justice system is no longer appropriate. Direct filing or certification (depending upon the terminology used in the state) refers to a situation in which the child is initial-

ly sent to the adult court for trial and sentencing, based upon that state's particular statutory framework. In some states and for certain crimes, a child can petition to transfer back to the juvenile court.[2]

The second category of incarcerated children includes those who come before the adult criminal court as adults. These children will be tried as adults and, if convicted in a jurisdiction where there is no reverse transfer for dispositional purposes, will be incarcerated in the adult prison system. As shall be seen, in some jurisdictions children are placed in separate youth offender sections of facilities within the adult correctional system.

◀ those who come before the adult criminal court.... if convicted, [often] will be incarcerated in the adult prison system.

The third category of children found in correctional institutions are status offenders. Also known as children or persons in need of supervision, these are children who commit acts that would not be crimes if committed by adults. Status offenses occasion court intervention solely because of the offender's status as a child. Typical examples include running away from home, school truancy, and being beyond parental control. Until recently, a large number of status offenders were held pretrial in secure detention. The passage and implementation of the federal Juvenile Justice and Delinquency Prevention Act (JJDPA), which included a provision for the deinstitutionalization of status offenders, has effected the removal of large numbers of status offenders from secure detention. At one time, these children were held with delinquents in juvenile correctional institutions, most often training schools. Due in large part to the passage of the JJDPA, states rarely place adjudicated status offenders in correctional settings.

◀ status offenders... are children who commit acts that would not be crimes if committed by adults.

The fourth category of children who may be found in correctional care are those who are abused or neglected. They are also known as dependent children. Abused and neglected youngsters are defined in different ways by the states. Abuse often refers to physical injury, including sexual abuse. Neglect often refers to the failure of the parent to provide adequate food, health services, education, and emotional support to the child. In some states, the term *dependency* refers to both abuse and neglect. Dependent children are rarely held in correctional settings. In most states, only a few dependent children are held even pretrial in secure detention. As with status offenders, the JJDPA outlawed placement of these children in secure detention in states receiving funding from the federal government.

◀ children... who are abused or neglected.... are defined in different ways by the states.

Where a child is placed has a direct impact upon the health care the child receives. The size of the institution, its location, who operates it, and the legal status of the children held in the facility all affect the legal issues relating to the health care of the child.

However, dependent children may be held in congregate care living arrangements that are not referred to as correctional but that may be institutional in nature.

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Detention centers, used primarily to hold accused juvenile delinquents prior to trial, vary in size and operation from jurisdiction to jurisdiction. Detention centers, however, also hold status offenders and dependent children, sometimes in violation of state law and sometimes based upon findings that such children are in contempt of court for violation of status offense or dependency orders. In large cities, most detention centers are locked institutions that employ a variety of operating philosophies. In rural areas, they exist as regional detention centers or as jails or lockups with a small section or even a single cell devoted to the secure detention of children. In most jurisdictions, detention centers are operated by county governments or by the courts.[3] There are some exceptions. For example, Spofford, the detention center in New York City, is operated by the City of New York.[4,5] In Florida, the state welfare department, the Department of Health and Rehabilitative Services, operates the detention centers.[6]

Training schools are generally understood to include locked and typically large congregate facilities where adjudicated delinquents are placed. Usually operated by the state, they are viewed as the most secure facilities and therefore the deep end of the juvenile justice system. They exist in most states, vary in size, and often compare in operational format to parts of the adult prison system. They have been the subject of numerous lawsuits regarding conditions over the past two decades.

Convicted juveniles are housed in the adult prison system, albeit often in separate facilities. Though they may provide greater access to both regular and special education services, these separate facilities generally resemble other parts of the adult prison system.

This chapter focuses primarily upon children held in secure detention, training schools, and adult jails and prisons. It is therefore concerned largely with juvenile delinquents and juveniles in the adult criminal justice system.

Access to and Adequacy of Health Care

Perhaps the most common issues concerning children in correctional institutions involve access to and adequacy of health care services in the facilities. The issues become legal in nature when a child alleges a failure to provide care or claims inadequacy in the provision of care, usually in the form of a lawsuit brought at some point after the youngster leaves the institution. The law evaluates access to and adequacy of care in the context of questions of liability or legal responsibility. A review of the theories of liability of health care providers helps elucidate the issue of what constitutes appropriate care.

Essentially, there are two theories of liability and two methods of relief. The first theory involves claims of civil rights violations of either the Constitution or federal law. The second theory involves state tort claims based primarily upon the tort of negligence or violations of state statutes.

The methods of relief are twofold. The children may seek injunctive relief whereby they ask the court to enjoin public officials to change policies, procedures, and systems in order to produce access to or create adequate health care services; similarly, children may seek injunctive relief based upon state law and seek enforcement of rights premised upon state statutes. Alternatively, through either civil rights or state tort claims, the children may seek compensation in the form of money damages.

◀
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Civil Rights Claims

Lawsuits alleging violations of federal rights may be brought in either state or federal courts under the civil rights statute 42 U.S.C. § 1983. Claims against the federal government may be brought directly under the Constitution.[7] Section 1983 claims are brought against state or local agencies and officials. The Supreme Court has held that private contract health care providers are considered public officials for the purposes of civil rights liability and therefore may be sued under the Civil Rights Act.[8] State sovereign immunity is not a defense to a federal or state court Section 1983 cause of action.[9,10] Section 1983 provides that:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia,

> subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and the laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.[11-14]

The most typical claims involve denial of the right to privacy, denial of equal protection, denial of procedural due process, denial of substantive due process, and/or cruel and unusual punishment.

The constitutional rights that the child may claim were violated include the First, Fourth, Fifth, Sixth, Eighth, and Fourteenth Amendments to the U.S. Constitution. The most typical claims involve denial of the right to privacy, denial of equal protection, denial of procedural due process (the obligation of the government to give an individual notice and an opportunity to be heard before taking away one's life, liberty, or property), denial of substantive due process (the obligation of the government to demonstrate that it has the right to take away one's life, liberty, or property regardless of the procedures used), and/or cruel and unusual punishment. The most common of these claims is that the health care is so inadequate as to constitute a denial of substantive due process or cruel and unusual punishment. The Supreme Court has not explicitly stated how one interprets a violation of substantive due process in the case of children in detention or other juvenile correctional care. The Court has spoken in other contexts involving adult convicted prisoners and the civilly committed. Based upon the holdings in a grouping of Supreme Court cases—including *Hudson v. McMillian*,[15] *Whitley v. Albers*,[16] *Estelle v. Gamble*,[17] and *Youngberg v. Romeo*[18]—one can articulate some guidelines for the likely constitutional test of adequacy of health care in juvenile institutions as compared to care of juveniles in adult institutions.

For convicted individuals, including juveniles held in the adult system, the Eighth Amendment provision against cruel and unusual punishment forbids "the unnecessary and wanton infliction of pain."[16] In *Estelle v. Gamble*, the unnecessary and wanton infliction of pain was defined in the context of convicted prisoners as the failure of prison officials to attend to a prisoner's "serious" medical needs and the exhibition of "deliberate indifference" to those needs.[17] The Court recognized that "the standard is appropriate because the state's responsibility to provide inmates with medical care ordinarily does not conflict with com-

peting administrative needs."[16] Thus, simple negligence by a health care provider is not a constitutional violation.

On the other hand, in *Youngberg v. Romeo*, the Supreme Court held that a civilly committed individual has the right to habilitation (reasonable care and safety) but not to rehabilitation (being made better). That would suggest a much more heightened constitutional responsibility than specified under *Estelle*, and *Youngberg v. Romeo* should apply to children who are not held in adult prisons.[16] Thus, for a child in juvenile pretrial detention or in a state training school, the constitutional obligation may be viewed at most as a right to expansive health care treatment and at least as a right to be protected from medical harm. It is impossible to say which standard applies because the Supreme Court has yet to answer the question. On the other hand, the law is clear regarding children held in the adult correctional system. The *Estelle* deliberate indifference standard applies.

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Civil Rights Defenses

The Supreme Court has ruled that constitutional due process rights are not violated by an official's failure to protect a child against private or third-party violence as long as the child is not in state care, even when the official had notice of the danger. Health care providers therefore have no obligation to protect children from the society at large, certainly not before the child is housed in the correctional facility.[19] When the child is in a state or local correctional facility, health care officials do have an obligation to provide a constitutionally adequate level of care.

One particularly important legal defense exists even when the child is clearly in custody and health care providers have an obligation to protect the child. It is qualified immunity from constitutional or other civil rights liability. This defense arises when the constitutional standard for the provider's obligation to the child has not been clearly established by prior federal civil rights case law.[20] In order for an official to lose his or her qualified immunity, "the contours of the [child's] right must be sufficiently clear that a reasonable official would understand what he is doing violates that right."[21] In the context of health care for children in correctional institutions, it is hard to use this defense because the law is clearly established, at least at the

◀ qualified immunity from constitutional or other civil rights liability... arises when the constitutional standard for the provider's obligation to the child has not been clearly established by prior federal civil rights case law.

level of deliberate indifference. Under the *Estelle v. Gamble* standard, public officials will be held accountable for violations of the constitutional rights of incarcerated children if they act with deliberate indifference to the children's serious medical needs.

National Standards

Over the past 20 years, the medical community has promulgated three sets of national standards that govern the provision of health care in juvenile institutions. The most recent is the newly revised Standards for Health Services in Juvenile Confinement and Detention Facilities, developed by the National Commission on Correctional Health Care. Previous standards have been enacted by the American Correctional Association (1979 and 1983) and by the American Medical Association in conjunction with the American Bar Association (1974). Similar standards have also been drafted regarding prisons and jails. It seems clear that violation of these national standards alone will not give rise to a successful claim of civil rights violations. In *Bell v. Wolfish*,[22] a case involving adult prisoners in a federal correctional facility, the U.S. Supreme Court held that violations of national prison standards by themselves did not constitute a violation of civil rights. On the other hand, these standards may have substantial weight when the issue involves what is reasonable or acceptable under contemporary standards in a tort case.

▶
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State Tort Claims

There are two obvious sources of liability on state tort law grounds. The first involves claims of violations of state statutory duties to provide health care, and the second involves negligence. State statutory violations may arise from the failure to conduct mandated tests and vaccinations or to license, test, and train health care staff or otherwise comply with state health law. The evaluation of a statutory claim involves determining whether there was a statutory duty to act, whether the public official violated the statutory duty, and whether the child suffered damages as a direct result of the failure to comply with the law.

▶
There are two obvious sources of liability on state tort law grounds. The first involves claims of violations of state statutory duties to provide health care, and the second involves negligence.

Negligence claims are formulated along similar lines. The four-part test is the following: (1) Did the public official have a duty toward the child to either act or refrain from acting? (2) Did the public official violate that duty by acting unreasonably? (3) Was the act or inaction the cause of the injury? (4) Did the child

suffer damages? A comparison of the test for a civil rights claim the test for a state tort claim demonstrates that the state negligence or statutory tort claim is easier to substantiate.

There is, however, a significant defense to both statutory tort and negligence claims under state law. The defense involves the doctrine of sovereign immunity. The application of the law differs greatly from jurisdiction to jurisdiction. Therefore, one must carefully review the doctrine of each state.[23]

Sovereign Immunity Defenses

Sovereign or governmental immunity is defined as freedom from suit or liability.[24] It is premised upon the policy notion that although government officials may act wrongly, they ought to be protected from liability because of the countervailing social value of their work on behalf of government. In this sense it is very much like the qualified good faith immunity defense that applies to civil rights claims. Over time, however, sovereign immunity has been reduced by a combination of court decisions and legislation. The United States waived immunity and consented to suit in tort in 1946 with the passage of the Federal Tort Claims Act.[25] In the majority of states, the immunity has been substantially abrogated with respect to state government. A second group of states has waived immunity for certain kinds of cases. And a small group of states has retained immunity but has established administrative agencies to hear claims against the state. Sovereign immunity on behalf of municipal government has also been abrogated significantly by court decision and legislation, although again to varying degrees. On all levels, a degree of immunity continues to exist for legislative and judicial decisions of the governmental entities.

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The doctrine of sovereign immunity also applies to federal, state, and local officials, including health care providers employed by governmental agencies. Officials and other governmental employees are provided with no immunity for acts which are "ministerial" in nature and with qualified immunity for acts which involve discretion.[25] The qualified sovereign immunity is destroyed when the official acts maliciously or in bad faith. Obviously, the distinction between a ministerial and a discretionary function is crucial in determining liability for public officials, including health care providers. To decide whether immunity applies to an act, one generally looks at the

◀ **qualified sovereign immunity is destroyed when the official acts maliciously or in bad faith.**

nature of the plaintiff's claim, alternative remedies available to the plaintiff, the ability of the court to determine fault without unfairly invading the governmental function, and the importance of protecting certain forms of official conduct.[26] Perhaps key to this entire analysis is the question of whether the activity in any way appears legislative, judicial, or executive in nature. If it does, immunity will apply. Even if it does not, immunity will apply if the act is discretionary enough. If the action or inaction is routine and involves very little if any discretion of an executive nature, liability will exist.

Specific Issues

Conditions of Confinement

The incarceration of children in juvenile or adult correctional institutions produces health care issues almost by definition. First, health care staff are faced with a constantly changing population whom they must screen regularly for a variety of medical, psychological, and dental maladies. They must do so on intake and periodically while the child is in the institution.

▶ health care staff are faced with a constantly changing population whom they must screen regularly... must provide ongoing medical services on a 24-hour basis...[and] must have knowledge of and sensitivity to a variety of illnesses.

Second, health care staff must provide ongoing medical services on a 24-hour basis, including sick call and access to hospital services. The failure to employ trained staff who make such services available also gives rise to liability concerns.

Third, given their background and circumstances, children coming into the correctional system often have significant health care needs. Thus, staff must have knowledge of and sensitivity to a variety of illnesses. For example, health care staff should screen for and provide services for such health concerns as suicide, depression, and other psychological problems; the human immunodeficiency virus (HIV)[27] and other sexually transmitted diseases; pregnancy; and poor dental hygiene. The failure to diagnose a child as suicidal in a situation where a medical doctor in the community would reasonably do so may constitute negligence, and the staff could be held liable for damages in a tort action if the child attempts or succeeds in an act of suicide. If the failure to diagnose is exacerbated and amounts to deliberate indifference to the child's medical needs, a civil rights violation occurs. If it can be shown that a number of children in the institution are suicidal and no services exist to screen them or to provide mental health care, a claim for injunctive relief based on violation of civil rights may be made.

Once the child is in the institution, health care providers need to be aware of an additional set of issues produced by the correctional/institutional environment itself. By virtue of their background, these children are at increased risk for injuring themselves and others inside the institution. Violence in the form of fights, self-inflicted injuries, and sexual assaults are common in correctional institutions. Health care personnel will consequently be involved in providing ongoing medical, mental health, and dental services to children who are injured in the institution. For example, if a child attempts suicide and health care staff knew of or should have known of the child's propensities, a claim of negligence may arise. If the staff knew that there were ongoing instances of self-injury or suicide attempts, and if it set up no ongoing screening system nor any system to care for children who had made attempts, a civil rights claim of deliberate indifference may arise and a court order granting injunctive relief to correct the system might result.

Once the child is in the institution, health care providers need to be aware of an additional set of issues produced by the correctional/institutional environment itself.... Violence in the form of fights, self-inflicted injuries, and sexual assaults are common....

Health care staff may become involved in administrative matters related to health care. They may be drawn into policy-making decisions regarding issues such as mandatory HIV testing, classification, security, discipline, and standards for the use of isolation and segregation (e.g., on the basis of HIV infection).[28] They may also become involved in decision-making regarding such issues as rights to and limitations on mail, telephone calls, and visitation, as well as food, exercise, education, and religion.[29] In all of these situations, staff may be liable for their decisions, both as they affect individual children and as they affect inmates as a whole.

Health care staff may...be drawn into policymaking decisions....In all of these situations, staff may be liable for their decisions....

Confidentiality and Privacy

Interest in questions of confidentiality and privacy has been heightened by the attention now being focused on the transmission of the human immunodeficiency virus. However, the law's treatment of these matters predated the HIV crisis. In fact, confidentiality has been addressed in cases involving a variety of other illnesses, including tuberculosis, small pox, and scarlet fever.[30]

Issues of confidentiality arise in several contexts, all of which are complicated by the fact that a child is involved. A typical context involves the obligation of a health care provider

to notify a third party of an individual's medical condition. A second issue involves the obligation of the provider to breach the child's confidence in order to obtain permission from the parent or guardian to provide care. The initial confidential relationship may be governed by state statute or common law tradition, as in the case of the doctor-patient privilege. A third issue involves the degree to which a child in correctional care retains a right to privacy.

Children are not viewed legally as *sui juris*—that is, possessing the rights and obligations of an adult. Therefore, decisions may be made on their behalf by parents, guardians, next friends, or the state. State law often dictates the rights and obligations of third parties to act on behalf of children. As a result, health care decisions are generally made by parents for their children. This situation is complex when the child is in state care and when the interests of the state, parent, and child conflict. The state may be the child's guardian by virtue of a juvenile court order and may then take the place of the child's parent. Yet, the state or municipality may have responsibilities to other wards and other parties, producing a conflict in its fiduciary responsibilities. Furthermore, if the individual with whom the child has a confidential relationship is also a health care provider, the doctor-patient privilege may be compromised.

▶ health care decisions are generally made by parents for their children. This situation is complex when the child is in state care and when the interests of the state, parent, and child conflict.

The law on the obligation of a health care provider to third parties is fairly clear. The reported decisions almost uniformly hold that medical doctors are responsible for advising family members that someone in the family has a contagious disease.[31] In the mental health setting, the well-known California case *Tarasoff v. Regents of the State of California*[32] held that while there is no general duty to control another individual's conduct or to provide warning of danger, the health care provider may be obligated to control a patient's behavior when there is a special or therapeutic relationship such as that between therapist and patient.

With regard to unauthorized disclosure of confidential information (e.g., HIV infection), the cases suggest that liability may result from such violations of the right to privacy as well as from violations of state statutes.[31] It is important to read state statutes carefully because they may require health care providers to maintain confidentiality, although state law often includes explicit exceptions. One example of an exception is the reporting of child

abuse and neglect.[33] For nearly 20 years, the states have required public officials to report suspected abuse and neglect and have encouraged private citizens to do so. States maintain registries of reports, and every state provides immunity to persons who make reports in good faith.[23] Health care providers in correctional settings are included among those who must report child abuse. This duty may create tension between health care personnel and other staff about whom the report is made.

A child's right to privacy in a correctional setting is based upon constitutional rights found in the Fourth Amendment and in what is described as the "penumbras" of various other amendments to the Constitution.[34] This right has been significantly limited by the Supreme Court for adult prisoners in the context of cases involving searches and seizures under the Fourth Amendment.[35] Health care providers become involved in Fourth Amendment privacy matters in body cavity search situations. The Supreme Court has held that requiring inmates to expose body cavities for visual inspection is reasonable under certain circumstances.[22] Health care providers are often called upon to conduct body cavity searches as well as other kinds of screening, such as urinalysis.[36] The issue of privacy also arises in the context of HIV testing.[28] Clear administrative guidelines reviewed by agency counsel are helpful in avoiding or reducing liability in this area.

◀ providers become involved in Fourth Amendment privacy matters in body cavity search situations.... The issue of privacy also arises in the context of HIV testing [as well as other types of screening]. The courts are grappling with... the obligation of correctional agencies to provide abortion services and [with] forced administration of food and medication.

A second context in which health care providers become involved in privacy matters is the termination of pregnancy and forced health care. The courts are grappling with two current legal issues concerning the obligation of correctional agencies to provide abortion services and forced administration of food and medication. The Supreme Court has held only that a judicial hearing is not mandatory prior to state treatment of a mentally ill prisoner with antipsychotropic drugs against his or her will.[37]

Consent to Health Care

The law recognizes that some persons are incompetent to make decisions about their own health care, due to physical disability, illness, or age. The general rule is that parental consent is required before medical care can be given to children. This rule is based upon the reasoning that children lack the age and experience to give informed consent and that parents have the right and responsibility to make decisions on their behalf.[38]

Issues involving a child's capacity to consent to health care services arise in a variety of settings....A separate but related issue involves the child's right to independently consent to health care.

Issues involving a child's capacity to consent to health care services arise in a variety of settings. For example, a parent may refuse to authorize medical care on religious or political grounds. If the parent refuses to authorize medical care and the illness is life threatening, the courts generally approve the medical intervention.[39] However, when the health problem is not life threatening, most courts refuse to intervene against parental wishes.[40]

A separate but related issue involves the child's right to independently consent to health care. Some states authorize the child's consent by statute in certain situations.[38] If the child is mature enough, the courts may also elicit the child's opinion on the provision of medical care even in the absence of a state statute.[41] The issue of whether a mature minor can consent to a termination of pregnancy without parental approval is a perplexing current problem.[42] The issue is further complicated by the Supreme Court's decision regarding parentally authorized psychiatric hospitalization. The Court has held that the child has only minimal due process rights to notice and to challenge the institutionalization.[43] If a child is placed in a publicly operated hospital by parents, the only review procedure required under the Fourteenth Amendment due process clause is that a medical doctor determine the legitimacy of the placement. However, the point at which the patient, including a child patient, is determined incompetent to make decisions is sometimes quite difficult to define.[44] The issue becomes even more complicated when the young person is incarcerated.

If a health care provider determines that the child patient cannot make decisions on his or her own, the provider may contact relatives or state officials and ultimately make application to the court for an order appointing a guardian or otherwise seeking approval for the medical care. It is also possible to provide health care services without consent from the child or parents based upon the doctrine of medical necessity or emergency.[24] There are circumstances in which there is no time to obtain consent.

These problems are exacerbated when the child is in state custody. In this situation, the custody generally but not always has been transferred to the state, with the result that the state has the authority to make medical decisions. However, whether this occurs as a matter of state law requires research in each jurisdiction. Even when the child remains under the legal custody of the parent while in state care, the state has the authority under the

parens patriae doctrine to intervene to provide medical care if it will protect the child's health and welfare.[45,46]

In any of these situations, the health care provider is concerned with possible liability resulting from the provision of care against the will of the child. Concerns include liability for battery, invasion of the right to privacy, cruel and unusual punishment, intentional infliction of emotional distress, and other torts. However, as this chapter demonstrates, professional competence and reasonable policies and procedures sensitive to the child's interests, developed with the assistance of legal counsel, should assuage these fears.

◀ professional competence and reasonable policies and procedures sensitive to the child's interests, developed with the assistance of legal counsel, should assuage... fears [of liability].

Conclusion

Providing adequate health care services to incarcerated youth is a complicated, frustrating, and sometimes thankless task. The law provides some general guidelines for ascertaining minimal levels of access to care as well as an adequate level of care. Health care personnel may be liable if they fail to comply with basic legal notions of access and adequacy, act negligently or in violation of state law, or violate constitutional rights. The relief sought by children may include claims for money damages and/or injunctive relief. The single most effective way of avoiding liability is to understand both one's professional obligations and the legal standards of care required for children in correctional institutions.

Understanding the impact of the law on the health care of incarcerated youth may assist the health care provider in serving these children better and more humanely.

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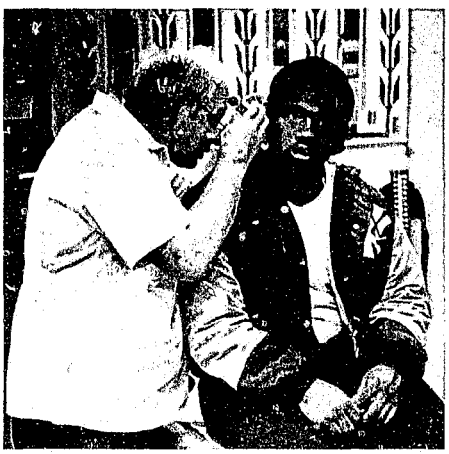
5

Comprehensive Health and Psychological Assessment



Felton Earls, M.D.
Jacqueline McGuire, Ph.D.

"The assessment of the adolescent must address the social, educational, and behavioral aspects of health, for it is the integration of these domains, along with a prevailing concern for physical well-being, that constitutes good health care."

BECAUSE MANY INCARCERATED youth come from economically disadvantaged backgrounds, they are likely to have experienced inadequate health care as well as other impediments associated with low socioeconomic status. Many seriously delinquent youth have histories of parental neglect or abuse, further placing them at risk for poor health. Incarcerated youth are also more likely to belong to minority groups who face discrimination due to racial and cultural stereotypes, again contributing to suboptimal care. These issues serve as the backdrop to the health assessment of incarcerated youth.[1]

Thorough health assessment of high-risk youth requires methodical adherence to a set of procedures, with no shortcuts. Professionals charged with this responsibility must be as skilled in handling risk factors as they are in performing physical examinations. The assessment of the adolescent must address the social, educational, and behavioral aspects of health, for it is the integration of these domains, along with a prevailing concern for physical well-being, that constitutes good health care. Substance abuse, mental disorders, and sexually transmitted diseases, all among the most common health problems in adolescents, demand training that permits the detection of behavioral and lifestyle problems that were not focused upon in decades past.[2]

New types of professionals are being trained to combine skills that once were the province of [pediatricians, psychiatrists, or psychologists].... Structured interview schedules... permit nonphysicians to systematically document the psychological and developmental history of children and adolescents....

The scope and complexity of performing a complete health assessment of an adolescent easily demands the skills of several professionals—a pediatrician, a psychiatrist, and a psychologist. While this arrangement works well with an integrated team, cost containment efforts and managed care are changing conventions rapidly. New types of professionals are being trained to combine skills that once were the province of one of the three traditional specialists. For example, pediatric nurse practitioners and physician's assistants are now able to take complete medical histories, perform physical examinations, and order laboratory tests.

Structured interview schedules have been developed to permit nonphysicians to systematically document the psychological and developmental history of children and adolescents, and others schedules exist for psychiatric diagnoses. The specialized skills required for psychological assessment have shifted from those needed for complex interpretations of personality functioning to more objective techniques used to evaluate learning handicaps. At the same time, an acute concern over the cultural relevance of test material has encouraged a more cautious use and interpretation of intelligence and achievement tests in minority groups.

One of the most important changes affecting the care of adolescent patients has been the development of more specifically delineated diagnostic criteria for mental disorders.[3] The development of these specific criteria has been in part a response to progress in the area of therapeutics, particularly for depressive disorders.[4] With increasing reliance on these new definitions have come several important achievements. First, there is greater emphasis on issues of reliability and validity of diagnoses. These issues have long been relevant for standardized psychological testing; in fact, the specialized field of psychometrics has evolved in direct response to the need to demonstrate test accuracy. Similar concerns in psychiatry have encouraged higher standards for diagnostic procedures, requiring careful training and supervision of those who administer the procedures.

There is now a keener appreciation for the health risks associated with factors such as poor nutrition, obesity, learning disorders, and head injuries.[5] Improvements have also been made in the management of many relatively common diseases of childhood, including asthma and diabetes. The virtual elimination of many infectious diseases (e.g., polio and measles) has contributed to overall improvements in adolescent health. However, sexually

transmitted diseases (including AIDS) and substance abuse are newer problems that compromise the health of young people.

Comprehensive health assessment should go beyond the detection of disease and the recommendation of a treatment plan. Optimal management of youth involves the promotion of good health as well as the detection and treatment of medical and psychological problems. This requires reducing risks associated with unintentional and intentional injuries, poor diet, use of alcohol and illicit substances, and unsafe sex practices.[6] The person conducting the assessment must provide information and incentives that build on existing positive health practices. For example, when encountering youth who do not carry weapons, it is important to reinforce the custom. Assessors must of course inquire into adolescents' behavior if they are to provide reinforcement.

assessment... requires reducing risks associated with unintentional and intentional injuries, poor diet, use of alcohol and illicit substances, and unsafe sex practices.

Before describing a clinical approach to the examination of incarcerated youth, it is prudent to make clear what will be covered and what will not. Several reviews of the health of incarcerated youth have been published recently and need not be repeated here.[5,7,8] The training requirements of health professionals working with incarcerated youth have also been covered elsewhere and need not be repeated here.[9] This paper addresses the purpose of the health examination, useful strategies for soliciting information about current health status and future risks, important concepts to keep in mind while conducting the assessment, and selected methods that seem well suited to the incarcerated youth population.

Purpose of the Examination

Numerous aids exist for providing a rationale for and a structure to the assessment. The description provided suggests strategies for conducting the assessment. Emphasis is geared toward the social, behavioral, and cognitive aspects of adolescent health and development because these have become the areas related to major forms of morbidity and mortality in adolescents. The utility of available methods is given particular attention, especially as it relates to characteristics likely to exist among individuals in institutions.

The Setting

One of the most significant challenges in conducting a health assessment of adolescents is to provide and maintain

confidentiality.[10] Health providers in institutional settings should begin their assessments by informing adolescents of the extent to which information obtained will remain confidential.

The setting itself should be as comfortable as possible. Youth-oriented magazines, posters, and music send a welcoming message to most adolescents. In selecting these materials, changes in youth culture should be considered. Responsiveness to youth culture helps enhance the cooperation of the adolescent patient.

Developmental and Medical History

Most clinical settings have preformatted documents for recording patients' developmental and medical histories. The quality of information obtained depends greatly on who provides the information and on the availability of medical records or other documents that can confirm the reports of parents or youth themselves. Making the effort to obtain past records is an essential aspect of the assessment but is too often dismissed, especially when there are personnel shortages.

▶ Making the effort to obtain past records is an essential aspect of the assessment but is too often dismissed....

The purpose of the history is to gather clues about the adolescent's past that may be relevant to the development of delinquency. What follows is an overview of pertinent information, grouped according to five developmental periods.

Prenatal and Perinatal Periods

The parents' health prior to the pregnancy provides a background against which changes during gestation can be measured. It is important to ask about the health of both mothers and fathers, although most of the evidence directly associated with insults during gestation relates to maternal health. Specific areas that bear on delinquent behavior include the mother's use of alcohol, nicotine, and other drugs during pregnancy; injuries incurred; infectious illnesses experienced; and failed attempts at abortion. The child's birthweight and gestational age at the time of delivery will establish his or her relative maturity at birth. If the child was born in a hospital, evidence from the medical record regarding the number of days the mother and child spent in the hospital prior to discharge will also provide clues about their separate health conditions.

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Infancy

The most rapid growth in human development occurs from birth to two years of age. During this period, the child is particu-

larly vulnerable to deficiencies in the caretaking environment. Thus some effort should be made to establish the adequacy of caretaking arrangements during this time. At a minimum, there should be an attempt to ensure the absence of several distinct disadvantages, such as prolonged separation from the primary caretaker, placement in foster care, and abuse or neglect.

Several important milestones of development (e.g., age at walking or uttering first word) should also be asked about, although skepticism about the accuracy of recall of such events should be maintained. Delayed milestones may constitute early evidence of serious behavioral and learning problems.

At a minimum, there should be an attempt to ensure the absence of several distinct disadvantages, such as prolonged separation from the primary caretaker, placement in foster care, and abuse or neglect.

Toddlerhood and the Preschool Period (Ages 2–5)

Many children are introduced to out-of-home care during this period. The nature and quality of care provided should be explored with the parent since abuse or neglect may have occurred. The number of different placements alone may raise questions about a potential negative impact on the child.

During this period, the child should be using language in an increasingly sophisticated way. It may be more important to capture the parents' memory of the overall quality of language at this age than to determine the age at which the first word or sentence was spoken. Though other areas of development may be assessed, focusing the inquiry on language development is a good strategy since it can reveal other aspects of social and cognitive development.

◀ focusing the inquiry on language development is a good strategy since it can reveal other aspects of social and cognitive development.

Middle Childhood (Ages 6–11)

Achievement during the first four or five years of school represents the most important area of development during the period between 6 and 11 years of age. In addition to soliciting reports of parents and teachers on academic achievement and behavioral problems, it is advisable to obtain school records. Documented absenteeism, antisocial behavior, and placement in special classes may all indicate early onset of conduct problems. Deviant behavior and academic underachievement in elementary school may signal chronic problems predating the immediate circumstances leading to a youth's incarceration.

◀ Documented absenteeism, antisocial behavior, and placement in special classes may all indicate early onset of conduct problems.

Early Adolescence (Ages 12–14)

During early adolescence, the child is at particularly high risk for adopting pathological behaviors and a deviant lifestyle.[11,12] The

[Early adolescent] developmental history should focus on the nature of peer friendships and the activities engaged in with these associates.

developmental history should focus on the nature of peer friendships and the activities engaged in with these associates.[13] Ask about the age of initiation of tobacco, alcohol, or drug use and of sexual activity. The onset and pace of pubertal changes may influence the adolescent's selection of associates. Girls with an early onset of puberty may be attracted to older males, leading in turn to early initiation of sexual activity.[13] The effects of early onset of puberty in boys are not well established, due in part to difficulty in establishing stages of puberty in males.

As with middle childhood, it is important to inquire about academic achievement during this period. Learning problems may not have been recognized in the earlier grades, resulting in a serious degree of impairment at adolescence. Again, school records are the optimal source of documentation.

The nature and extent of involvement in extracurricular activities may provide another source of evidence from which peer influences can be evaluated.

Middle Adolescence (Ages 15–17)

▶ Sexual activity... drug use....Gang membership and...weapons.... Hopelessness and suicidal behavior. . . become prominent problems during this period.

Sexual activity and drug use may become ingrained into lifestyle patterns at this age. Gang membership and possession of weapons increase the likelihood of violent encounters. Hopelessness and suicidal behavior also become prominent problems during this period, increasing the risk of fatalities.[14,15] Unprotected and unsafe sexual activity increase the risk of pregnancy and sexually transmitted diseases.[16,17] It is important to remember to ask males if they have fathered a child.

Family History

The review of medical and psychiatric illnesses should focus on first-degree relatives, although it is not necessary to limit the questions to parents and siblings. In asking about family illnesses, the biological relatedness of the youth to other family members in question should be ascertained. With step-parents, half-siblings, and adopted children, care must be taken in interpreting information on family resemblance.

▶ If time permits, it is a good practice to place information about family members into a genogram.

If time permits, it is a good practice to place information about family members into a genogram. This not only serves as a useful way of collecting information systematically but can also stimulate discussion on the importance of family relationships that might not be elicited otherwise.

The list of heritable disorders that might relate directly to delinquency is growing. They include mental retardation, learning disorders, bipolar affective disorder, and epilepsy. Other behavioral problems in family members, such as criminality, substance use, and sexual deviations, should be covered systematically, though their genetic heritability may not be established. Indeed, cultural transmission may be more significant in delinquency.[18]

Psychological Background

Many health professionals consider this component of the assessment the most difficult to approach. A well-organized and precoded schedule can help ensure that the essential information is obtained. If conceptualized properly, this part of the assessment can place the child's deviant behavior in the context of family, school, and community environments.

◀ If conceptualized properly, this part of the assessment can place the child's deviant behavior in the context of family, school, and community....

The assessment should begin with questions about the occupations and/or sources of income of the parents. Once the socioeconomic status of the family is determined, a description of the family's neighborhood should be obtained. Understanding the family as a unit and the adolescent in the context of the community elucidates constraints operating to encourage or discourage deviant development and antisocial lifestyles. Lack of recreational facilities, high danger level, deteriorated housing, presence of illicit drug markets, and easy access to alcohol may all encourage delinquent activity and gang formation.

Once the family and neighborhood environments are understood, the examiner can inquire about significant life events. Deaths of family members or close friends, illnesses, changes in residence, and exposure to catastrophic events or violent encounters are just a few events that may be linked to heightened delinquent behavior. Recent changes in family structure and household composition should be carefully documented. Many incarcerated youth will have experienced out-of-home placement since childhood; these placements should be documented as well. After collecting information about the adolescent's development within family, neighborhood, and school contexts, the examiner is ready to assess the adolescent's physical health status.

Physical Examination

Special skill is required in approaching adolescents for a thorough physical examination. The examination should

involve inspection of the body surface—including the scalp—for evidence of scars. The adolescent's stage of puberty should be estimated. For males, an accurate determination of pubertal stage requires an appropriate calibrating device. At a minimum, the clinician should determine if puberty is delayed. Measurement of height, weight, and nutritional status should be routine. The effects of alcohol and drug use on nutritional status should be of particular concern. Examination of the external genitalia is required, and a pelvic examination should be carried out routinely in females.

▶ A carefully performed neurological examination should be part of the physical examination.

A carefully performed neurological examination should be part of the physical examination. The two main purposes of the neurological examination are to detect the presence of disease or anomalies of the nervous system and to uncover delays in the maturation of certain functions. It has been an axiom in neurology that a good history is the most informative part of the physical examination, and this may well be true for seizure disorders, mental retardation, and other disorders. However, it should be kept in mind that assessment of brain functions is assisted by cognitive capacity tests and laboratory procedures. Cognitive testing is described separately in a section to follow. Referral to a laboratory for electroencephalographic or neuroimaging examination may be required.

At a minimum, the standard neurological examination should address:

- Gait
- Dysmorphic features of the head and face
- Speech and language patterns
- Laterality of motor function
- Stereognosis
- Muscle tone and power
- Abnormalities of the cranial nerves
- Motor coordinating capacities
- Constructional skills
- Tremors and choreiform movements
- Mirror movements of the hands
- Tendon and plantar reflexes

This type of examination must be administered by a physician (or possibly a physician's assistant) since its reliability is

thought to be poor when performed by inexperienced personnel. A major concern in examining incarcerated youth is the documentation of subtle abnormalities. Diagnosed neurodevelopmental delays in younger children could represent more lasting handicaps in adolescents. Such subtle abnormalities as choreiform movements and poor fine motor coordination have been linked to aggression and violence. However, these features are only part of a complex of problems that usually includes psychosocial disadvantages as well as compromised nervous system functioning.

Psychiatric Examination

With the advent of structured diagnostic interview methods, the character of the typical psychiatric interview is changing. Although designed for research purposes, the interview methods have characteristics that are promoting their gradual introduction into clinical practice. First, the interviews are carefully keyed to prevailing classification systems. The current nosology used by U.S. psychiatrists is DSM-IIIR, but revisions are being made, and DSM-IV will soon be published. Most interview schedules can be adapted to changes in nosological systems without great difficulty. Second, the schedules are relatively easy to administer. Psychiatric training is not required and, for most of the available instruments, training required for nonspecialist interviewers is not extensive. Third, a minimum standard of thoroughness is met for examinations by ensuring that each youth receives an interview that covers diagnostic criteria for a wide range of disorders. Fourth, some interview schedules include separate, parallel versions for parents and children. Systematic interviews of multiple informants have proven important, since most studies produce findings which demonstrate a high degree of discrepancy between informants.[21] Fifth, the reliability of measuring psychiatric symptoms and disorders is enhanced by the use of structured interview methods.

◀ **Although designed for research purposes, [structured diagnostic] interview methods have characteristics that are promoting their gradual introduction into clinical practice.**

Some of the more popular structured interview methods are the Schedule for Affective Disorders and Schizophrenia for School Age Children (K-SADS)[22] and the Diagnostic Interview Schedule for Children (DISC).[23] The K-SADS is less structured than the DISC and is meant to be administered by a clinician with several weeks of training and supervision. It has a semistructured format in which the interviewer is free to reorder the

questions as appropriate. A degree of interpretation is allowed as well, so that answers given by respondents can be filtered and clarified by the interviewer. The DISC is designed for field studies involving large samples and does not require clinical training. It has a highly structured format that permits little deviation from the prescribed wording of questions, and it allows minimal interpretation of respondents' replies to questions about the presence or absence of specific symptoms.

One of the important issues discovered through use of the DSM-III and DSM-IIIR in conjunction with systematic interview methods is that many disorders coexist. The conventional wisdom in psychiatric clinical practice had been to focus on a single disorder. It can be assumed that in a sample of incarcerated youth, many (perhaps the great majority) will meet diagnostic criteria for conduct disorders. Many will also have established patterns of drug and alcohol abuse. It should come as no surprise that a significant degree of overlap exists between these two groups. What has been more unexpected is the finding that many youth with conduct disorders also have anxiety and depressive disorders.[25]

▶ many [incarcerated youth] will meet diagnostic criteria for conduct disorders. Many will also have established patterns of drug and alcohol abuse....[and/or] anxiety or depressive disorders.

Such patterns of comorbidity raise a number of questions. Clear evidence that a depressive disorder preceded conduct symptoms would suggest that treatment of the depression might alleviate the conduct problems. Such patterns are also important prognostically. Coexisting conduct disorder and substance abuse have a worse prognosis than either problem alone.[26] Conversely, anxiety disorder in conjunction with conduct disorder reduces the likelihood of subsequent police contacts.[27]

Cognitive Functioning and Academic Achievement

Psychological assessments should focus on the characteristics of thinking, learning, and integrating information most relevant to behaviors that lead to institutional placement:

- Overall intellectual functioning
- Language competence
- Academic achievement, especially reading comprehension
- Executive functions
- Impulsivity
- Responsiveness to punishment/reward

Overall Intellectual Functioning

If a trained clinician is available, the Wechsler Intelligence Scale for Children (WISC-R) or its current revision, the WISC-III, may provide the best estimate of current intellectual functioning. Briefer measures may, however, give a good approximation, and those that involve minimal use of language may be preferred for nonnative speakers of English or for individuals with language delay. For example, Draw a Person[28] has been recommended for children and adolescents whose behavior could impede their performance on the WISC-R.[29] After assessing adolescents with learning difficulties, the Matrix Analogies Test, Expanded Form,[31] or the Peabody Picture Vocabulary Test[32] may be used.[30]

Language Competence

The majority of instruments for evaluating language comprehension are designed for young children, but there is good reason to believe that language competence is increasingly important during later childhood and adolescence, when it interacts with both academic performance and social behavior. Language disorders of delinquent adolescents are frequently overlooked because of the adolescents' disruptive behavior.[33] Evaluation ideally includes expressive components such as syntax, semantics, and phonology, as well as receptive skills. Language comprehension can be evaluated by the Test of Language Competence, Expanded Edition,[34] or by the Test of Auditory Comprehension (TACL-R), which has been used in bilingual populations.[35] Several fairly brief methods are also being developed for examining the quality and complexity of narratives[36] and other types of discourse such as simulated "talk shows."[37] While the assessment of language use as revealed through such narratives is not customarily included in cognitive assessment, deficits may affect the incarcerated youth's ability to represent ideas and emotions effectively.

◀ language competence [may become] increasingly important during later childhood and adolescence, when it interacts with both academic performance and social behavior.

Academic Achievement

In the evaluation of reading achievement, it is important to look at text comprehension as well as word recognition. Instruments such as the Wide Range Achievement Test (WRAT)[38] can give a reasonable estimate of word recognition. However, errors made in comprehension of written passages or

during oral reading are much more useful in understanding school failure and planning effective intervention strategies. One well-established measure is the Gray Oral Reading Test;[39] the newly developed Diagnostic Assessment of Reading is a useful alternative.[40]

The Rapid Alternating Stimulus Tests,[41,42] strongly predictive of reading success and easy to administer with little clinical expertise, are important additions to any psychological evaluation. The "automatic" skills involved in rapid naming of letter or number sequences appear to distinguish between children with learning problems and fluent readers.[42,43]

Executive Functions

▶ delinquency [may correlate] with deficits in "executive" functions—those thought to be subserved by the frontal lobes of the brain.

There is strong evidence that delinquency correlates with deficits in "executive" functions—those thought to be subserved by the frontal lobes of the brain.[44,45,46] Several brief measures can provide information on executive processes, including the Stroop Color-Word Test,[47] which requires inhibition of an overlearned automatic response; Trail Making B,[48] which requires the subject to sustain attention to two competing sequences; and Mazes from the WISC-R, which requires planning and inhibition of impulsive responses.

Memory and learning ability are useful indicators of executive functioning, and their assessment may be more important than global assessments of intellectual ability. The Rey Auditory Verbal Learning Test (RAVLT) provides information on immediate memory span, a learning curve following successive trials of a word list, and recall after a 15-minute delay.[49,50] The newly developed Wide Range Assessment of Memory and Learning[51] can provide information about verbal and visual memory, and provides an assessment of learning of visual, auditory, and verbal material.

Impulsivity

▶ *Impulsivity*, or poor control of immediate behavior... predisposes developing individuals to externalizing behavioral disorders and delinquent behavior.

Impulsivity, or poor control of immediate behavior, appears to be a stable characteristic that predisposes developing individuals to externalizing behavioral disorders and delinquent behavior.

The Kagan Matching Familiar Figures Test,[52] designed to assess an individual's tendency toward impulsivity as opposed to thinking before taking action, is easy to administer and is considered culturally sensitive, in that the stimuli are nonverbal. Performance may, however, be facilitated by experience with

multiple choice tests commonly used in schools for group achievement testing. The Kagan Matching Familiar Figures Test, while designed for use with children, has been used with incarcerated adult males. Performance on the test has a low, significant correlation to IQ and reading ability[53] and provides additional information about cognitive style. This can be very helpful in planning remedial strategies for academic and behavioral problems.

Assessment by computer may be effective in gaining the cooperation of institutionalized youth, who might be less interested in paper and pencil measures. The delayed response task,[54] a computerized method of evaluating impulsivity, is easy to administer and available in a self-contained unit that facilitates administration within institutional settings. It has distinguished between hyperactive boys and nonhyperactive clinical controls[54] and between hyperactive and nonhyperactive subjects.[55]

Response to Punishment/Reward

Another key characteristic of behavioral/cognitive style is responsiveness to positive or negative sanctions. Some individuals will persist with behavior in the face of many negative reactions if they experience intermittent reward. This characteristic is known as *reward salience.* In contrast, others are more responsive to punishment/negative sanctions.

◀ **Some individuals will persist with behavior in the face of many negative reactions if they experience intermittent reward.**

A number of computerized techniques are now available to assess response to punishment and reward. The Card Playing Task, developed by Newman with incarcerated adults,[56] shows how the subject responds to reward and also to punishment, when the odds of winning are reduced and mistakes lead to loss of earnings.

Conclusions

This description of the strategies and procedures used to assess the overall health of incarcerated youth covers a broad range of areas. This range is necessary because the adolescent is still developing, and the detection of health problems may serve both the short-term goal of disease detection and symptom relief and the long-term goal of health promotion.[6]

Because adolescents are less likely to be physically ill and more likely to be in the process of assuming health-damaging behaviors, the physical examination must be conducted in the

Clinician[s] should expect more diagnoses to relate to mental health, substance abuse, and sexual concerns than to diseases of organ systems. [But] the need to detect... common physical problems cannot be minimized.

context of an engaging and sensitive clinician-patient encounter. The clinician should expect more diagnoses to relate to mental health, substance abuse, and sexual concerns than to diseases of organ systems. However, the need to detect many common physical problems cannot be minimized. These range from dental caries and poor eyesight to more serious conditions such as obesity, asthma, and diabetes. This paper has not dwelled on these medical conditions largely because they constitute the most fundamental components of a health examination. Even under very good conditions, mental, cognitive, and substance abuse problems are more likely go undetected than physical problems. This is the greatest challenge of working with incarcerated youth. A thoroughly performed assessment represents a useful and productive encounter for both adolescents and those charged with their care, contributing to the aims of rehabilitation.

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6

Chronic Illness

James W. M. Owens, M.D., M.P.H.

"Newacheck et al. studied a sample of nearly 7,500 persons ages 10–17 and found that 31.5% of U.S. adolescents were reported to have one or more chronic conditions. . . . The most commonly reported conditions included respiratory allergies, asthma, diabetes, and severe or frequent headaches."

THE MANAGEMENT OF ILLNESSES that occur in incarcerated youth populations poses significant problems for all institution staff, including health care providers, administrative personnel, child care providers, and security and social work staff. Chronic illness adds additional concerns that will be discussed in this chapter.

The time of incarceration may be an opportunity to provide quality health care, patient education, and linkage with community resources. Increased feelings of self-worth and empowerment, and steps towards independence and self-care, may result as the patient asks: "What can I do to manage my own disease, to improve its outcome?" "How can I get care when I leave?" "How can I lessen the impact of this disease on my life, my education, my job, my future?"

Topics to be discussed in this chapter include:

1. The prevalence of chronic illness in the general adolescent population.
2. The impact of chronic disease on adolescents.
3. The added burden of delinquency and incarceration in disease manifestation and management.
4. Recommendations for health care providers.

The Prevalence of Chronic Illness in the General Adolescent Population

The 1988 National Health Survey on Child Health Care studied the prevalence and impact of chronic conditions in adolescents. From this survey, Newacheck et al.[1] studied a sample of nearly 7,500 persons ages 10–17 and found that 31.5% of U.S. adolescents were reported to have one or more chronic conditions. The term *chronic* was defined as pertaining to a condition first noted more than three months before the interview or a condition ordinarily of long duration (e.g., arthritis or heart disease). The most commonly reported conditions included respiratory allergies, asthma, diabetes, and severe or frequent headaches.

The Impact of Chronic Disease on Adolescents

Much has been written about the significant impact of chronic illness on adolescents at different stages in their development. An excellent reference text on the subject[2] describes the effects chronic disease may have, depending on the age of the adolescent at the time of onset, the severity of the disease, and its ultimate prognosis.

The developmental tasks of adolescence—which differ for early, middle, and late adolescence—are important to consider when working with a youth with chronic illness. The physical and emotional symptoms seen in the patient, as well as the management provided by the health professional, will depend on the youth's developmental stage.

The many factors that bring adolescents into the juvenile justice system may significantly affect the ages at which particular developmental goals become important to them. For example, the 17-year-old juvenile diabetic in your care may be more concerned about his body image and peer acceptance than about his future academic or vocational plans; he may focus upon his physical appearance and bodily strength, denying any difference between himself and his peers. However, it is still useful to look at generally accepted guidelines for developmental stages. The three periods of adolescence are:

▶ the 17-year-old juvenile diabetic in your care may be more concerned about his body image and peer acceptance than about his future academic or vocational plans . . . denying any difference between himself and his peers.

1. Early adolescence (ages 10–13). This period is usually a time of adaptation to the physical changes of puberty, accompanied by an intense concern with body image.

2. Middle adolescence (ages 14–17). This period is marked by a striving for independence from family and by strong peer group identification.
3. Late adolescence (ages 18–21). This period brings concerns about the future, academic and vocational plans, and the physical, emotional, and intellectual requirements for self-sufficiency and independence.

The impact of a chronic illness will depend on whether the process is stable or progressive: When did it begin, what is its expected outcome, and how will it interfere with the youth's normal activities? Age at the time of onset and diagnosis is a critical factor. The later in development the diagnosis is made, the more opportunity there will be for normal growth and development.

The Added Burden of Delinquency and Incarceration in Disease Manifestation and Management

The following diagram (Figure 1) may be useful in understanding the problems that many children entering the juvenile justice system experience prior to incarceration. Illness is only one of these problems. The chapters by Thompson and Farrow (see chapter 1, page 1, and chapter 2, page 21) give important information regarding ways in which the prevalence of illness in incarcerated youth differs from that in their nonincarcerated peers.

Litt and Cohen[3] describe five years of experience in directing the health care program at the Bronx Detention Center in New York City. They summarize the results of evaluations on 31,323 children and state that 46% of these presumably healthy adolescents were found to have health problems. They report that 1,902 youth were admitted to the institution infirmary and that 402 were transferred to the tertiary hospital. Problems identified included infectious diseases (478 cases of sexually transmitted disease and hepatitis), metabolic problems (49 cases of diabetes and hypertension), trauma (193 cases), toxic reactions (343 cases of overdose or withdrawal from drugs including alcohol, with an additional 944 detoxified on an ambulatory basis), congenital malformations (121 cases), allergic problems (30 cases of asthma), and psychiatric disorders (61 cases). Ninety percent of the youth had dental problems indicative of

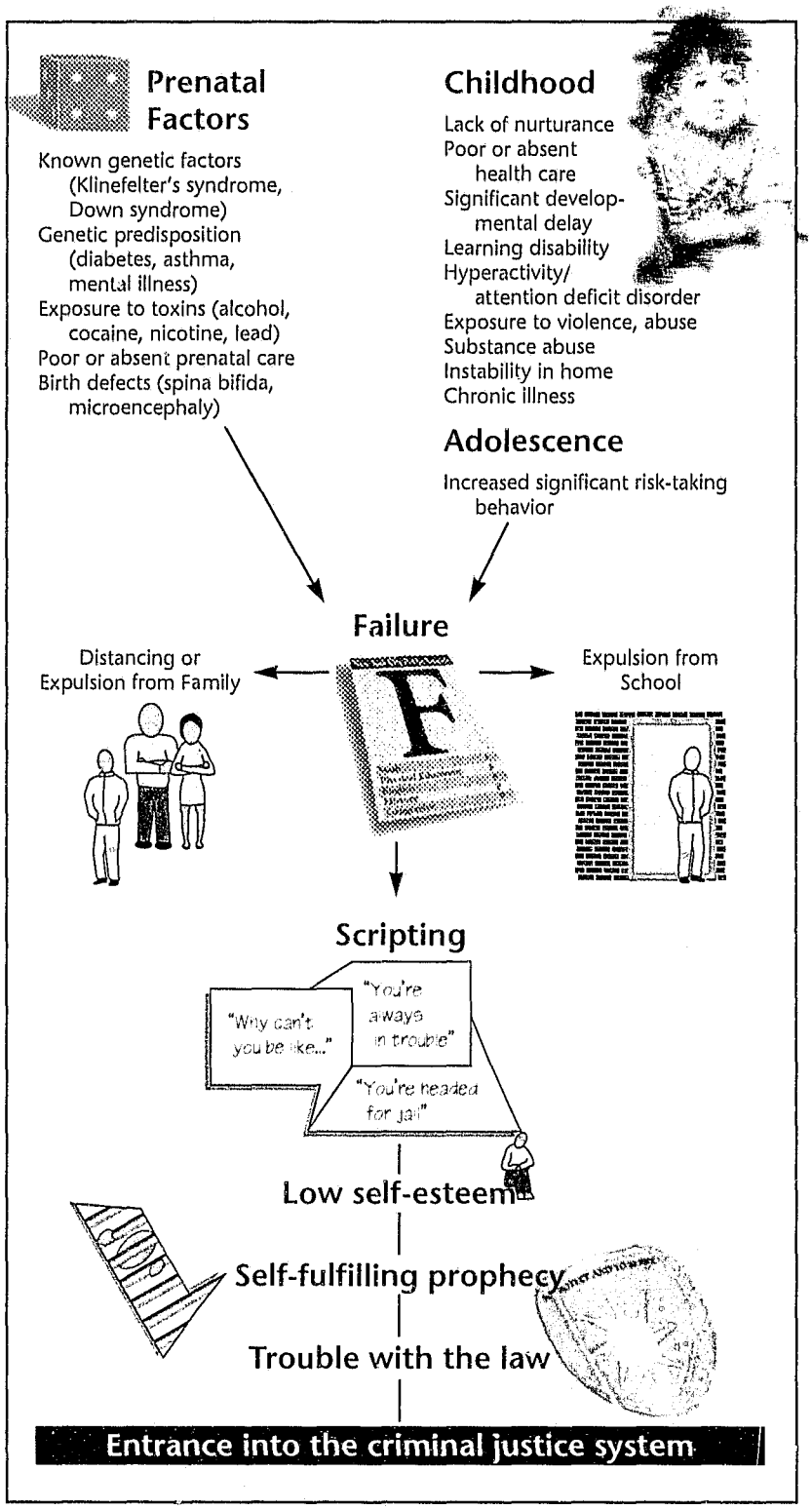

Figure 1
Some Factors in the Life History of Juvenile Delinquency
This figure lists some of the important life events that predate many children's entrance into the juvenile justice system.

inadequate dental care (caries and missing, fractured, or infected teeth).

Litt subsequently divided the problems encountered into four categories:[4]

1. Problems related to rapid growth and development in adolescence. This category included changes in body configuration due to pubertal and hormonal changes, emerging sexuality, and growth. Examples include orthopedic, endocrinologic, dermatologic, and gynecologic conditions with onset during puberty—e.g., growth failure, menstrual irregularity, and skin problems such as acne.

2. Preexisting health problems not detected earlier because of lack of adequate health care. These problems were usually congenital anomalies that could have been diagnosed earlier had the children received adequate evaluations prior to adolescence. Examples include congenital heart disease, hernias, and undescended testicles. Chronic illnesses for which adolescents had not received adequate care were included in this group—e.g., asthma, diabetes, and vision and hearing problems.

3. Health problems related to adolescent risk-taking and experimentation. Examples include drinking and drug abuse, especially in combination with driving. This combination is the major killer of adolescents in our society. Further examples include early and frequent sexual contacts resulting in venereal disease, pregnancy, and HIV infection.

4. Health problems related to institutionalization. Examples include depression, suicidal behavior, physical or mental institutional abuse, and trauma related to fights between youth in the facility.

Litt compared the frequency with which incarcerated adolescents suffered from illnesses in the first two categories with the frequency with which nonincarcerated adolescents suffered from them. Data from the National Health Survey in 1973 had demonstrated that these problems were found in 20% of all adolescents examined and therefore not unique to detained populations. For problems falling under the third category, the sequelae of adolescent risk-taking behavior and experimentation, there was a much higher incidence in the detained popu-

lation. This type of behavior often causes conflicts with the legal system. The selection process for detention also tends to result in a concentration of youth with sexually transmitted diseases, hepatitis, drug addiction, learning disabilities, and mental illness. Litt's study validates the concept of incarcerated youth as having a high prevalence of diseases that are chronic and complicated.

Today's studies must include other types of chronic health problems and disabilities that we encounter daily in institutions for delinquent children. The following two examples, which occurred at Echo Glen Children's Center where I am based, may serve to illustrate some of the health problems commonly seen.

▶ "Brad" was the worst asthmatic I had ever seen. Although 17 years old, he was just under five feet tall.... His asthma had required hospitalization at least once per month over the past two years....

"Brad" was the worst asthmatic I had ever seen. Although 17 years old, he was just under five feet tall and had been on an unsuccessful course of growth hormones for three years when he came to us. His asthma had required hospitalization at least once per month over the past two years, but the allergy consultant who examined him the day after he arrived diagnosed him with "intrinsic" or "adult" asthma related to inflammation and structural changes in his lungs, not to the pollen and dust that affect most child asthmatics. The recommended treatment was the use of three inhalers four times daily in the cottage, with an aerosol nebulizer in the infirmary for "bad times." Brad spent two nights in the infirmary and no nights in the hospital during his 1 1/2–year stay with us. Brad would tell us when "a bad one" was coming, and he was always right. He became his own primary medical caretaker, with the allergist and our nursing and medical staff as supporters, encouragers, and back-up help for the bad times. Brad saw the allergist once a month and came to the clinic once a week, with other visits as needed. He became fully involved with school and his delinquency counseling and treatment. He was placed in a group home where he could still have monthly contact with the allergy consultant.

"Todd," age 13, is one of the many diabetics we have come to know over the years. He was described by the county that sent him as a "brittle" diabetic, in poor control and uncooperative. In detention he had been difficult for the staff to treat and made two trips to the hospital with very high blood sugars. He was initially resistant to patient education, much of which he had heard before but ignored. However, Todd began to take responsibility for doing his own blood sugar checks twice daily and administering the prescribed dosage of insulin in the presence of a nurse.

Although Todd initially didn't take the advice of the nutritionist who spoke to him about reasonable eating, he began to keep the food diary as requested and developed a positive relationship with the nutritionist, the nurses, and me. We transferred his blood sugar testing and insulin administration to the cottage, making them less disruptive to his activities. His diabetes stabilized without hospitalization and with minimal control from the health care team, whose primary role was to adjust Todd's insulin dose as he grew and became more active. Todd had become involved in the management of his own illness. He was empowered and developed a better self-concept.

The examples of Brad and Todd illustrate two health problems, asthma and diabetes, commonly found in institutions for delinquent children. Asthma and diabetes represent only a small fraction of the chronic health problems, often with lifelong consequences, seen in incarcerated youth.

Pregnancy is another health problem prevalent among incarcerated youth. According to the National Center for Health Statistics,[5] in the past 15 years there has been the sharpest rise ever in U.S. adolescent birth rates. The same report notes that only 54% of mothers under age 20 begin prenatal care in the crucial first trimester. The number of homeless adolescents is estimated to be between 500,000 and 2 million,[6] and a high proportion of them become involved with the juvenile justice system. If homeless adolescents become pregnant, their street lives, prostitution, sexually transmitted diseases, substance abuse, and poor nutrition all serve to make their pregnancies high risk.

In addition to pregnancy, there are other major concerns related to sexual activity and sexually transmitted diseases. These include gonorrhea and chlamydia, which were present at rates of 20% and 18%, respectively, in females in one detention facility.[7] The incidence of abnormal cervical cytology in this institution was only 3%, but today—largely because of an epidemic of papillomavirus—abnormal and possibly precancerous pap smears are much more frequent among sexually active females. This problem often requires extensive and expensive follow-up involving laparoscopy and sometimes cone biopsy. The incidence of human immunodeficiency virus (HIV) seropositivity in adolescents has increased steadily, and acquired immune deficiency syndrome (AIDS) is now found in

◀ In addition to pregnancy, there are other major concerns related to sexual activity and sexually transmitted diseases. These include gonorrhea and chlamydia, which were present at rates of 20% and 18%, respectively, in females in one detention facility.

juvenile detention facilities, especially in high-incidence states. Intravenous drug use accounts for much of this increase, particularly in New York State; 95% of the AIDS cases in New York correctional facilities are related to intravenous drug use.[8]

"Lori," age 16, came to us with a history of trading sex for drugs. After counseling, she tested positive for HIV. She also had a number of treatable sexually transmitted diseases. Washington state law requires strict confidentiality regarding HIV testing and results. Over the course of several weeks of counseling, Lori signed consent forms to permit notification of her parents and cottage staff of her HIV infection. We had a conference with the family, and Lori was seen by an infectious disease specialist. She was counseled by her staff, the medical team, and her physician at home. She was started on zidovudine (AZT), and her clinical condition and laboratory tests showed some improvement. The involvement of a local HIV support group was helpful to both Lori and her staff. When she left us, there were elaborate arrangements for follow-up with her doctor and for support for Lori and her family. She stayed at home for only one night and then was back on the streets selling herself for drugs. She returned to us following what her doctor described as a miscarriage in detention. On her second day with us, she developed severe abdominal pain, and our head nurse and I took her to the hospital. A ruptured ectopic pregnancy was diagnosed and treated just in time to save her life. Lori felt comfortable living with us and wanted to stay, but when her short parole violation sentence was up, she returned home. She is now over 18. We were unable to achieve the behavioral results we had wanted, but Lori felt valued and well cared for during the time she was with us. We had been her advocates as well as her health care providers. We had built trust but were unable achieve compliance with recommendations.

Pap smears, referral sources for HIV counseling and testing, and early detection and treatment of sexually transmitted diseases are essential in health care programs for incarcerated youth.

Tuberculosis, once slated for extinction in the United States by the year 2010,[9] has had a major resurgence in this country, especially among minorities.[10] The increased incidence of HIV infection in correctional facilities, and the often discontinuous health care incarcerated populations receive, have contributed to the emergence of extremely dangerous multiple strains of tuberculosis. Attempts to halt the spread of tuberculosis have been

complicated by the release of infected inmates, including youth, into communities. This situation reemphasizes the critical need to screen juveniles for tuberculosis when they enter correctional facilities.

Learning disabilities, attention deficit disorder hyperactivity, and significant developmental delays may have their roots in causes already mentioned—e.g., prenatal toxins, birth defects, and high-risk pregnancies. These conditions represent major service needs for our patients and place major strains on the educational child care staff of the facility. Forty percent of the children in the "normal" adolescent population in the state residential facility where I work receive special education services.

◀ Forty percent of the. . . "normal" adolescent[s] in the state residential facility where I work receive special education services.

"Al," a 15-year-old, mildly retarded young man with epilepsy, was in the waiting area when I came to do his check-in physical. A staff person with him said, "Al isn't in a very good mood this morning." He had been followed in a neurology clinic and was on medication, but he had recently refused to have blood levels of his medications tested, and he was having more seizures. When I met Al he said, "Ain't having no physical. I've had too many." I asked him to come to my office with me, which he grudgingly did. I told him that I didn't know why he was having more seizures but that I should evaluate him to see if I could discover the reason. As soon as the physical was completed, Al grabbed his arms and said, "But you ain't drawing any blood!" I told him that he was healthy as far as I could tell from his physical, but that maybe he was getting too much or too little of his medication. Eventually the blood was drawn, and Al and I talked for a few minutes. He hung his head and told me, "It ain't easy being different—kids call me 'seizure kid' and make fun of me." The blood levels of Al's medications were tested, and he turned out to be in the toxic range for one of them. Over the next few weeks, Al's seizures came under better control, as his stress level, medication level, and trust all improved. The few extra minutes we had spent discussing what was wrong had helped empower him to begin taking control of his own health.

Violence is a cause of chronic illness in incarcerated juveniles. In addition to the disabilities caused by gunshot wounds and by physical and sexual abuse, subsequent posttraumatic stress disorder (PTSD) is becoming one of our most common and difficult to treat psychiatric diagnoses.

posttraumatic stress disorder is becoming one of our most common . . . psychiatric diagnoses.

Most youth in the juvenile justice system have failed in school and in social relationships. As a result, they are frequently alienated and angry. They are also highly stressed. In 1974, Holmes developed the Life Change Events Scale for adults,[10] showing in rank order the amount of stress produced by 43 different life events. Other researchers have correlated stress with illnesses ranging from those traditionally considered stress-related (e.g., ulcers and tension headaches) to infectious illnesses resulting from stress-damaged immune systems and other conditions. Several adaptations of Holmes' stress scale have been done for adolescents. An example is the widely used Adolescent Life Change Events Scale.[11] The top nine stresses for adolescents were:

1. The death of a parent.
2. The death of a brother or sister.
3. The death of a close friend.
4. Divorce or separation of parents.
5. Failure of one or more subjects in school.
6. Arrest by the police.
7. Failure of a grade in school.
8. A family member's problems with alcohol.
9. Involvement with drugs or alcohol.

▶ Most adolescents in secure institutions have experienced many of these identified stresses. Stress predisposes people to many illnesses, causes many illnesses, and worsens the course of many illnesses.

Most adolescents in secure institutions have experienced many of these identified stresses. Stress predisposes people to many illnesses, causes many illnesses, and worsens the course of many illnesses. We realize that stress is a major factor in the illnesses we see, and we attempt to teach stress management as a primary disease control technique. We have found this approach quite effective.

Recommendations for Health Care Providers

The following recommendations may be of use in meeting the health needs of institutionalized youth. The first goal is to provide the best health care possible, including diagnosis, early treatment, and follow-up. When there are needs beyond what can be provided in the facility, the following suggestions may be helpful.

1. Ensure that you have the backup services that you feel are needed for each child. This requires close coordination with

the facility administrator and many other staff members. Your presentation of a plan for the care of the patient should make clear what you feel is needed and why. What are the dangers of delaying treatment? Remember that when any person is incarcerated, the level of health care provided for them must at minimum meet community standards. In the case of an HIV-positive patient, you may feel the need to have an infectious disease consultant. Such a consultant can help you provide good care during the patient's time in custody, and can provide care or referral to appropriate community resources on release. Consultants are often willing to provide staff education in their area of expertise.

2. Network with agencies in the field that provide services your patient needs. One example is the local health department, with its expertise in the diagnosis and treatment of sexually transmitted diseases, including contact tracing and patient follow-up. Public health nursing services also can be an invaluable asset in providing home care and follow-up. Other resources include: Maternal and child health programs for pregnant adolescents (e.g., First Steps) and the Special Supplemental Food Program for Women, Infants and Children (WIC); the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program; school-based health clinics; and federal or state programs. Another excellent program is Coordinated Children's Services, which serves children with birth defects such as cleft palate.

   Voluntary service-oriented groups such as the Rotary, with its interest in services for disabled children, and the Lions Club, with services for the visually impaired, may be good resources. Disease-oriented associations (e.g., the Juvenile Diabetes Foundation and the National Asthma Foundation) not only act as advocates but also provide valuable educational materials for children and families. Many of these associations are willing to provide inservice education programs for institution staff. Advocacy groups for the disabled, developmentally delayed, and mentally ill are valuable community resources.

   There may be other available community resources, including multiservice organizations such as the Red Cross, which has many worthwhile education programs and

services for special needs children in the community, and the Shriners Hospitals, which provide excellent burn care, orthopedic surgery, and rehabilitation at no cost.

Learn who your regional, county, and state maternal and child health program coordinators are, and find out what services may be of assistance to you in caring for your patients during incarceration and after discharge into the community.

Finding available backup services for your patients and utilizing community resources emphasizes your role as a child advocate, a role critically important in providing quality comprehensive health care for extremely needy children in difficult circumstances.

The standards of the National Commission on Correctional Health Care[12] require the kind of comprehensive care services discussed in this chapter. These standards may assist you in your requests for needed services, especially if your facility is seeking National Commission accreditation.

No matter how small your facility or how limited your time with the children, there is much that you can accomplish in addition to providing good health care. You can provide each child with education, empowerment, advocacy, and referrals to community services. These elements may make incarceration a time of real health improvement, leading to increased ownership of health and improved self-esteem.

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7

Minority Overrepresentation

Gordon Bazemore, Ph.D.
Jerome McKean, Ph.D.

"Most people, especially males, have committed crimes at some point in their lives. . . . Those we refer to as 'criminals' are those who get caught."

THE SUBJECT OF THIS CHAPTER IS the intersection of three areas of concern that provoke passionate argument in this country: the treatment of children, the treatment of minorities, and the treatment of offenders. Each of these concerns reflects our most deeply held notions of what is right and what is wrong, what is good and what is evil.

As criminologists, the authors have the task of sorting through facts about minority overrepresentation in U.S. juvenile justice systems and examining recommendations for dealing with the problem. Though we are trained to treat issues such as these in a dispassionate fashion, our own deeply held notions and values come into play.

We have long been convinced that, however benign the motives of juvenile justice practitioners, juvenile justice custodial facilities are poor substitutes for remaining with one's family and attending schools in one's own community. Our bias is toward efforts to prevent juvenile delinquency and involvement with the juvenile justice system.

We are also convinced that the United States remains a racist society. We agree with Andrew Hacker's recent assessment:[1]

> America is inherently a "white" country: in character, in structure, in culture. Needless to say,

> black Americans create lives of their own. Yet, as a people, they face boundaries and constrictions set by the white majority. America's version of *apartheid*, while lacking overt legal sanctions, comes closest to the system even now being reformed in the land of its invention.

Many white Americans will disagree with Hacker's statement. They will deny the existence of "boundaries and constrictions" and even argue that affirmative actions programs make it advantageous to be black. A parable that Hacker presents to white college students belies this argument and illustrates the value of being white in the United States.[1] In Hacker's parable, an official informs you (the white student) that a mistake has been made: You were supposed to have been born black, to another set of parents. The error must be corrected, so at midnight tonight, you will become an African American in skin color and physical features. You are scheduled to live another 50 years as a black person. Since the error is not your fault, the official offers you generous compensation. How much financial compensation would you request?

▶ In Hacker's parable, an official informs you (the white student) that a mistake has been made: You were supposed to have been born black.... How much financial compensation would you request? Most of the white students to whom the parable is presented ask for $50 million, or $1 million for each black year.

Most of the white students to whom the parable is presented ask for $50 million, or $1 million for each black year. Hacker's comments on his parable are instructive:

> And this calculation conveys, as well as anything, the value that white people place on their own skins. Indeed, to be white is to possess a gift whose value can be appreciated only after it is taken away. And why ask for so large a sum? Surely this needs no detailing. The money would be used, as best it could, to buy protection from the discriminations and dangers white people know they would face once they were perceived to be black.

Race, Ethnicity, and Minority Identification

As our introduction suggests, we will emphasize the overrepresentation of African Americans in the juvenile justice system. Our emphasis reflects the fact that African Americans are by far the most overrepresented minority in the juvenile justice system, and their overrepresentation is the most remarked upon and analyzed in the literature.

▶ African Americans are by far the most overrepresented minority in the juvenile justice system....

Our emphasis—and that in the literature—reflects the crude categorization of minority and majority status in official statistics.

For example, statistics compiled by the Office of Juvenile Justice and Delinquency Prevention usually use the categories "nonminority," "black," "Hispanic," and "other."[2-5] Both whites and blacks of Hispanic origin are included in the Hispanic category. In many cases, official statistics simply divide the population into "white" and "nonwhite," and it is not clear how persons of Hispanic, Native American, or Asian origin are categorized.

Obviously, the ethnic and racial landscape of the United States is far more complex than official statistics convey. Typically, even local agencies use very broad categories to describe the populations they serve. We will discuss policy recommendations in detail later, but at this point it is appropriate to note that the record-keeping of most local juvenile justice agencies could benefit from incorporating information about how persons identify themselves and are identified by others. Minority populations must be appropriately and accurately identified before they can be properly served.

Minority populations are far from the homogeneous groups that statistical categories imply. For example, Americans of Hispanic, Chicano, or Latino origin may or may not choose to identify themselves as white or black. In the 1990 U.S. Census, just over half the Americans of such origins chose to identify no race at all.[1] National identities such as Puerto Rican, Cuban, and Mexican often seem of greater relevance, and further divisions within nationalities may be quite important. To cite one example, Cuban Americans often distinguish themselves by the year they migrated to the United States and by the social and economic standing of their families in Cuba prior to their migration.

Native Americans (American Indians) distinguish themselves by the Indian nation to which they belong, by tribal identity, and in some cases by clans within a tribe. The cultural gap between criminologists and Native Americans is apparently difficult to cross; despite the status of Native Americans as one of the most overrepresented groups in criminal and juvenile justice statistics, they have been all but neglected in the research literature.[6]

The categorization of people as "black," "African American," or even "persons of color" also masks a host of distinctions based on race, national origin, and religion. Some of the complexities have been noted by Daniel E. Georges-Abeyie:[7]

> Thus one can, and should, be cognizant of Black Puerto Ricans, Cubans, Virgin Islanders, Jamaicans,

> Africans, African-Americans, and others with very different religious traditions (e.g., Protestant, Catholic, Muslim, Baha'i, and Jewish). However, Black ethnic identities are further sub-divided by color and hue realities that affect social networking which ranges from informal social clubs and cliques to formal legal arrangements such as marriage. These color and hue realities engender such social classifications as moreno, mulatto, blanco sucio, and pardo.

Skin tone provides a basis for differentiation among African Americans that Keith and Herring[3] find to be a powerful predictor of social stratification, occupation, and income. Georges-Abeyie notes that African Americans may also distinguish themselves by geographic origin: suburban versus urban, East Coast versus West Coast, southern versus northern, and ghetto versus slum ghetto.[7]

▶ Distinctions within racial and ethnic categories have important consequences for the understanding of delinquent behavior and juvenile justice processing....

Distinctions within racial and ethnic categories have important consequences for the understanding of delinquent behavior and juvenile justice processing, as did the distinction between native white Protestant Americans and immigrant white Catholics from Eastern Europe when reformers of the former group undertook to "save" the children of the latter group from "moral depravity" by establishing juvenile courts at the turn of the century.[5] Incidentally, it was common at that time to refer to Eastern Europeans as belonging to a different race from Anglo-Saxon Protestants.

▶ it helps to know with whom one is dealing when making critical decisions about their futures.... [but] In Florida, for example, police...receive only 2 hours of cultural awareness training in a 520-hour curriculum, and... are not required to demonstrate mastery of this... knowledge.

It seems obvious that juvenile justice practitioners, especially police officers, should have extensive training in appreciating the cultural, linguistic, and behavioral significance of the ethnic and racial landscape of their jurisdictions, for it helps to know with whom one is dealing when making critical decisions about their futures. Yet training of this sort is only now—after the videotaped and nationally televised beating of Rodney King by Los Angeles Police Department officers—being strongly recommended by advisory commissions and researchers. The actual provision of meaningful training lags far behind the recommendations. In Florida, for example, police officers receive only 2 hours of cultural awareness training in a 520-hour curriculum, and they are not required to demonstrate mastery of this rudimentary knowledge.[8]

The subtle and complex ways in which persons identify themselves and in which they are identified demonstrate the

potency of race and ethnicity as *social constructions*.[9] Although physical anthropologists use "racial" categories to distinguish persons on the basis of body structure and facial features, their classifications indicate nothing about an individual's behavioral tendencies, emotional makeup, or intelligence. Whatever role that genes play in determining these aspects of a person's makeup is unrelated to physique, skin tone, and appearance. People, not nature, divide themselves into racial and ethnic groups and use these divisions as a basis for determining their own worth and the worth of others.

A Description of Overrepresentation

Measures of Overrepresentation

Despite the insensitivity of typical statistical categories to the complexities of racial and ethnic identity, it is still possible to make meaningful statements about overrepresentation. In many studies, the percentage of youth from a minority group at a particular point in juvenile justice processing is compared to the percentage of the total youth population from that minority group.[10] For example, Austin, Dimas, and Steinhart report that in 1989, African American males comprised 4.5% of the population of California between the ages of 10 and 17, but the same group comprised 34.4% of the juveniles in custody in secure public facilities.[10]

◀ Austin, Dimas, and Steinhart report that in 1989, African American males comprised 4.5% of the population of California between the ages of 10 and 17, but... comprised 34.4% of the juveniles in custody in secure public facilities.

In some cases, comparisons are made between the percentage of minority youth at one point in processing and the percentage of minority youth at a later point. For example, the Florida Supreme Court Racial and Ethnic Bias Study Commission notes that black males accounted for 42% of all juvenile arrests in Florida in 1989, but 57% of all juveniles who were detained prior to adjudication.[8]

Comparisons may also be made between minority and nonminority youth at one point in processing. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) found that for 12 states, minority males were referred to the juvenile court for violent offenses at a rate of 11.68 per 1,000 in 1987, while white males were referred at a rate of 2.80 per 1,000.[11]

As our examples show, there is ample evidence of overrepresentation in a number of different places and at a number of different stages of juvenile justice processing. We shall cite addi-

tional examples to round out our description of the problem, but it is worth pausing to consider whether overrepresentation occurs uniformly.

Diversity of Juvenile Justice Systems

The juvenile justice systems of the United States are numerous and diverse, and it is impossible to make generalizations that apply with equal weight to all of them. The processing of juvenile offenders varies widely from state to state and within states.

In some juvenile justice systems, overrepresentation is simply not an issue: There are no minorities to overrepresent. More generally, there are wide variations in the way juveniles are processed among jurisdictions within a state, although the jurisdictions share the same legal code and, in some states, the same structure and organization for intake, detention, adjudication, and disposition. In a recent study of juvenile justice in Minnesota, Feld found that:[12]

▶ there are wide variations in the way juveniles are processed among jurisdictions within a state....

> Juvenile courts' procedural characteristics and sentencing practices relate consistently to urban, suburban, and rural differences in social structure. Urban courts operate in a milieu that provides fewer mechanisms for informal social control than do rural ones; consequently, they place greater emphasis on formal, bureaucratized social control. . . . Structural influences on formal versus informal social control also affect the selection of delinquents and the administration of justice. Urban courts sweep a broader, more inclusive net and encompass proportionately more and younger youths than do suburban or rural courts. Social structure and procedural formality are also associated with more severe sanctions. The more formal, urban courts place over twice as many youths in pre-trial detention and sentence similarly-charged offenders more severely than do suburban or rural courts. As a result, where youths live affects how their cases are processed and the severity of the sentences they receive.

As we shall describe in the next section, differences in social structure may help to account for the extent of minority overrepresentation as well. At this point, we wish to note only that *questions of minority overrepresentation must be investigated on a jurisdic-*

tion-by-jurisdiction basis. Findings from statewide, regional, or national studies cannot be assumed to apply to a particular locale.

Overrepresentation and Criminal Behavior

It would be a great help in understanding overrepresentation if one could take into account not just the percentage of the general population that belongs to a particular minority group but also the percentage of the minority group that commits crimes. Few would have a problem with actual criminals being "overrepresented" in the juvenile justice system, regardless of their racial or ethnic identity.

Life is not that simple. While it is comforting to regard criminals as different from "normal" individuals, a large body of self-report studies indicate that most people, especially males, have committed crimes at some point in their lives, and are likely to have done so during their adolescence. Those we refer to as "criminals" are those who get caught.

Crime is not merely a behavior; it is also a *status* imposed on a minority of the population, "eligible" for this designation because of its behavior. Ideally, those who cause the most harm and loss are those caught up in the net. Justice system personnel are not even aware of most criminal acts, simply because the victims of crime fail to report them.[13]

Do minorities actually commit more than their share of serious crimes? The evidence is mixed. Official statistics on "offenses known to the police" as reported by the Federal Bureau of Investigation do not address the issue. However, when asked about the racial identity of their assailants, victims of crime report a proportion of black offenders that agrees well with official arrest statistics.[14] But victim reports are available only for the relatively few incidents in which the victim actually sees the offender, and they do not address the issue of whether the offenses are committed by a small number of chronic offenders.[13]

Another source of information is surveys of the youth population in which persons are asked about their own delinquent behavior. These "self-report" surveys generally show no significant differences between black and white respondents in the commission of serious offenses.[15-17] Obviously, surveys of self-reported delinquency are inherently open to questions

"self-report" surveys...show no significant differences between black and white respondents in the commission of serious offenses.

about the truthfulness of the respondents, but they typically reveal a far higher number of offenses and offenders than do official statistics, and more recent self-report surveys are quite methodologically sophisticated.

In sum, the available evidence lends greatest support to the view that there are no substantial differences in rates of offending between blacks and whites. But the available evidence is far too scanty to support this view with great certainty. Do minority youth commit more than their share of serious crimes? We do not think so, but we do not know for sure.

▶
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Minority Overrepresentation in Arrest Rates

The Federal Bureau of Investigation (FBI) compiles data on arrest rates by race, using information forwarded from state and local law enforcement agencies. Information from FBI statistics presented by Siegel and Senna[13] shows that black youth are taken into custody for serious crimes (murder, rape, robbery, aggravated assault, burglary, larceny, and vehicle theft) at rates far higher than those for whites. Blacks comprise about 12% of the population, but in 1988, 24% of adolescents arrested for burglary and 67% of adolescents arrested for robbery were black. Percentages for other serious offenses fall between 24% and 67%.

▶
Siegel and Senna [show] that black youth are taken into custody for serious crimes (murder, rape, robbery, aggravated assault, burglary, larceny, and vehicle theft) at rates far higher than those for whites.

White youth (including Hispanics) account for approximately 69% of arrests of persons under age 18, but they compose about 84% of the population. Whites are more likely to be arrested for less serious, "status" offenses (offenses that are illegal only for persons under the age of majority), especially drunkenness and violations of liquor laws.

Siegel and Senna also report that Hispanic youth (who are included in the "white" group) account for about 12% of arrests for all offenses. Hispanics make up about 15% of the population.[13]

A report by the National Council of Juvenile and Family Court Judges notes that the proportion of black youth arrested for violent crime has increased steadily in recent years, from 49.7% in 1977 to 54.6% in 1987.[4]

Overrepresentation in Referrals to the Juvenile Court

After a youth is taken into custody, the police may deal with him or her informally or refer the case to the juvenile court. Sickmund reports that the police are the source of juvenile court referrals in about 80% of the cases.[18] Cases may also be referred

by parents, schools, victims, social service agencies, and probation officers.

In addition to the aforementioned OJJDP report showing minorities referred to juvenile courts for violent offenses at a rate several times that for whites,[11] there is evidence of substantial differences in referral rates for cases of all types. Sickmund's study for the OJJDP shows this clearly:[18]

> In 1987 the nonwhite delinquency case rate (68.1) was 75% greater than the white rate (38.8). [Rates are cases per 1,000 youths in each category.] The most substantial racial differences in case rates were found for person [violent] and drug offense cases. The non-white person offense rate was more than triple the white rate, and for drug offenses the non-white rate was more than double the white rate.

Overrepresentation in Detention Facilities

Once a youth has been taken into custody, he or she runs the risk of being placed in a secure detention facility pending court hearings on the adjudication (finding of guilt) and disposition (sentencing) of the case. In some jurisdictions, detention may last one month or more—depending on statutory limits—while the local prosecutor decides whether or not to file a petition to the juvenile court asking that the youth be adjudicated a delinquent. Detention facilities may also be used for youth awaiting transferral to residential facilities or for short-term placements after disposition.[5,13]

◀ a youth... runs the risk of being placed in a secure detention facility pending court hearings on the adjudication (finding of guilt) and disposition (sentencing) of the case. In some jurisdictions, detention may last one month or more....

A recent report by Snyder for the OJJDP shows that in 13 states, the number of youth held in detention facilities increased by 15% between 1985 and 1987. But Snyder reports only a 1% increase for whites and increases of over 30% for blacks, Hispanics, and other minority youth.[19]

Detention is a critical stage in juvenile justice processing, for it strongly predicts whether a youth's case will be disposed of formally or informally by the authorities and whether the youth will receive a custodial or community-based disposition.[8] Snyder found that roughly 60% of cases in which youth were not detained received informal dispositions, compared to 20% of cases in which the youth were detained.[19] In turn, a formal disposition is far more likely to subject youth to formal behavioral controls such as probation or residential placement. A for-

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nal disposition also counts as a "prior" if and when a youth is arrested again, and a youth with prior dispositions is more likely to be treated severely by the courts.

Snyder found that detention occurred in 25% of the cases overall. Nonwhites were detained in 29% of cases in which they were charged with delinquent offenses, whereas in cases involving white youth, detention occurred in only 23%. There was an increase in detentions for minority youth, most of which was due to drug cases:

> The number of drug cases handled by the courts increased by only 1% between 1985 and 1986, while the number of detained drug cases increased by 21%.... Although the number of white youth detained annually remained constant between 1985 and 1986, the number of nonwhite youth admitted to detention facilities rose by 13%, primarily the result of a large increase in the number of nonwhite youth detained for drug offenses. Between 1985 and 1986, the number of white youth referred to court for a drug law violation declined by 6%, while the number of nonwhite youth referred for a drug violation rose by 42%. This increase in referrals coupled with the court's greater likelihood of detaining drug cases resulted in a 71% increase in the number of nonwhite youth detained for a drug offense.

Overrepresentation in Residential Facilities

In the vast majority of cases handled formally by the courts, the youth are adjudicated delinquent. At this point, the courts must "sentence" the delinquent youth—that is, decide on their disposition. The courts have a growing list of options, including returning juveniles to the custody of their parents, placing them on probation, requiring them to receive counseling or training at nonresidential facilities, or placing them in residential facilities. This last option is used in the most severe dispositions and, in theory, is reserved for the most severe offenders.

The OJJDP conducts a biennial census of public and private juvenile residential facilities that provides information useful in gauging minority overrepresentation. The latest reported findings are for public facilities in 1989 and show an increasing overrepresentation problem.[2] Between 1987 and 1989, the population of

juveniles held in public facilities increased by 5%, but the nonminority population there *decreased* by 5%. The population of black youth in public facilities increased by 13%, and the Hispanic youth population increased by 14%. Minority youth comprised 60% of the population in residential facilities in 1989.

As with detentions and referrals, it seems likely that much of the increase in the minority population in public facilities is due to enhanced prosecution and processing of drug offenses. Although figures do not compare percentages of minorities and nonminorities within offense categories, the number of youth held in 1989 for drug and alcohol offenses was 150% greater than in 1985.[2]

◀
As with detentions and referrals, it seems likely that much of the increase in the minority population in public facilities is due to enhanced prosecution and processing of drug offenses....the "war on drugs" of the late 1980s may interact with and amplify routine discrimination....

Other empirical reports suggest that police and prosecutorial targeting of drug offenders as part of the "war on drugs" of the late 1980s may interact with and amplify routine discrimination to further increase minority overrepresentation in residential facilities. In a recent study examining correctional commitment data from 24 states, Bazemore et al. report that juvenile drug commitments—those in which a drug offense is the primary commitment offense—increased by 300% as a proportion of total commitments between 1984 and 1989.[20] However, in states with available data on race (N=12), commitments for drug offenses as a proportion of total commitments increased tenfold for black juveniles during these years, increased fivefold for Hispanic youth, and remained constant for white youth. This disparity seems to support the conclusion that the war on drugs has been primarily a "war on minority youth."[21]

Conclusions About Overrepresentation

Although minority overrepresentation is likely to vary widely among jurisdictions, a brief look at the national data make it clear that:

1. Overrepresentation occurs at each stage of the juvenile justice process.
2. Overrepresentation is increasing.
3. Much of the increase in overrepresentation is due to drug cases.

The national data also suggest an "amplification effect"[22] on minority overrepresentation: As minority adolescents move through the juvenile justice system, they are more likely to be

selected for further formal processing—referral to the court, detention, and disposition to residential facilities. As this selection occurs, the proportion of the juvenile justice population composed of minorities increases and overrepresentation becomes more pronounced.[10]

The national data are alarming, but overrepresentation may be a greater problem in some states than in others, especially those in which minorities comprise a larger part of the youth population. Findings from a recent study of the Florida juvenile justice process by Tollett and Close[23] support this view. Tollett and Close found that although blacks made up 21.75% of the at-risk population, they accounted for 42% of the arrests in Florida. From 1982 to 1990, referrals to the juvenile court increased 119% for blacks and only 36% for whites. Black adolescents were incarcerated in adult prisons at a rate 8.5 times greater than the rate for white adolescents, a finding especially troubling in light of overall dramatic increases in the use of the waiver or "direct file" process, whereby youth are transferred to adult courts for sentencing.[24] Perhaps the most shocking finding of this study is that referrals to the juvenile court for felony drug cases increased 103% for whites between 1982 and 1989, but increased 6,706% for blacks during the same period.

▶ Perhaps [Tollett and Close's] most shocking finding is that referrals to the juvenile court for felony drug cases increased 103% for whites between 1982 and 1989, but increased 6,706% for blacks during the same period.

Explaining Minority Overrepresentation

Explaining minority overrepresentation in the juvenile justice system is important, for explanations help to determine whether phenomena are problems amenable to solutions or conditions inherent to the social and cultural structure of a nation. For example, broken traffic lights are problems, but traffic jams are the price to be paid for our preference for automobiles as a means of transportation.

▶ One [theory] treats minority overrepresentation in the juvenile justice system as a result of intractable social conditions....

One line of thought treats minority overrepresentation in the juvenile justice system as a result of intractable social conditions that cannot be addressed by the legal system. In this view, many of the minority youth formally processed by juvenile justice authorities come from an "underclass" that has developed a cultural predilection toward criminal behavior. This "culture of poverty" is a persistent, entrenched "tangle of pathologies" that cannot be changed by measures to alleviate poverty, disease, unemployment, or ignorance.[25] The overrepresentation of underclass members in the juvenile justice system is viewed as natural:[26]

> In effect, the discovery of the underclass allows justice officials to wring their hands in agony and then throw them up in despair, knowing that no reasonable person would expect the system to address such a mammoth social problem. As a result the problem can be effectively ignored.

Space does not permit a detailed critique of the culture of poverty position, but we can say that the reasoning involved is very old and very suspect. It was Aristotle who first argued that slaves were not fit for freedom: One had only to observe their surly demeanor, their ignorance, their bent backs, and their gnarled hands to see that they were not of the same order as Greek citizens. The same circular reasoning underlies the culture of poverty version of the underclass argument. The underclass is identified by the "pathological" behaviors indulged in by its members, and these behaviors are explained by noting that those who engage in them are members of the underclass.

A more defensible position is that the overrepresentation of minorities in the juvenile justice system is not the result of discrimination in the juvenile justice process. The strongest case for this position is made by William Wilbanks.[27] Wilbanks argues first of all that overrepresentation does not prove discrimination. The disproportionate number of minority youth in juvenile justice processing may be due to minority youth committing more serious offenses than white youth. Minority youth may have more prior arrests and referrals than white youth who commit similar offenses. Minority youth may come from highly dysfunctional families and environments that require judges to place them in residential treatment. Minority youth may be more likely to have problems such as drug addiction that require formal intervention. However, Wilbanks asserts his "no discrimination" hypothesis most strongly for the adult criminal justice system, where the discretion of legal officials is far more circumscribed than in juvenile proceedings.

◀ **Wilbanks argues first of all that overrepresentation does not prove discrimination. The disproportionate number of minority youth in juvenile justice processing may be due to minority youth committing more serious offenses than white youth.**

In order to prove discrimination, minority and white youth would have to be compared simultaneously with regard to a number of variables such as those described above. Only after taking all these variables into consideration could one determine the presence or absence of discrimination. Criminologists who research the issue collect information on race and ethnicity, age, sex, socioeconomic status, seriousness of the offense,

seriousness and number of prior arrests, seriousness and number of prior dispositions, and so on. These variables are subjected to multivariate analysis, permitting examination of the effects of each variable while controlling for all other variables. Only in cases in which racial or ethnic background predicts the outcomes of juvenile justice decision-making—taking into account all controls—can discrimination be charged.

▶ At first glance, the "no discrimination" hypothesis seems the one best supported by the literature. [But] Pope and Feyerherm reviewed 41 studies specifically dealing with discrimination according to minority status. They found that two-thirds of the studies showed both direct and indirect effects of minority status on juvenile justice decisions at some stage[s] of the process.

At first glance, the "no discrimination" hypothesis seems the one best supported by the literature. In a review of studies testing for discrimination by race, socioeconomic status, and family disorganization (measured by the absence of one parent or the presence of foster parents), Tittle and Curran found that in 19 studies, only 12 out of 41 tests revealed discriminatory effects.[28]

On the other hand, Pope and Feyerherm reviewed 41 studies specifically dealing with discrimination according to minority status.[26] They found that two-thirds of the studies showed both direct and indirect effects of minority status on juvenile justice decisions at some stage[s] of the process. Further, the studies showing bias were as methodologically sophisticated as the studies that did not show bias. The studies reviewed demonstrated that bias can occur at any stage in the juvenile justice process, and that "small racial differences can accumulate and become more pronounced as minority youths are processed further into the juvenile justice system."[26]

This brings us to one last comment about the multivariate research literature. As we have noted, it is common to control for prior arrests and prior dispositions in assessing the impact of minority status on juvenile justice decision-making. But these variables themselves may be influenced by biases of officials during processing. Prior arrests and dispositions may reflect prior biased acts.

▶ The one thing that virtually all criminologists can agree on is that further research is needed to sort out questions of bias.

The one thing that virtually all criminologists can agree on is that further research is needed to sort out questions of bias. As noted earlier, local juvenile justice systems vary a great deal in the way they process young persons; whether overrepresentation occurs and, if it does, if it reflects bias, can be answered definitively only by studies at the local level.

The importance of more detailed research is illustrated in the study by Tittle and Curran.[28] They sought to determine not only whether discrimination occurred but in what contexts. Their study of juvenile justice processing in Florida counties in 1979—before

the rapid rise in minority referrals—showed that race affected decisions statewide, but the effect was not uniform for all counties. Racial effects on decisions were far more pronounced in counties with large proportions of adolescents and of nonwhites, especially for drug and sexual misconduct offenses:

> Discrimination does not occur as a straightforward response to the individual's inability to resist [official processing]. Rather, differential sanctioning by social disadvantage occurs primarily in those ecological contexts where the groups of which the individual defendants are a part constitute symbolic threats that are made compelling by high visibility. Thus, there is strong evidence of racial disparity only when there are relatively large proportions of nonwhite and young.

[Tittle and Curran showed that] Racial effects on decisions were far more pronounced in counties with large proportions of adolescents and of nonwhites, especially for drug and sexual misconduct offenses

Tittle and Curran also suggest that drug and sexual misconduct offenses represent a similar symbolic threat to elites, representing ". . . overt behavioral manifestations of the very qualities we contend frighten white adults or generate resentment and envy on their parts."

Policy Recommendations

As overrepresentation has become more widespread and pronounced, various official and semiofficial agencies, commissions, interest groups, and study groups have made recommendations for addressing the problem.[4,6,8–10,25,26,29–32] Several recommendations are frequently heard. For example, training for police and juvenile justice personnel in the appreciation of cultural differences is viewed as essential to the tasks they perform. And there is no doubt about the need for further research into minority overrepresentation. Most groups also recommend that minorities, who are *underrepresented* among juvenile justice personnel, be recruited much more aggressively. We believe it is especially important to recruit more minority juvenile court judges. A recent evaluation in Florida, for example, showed that minorities comprised only 5.5% of the judges in the state. Only 1% of the judges were female minority members.[8] In contrast, blacks alone made up 14.2% of Florida's population in 1990. Reapportionment of judicial electoral districts and appointment of minorities to judicial selection commissions are ways in which this problem might be addressed.

Another area of concern addressed in several sets of recommendations is the relationship between juvenile justice officials and minority families. Intake counselors, juvenile officers, probation officers, and detention screening staff are often deterred from recommending informal adjustments because the minority family in question is headed by a single parent who must work and cannot be present when decisions are made about her child. Also, minority members are often quite suspicious and mistrustful of authorities. Juvenile justice staff members should be given the resources and encouragement to go beyond routine processing in such cases, and the training to relate more effectively to minority family members.

Such "cultural competency" training would have to build an appreciation for the diversity and resiliency of different ethnic and racial groups. The objective would be to make juvenile justice staff more proficient at identifying and building upon cultural strengths, as opposed to focusing upon deficits in minority families and neighborhoods, which tends to discourage creativity in developing community-based solutions.

A much neglected role for juvenile probation and community supervision professionals is that of advocate. Generally, juvenile probation and parole staff, now trained primarily in monitoring/enforcement and occasionally assessment, could be encouraged to become advocates for the minority adolescents they supervise and the adolescents' families. A broader advocacy role could involve mobilizing indigenous minority organizations to support alternative supervision programs or reforms in processing and supervision designed to reduce incarceration of minority youth. For example, black and Latino men's leadership and civic groups have supported mentoring programs in some jurisdictions; these and other groups could also be called upon for input into juvenile justice planning and policymaking generally.[10] Such groups may also be mobilized to apply pressure for basic reforms in detention practices and for other procedural changes which may encounter resistance from prosecutors and other groups or even be overturned without a visible group of community advocates.[33]

▶
black and Latino men's leadership and civic groups have supported mentoring programs in some jurisdictions; these and other groups could also be called upon for input into juvenile justice planning....

One of the problems many families face, whether white or black, is the absence of a parent from the home. Typically, the absent parent is the father, and in too many cases, he makes no contribution to the support of the family. Far more rigorous and

reasoned enforcement of child support payment laws would be a cost-effective way in which to assist such families. More broadly, comprehensive family support and full employment policies will ultimately be required to strengthen families and revitalize the communities that are their foundations of support.[34]

A critical area of concern is the processing of minority juveniles for drug offenses. As we have seen, such offenses seem to fuel overrepresentation throughout the juvenile justice system. While the relationship between drug use, drug trafficking, and other delinquent acts is not clear, recent research suggests that the simple notion that drugs cause crime and that crime will be reduced by dealing harshly with drug offenders is untrue.[31,32,35,36] Harsh drug law enforcement as a means of reducing juvenile crime is questionable policy at best and fuels suspicion that some police departments are using drug laws as a means of "cracking down" on minority populations that they see as threatening. Ultimately, the combination of perverted paternalism and racist policing is far more corrosive to the social order than the drugs themselves. It should not be surprising then that many African Americans view both the infusion of drugs into black neighborhoods and the severe penalties associated with drug offenses—especially those involving crack cocaine—as evidence of a structural conspiracy to destroy a generation of black males.[1]

◀ While the relationship between drug use... and other delinquent acts is not clear, recent research suggests that the simple notion that drugs cause crime and that crime will be reduced by dealing harshly with drug offenders is untrue.

We believe that the single most urgent need in American juvenile justice policy is a commitment to providing timely and accessible drug treatment to any young person who requests it. We suspect that one reason so many minority youth end up in juvenile institutions is that juvenile court judges believe—usually without foundation[21]—that drug treatment unavailable in the community will be provided there.

◀ We believe that the single most urgent need in American juvenile justice policy is a commitment to providing timely and accessible drug treatment to any young person who requests it.

Second, it has become increasingly apparent that many drug offenders placed on probation and many of those placed on parole (often called *aftercare* in the juvenile justice system) following institutionalization fail in these community dispositions by reoffending or by failing to comply with supervision rules; they are then committed or recommitted to state facilities.[21] This suggests a need to examine carefully the proportion of justice system resources devoted to community supervision versus "deep end" options (residential facilities).[10] There is also a need to rethink the basic logic of traditional community sanc-

tioning and supervision processes—especially as these may be insensitive to the diverse cultural backgrounds of probationers and parolees.[20]

Lest the above recommendations for juvenile justice reform be interpreted as unrealistic, we must assure readers that we do not believe that even the most sensitive and enlightened juvenile justice professionals and policies alone can have a significant impact on overrepresentation of minorities. Ultimately, we must acknowledge the obvious: Institutional racism is a much bigger problem than discrimination within the boundaries of the juvenile justice system. As revealed in recent studies of economic and structural changes in the nature of work and neighborhoods in urban, black neighborhoods, a generation of young black males is in danger of becoming a permanent underclass.[34] We agree with Troy Duster's view[37] that this state of affairs requires a comprehensive societal strategy addressing structural transformations that have so differentiated employment opportunities for black and white youth that the "bottom rung on the ladder of success" has been taken away from black youth.

▶ acknowledge the obvious: Institutional racism is a...bigger problem than discrimination within the boundaries of the juvenile justice system.

Acknowledging the need for broad structural change does not absolve the juvenile justice system of responsibility for advocating for both external and internal policy changes in the treatment of minority youth and the range of opportunities available to them. The juvenile court is the agency assigned primary responsibility for at-risk youth. As Mark Moore has observed:[4]

> The only institution that can reasonably exercise leadership on behalf of the society and the children is the juvenile court. The reason is simply that no other institution can claim to have as wide a range of action, or to be able to make decisions that are designed to reflect the values of the society as expressed in its laws and constitution.

Juvenile justice programs and institutions can make a difference and should be expected to proactively address the problem of racial discrimination both within and outside of the juvenile justice system.

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8

Mental Health

Janice Hutchinson, M.D.

" 'Clinton'...came to therapy cheerfully, boasting... 'I shot them. I got them good... no regrets... sometimes I feel like I am the devil. Sometimes I just look at people and hate them. You think I'm the devil, really? At night, I think I see the devil in my room... ' "

"THOSE LITTLE CRIMINALS, I DON'T want to be around them... They are the worst... Lock them up and leave them there for a long time... I have no sympathy for them... They are bad kids and they get what they deserve... How can you stand to work with them?" These are the feelings that many people have about incarcerated youth. A private practice that includes juvenile offenders does not usually appeal to even mental health professionals. Yet there is a growing perception that antisocial behaviors of youth are rooted in mental health problems and issues that are unrecognized, undiagnosed, and untreated.

Although the juvenile population has decreased, the number of juveniles arrested and detained has increased. Over 1 million adolescents have committed delinquent and status offenses.[1] More than 600,000 reside in juvenile detention facilities.[1] Another half million are kept in adult jails.[1] In 1987, the juvenile incarceration rate was 208 per 100,000, an increase of 10% from 1983.[2] Each day, 2,000 juveniles are detained in adult correctional facilities.[3] Males predominate (85%).[2] More than 55% are youth of color[2]—blacks predominate, and there are growing numbers of Hispanic youth. The number of nonwhite youth has increased by 8% from 1983 to 1987. The number of white youth has remained stable. Ages of juvenile

offenders usually range from 14 years to 17 years, with a mean of 15.4 years.

Most of those committed to juvenile facilities are delinquents—that is, they have committed a legal offense. Nondelinquents are status offenders who are committed to juvenile facilities because of running away from home, abuse or neglect, or voluntary admission. Youth are usually detained pending adjudication or are committed after being found guilty of an offense. Offenses include murder, rape, robbery, assault, burglary, arson, motor vehicle theft, alcohol and drug offenses, probation violations, and possession and distribution of drugs. The average stay for a detained youth is 12 days; the average stay of those committed to long-term facilities is eight months.[4] Recidivism rates are high: Forty percent of all U.S. juvenile court cases involve repeat offenders.[5] In the Washington, DC, area, recidivism is reported at 70%.[6] Movement from juvenile to adult detention will occur for 50% of juvenile offenders in Washington, DC.

▶ The average stay for a detained youth is 12 days; the average stay of those committed to long-term facilities is eight months.

The recognition of emotional disorders in this population has occurred only over the past two decades. A 1980 National Institute of Mental Health report found that 11 states had developed a total of 17 mental health programs for mentally disturbed juvenile offenders.[7] The Massachusetts Department of Social Studies reported that 2.6% of the 1,500 youth in its custody and 23.2% of its youth requiring secure facilities were in need of special programs for the treatment of mental disorders.[7] A 1978 New York State Division for Youth study revealed that facility directors identified 332 of 850 youth as needing psychiatric services.[7] Of these youth, 12–18% required major mental health interventions not available onsite. Moderate to severe psychiatric symptoms were identified in at least 10% of 2,000 residents of a New York juvenile correctional facility in 1983. This was also the year of the "Willie M." class action lawsuit, resulting in North Carolina's agreement to provide placements and services to mentally disturbed youth offenders. Several investigators have reported high rates of neuropsychiatric problems among residents of juvenile correctional facilities.[8,9]

▶ A 1980 National Institute of Mental Health report found that 11 states had developed a total of 17 mental health programs for mentally disturbed juvenile offenders....

Similarities between incarcerated youth and psychiatrically hospitalized youth have been reported. A 1988 Washington State study revealed that 76% of incarcerated adolescents were as severely emotionally disturbed as adolescents in a state psychi-

atric hospital.[10] Other researchers have found that emotionally disturbed white offenders are more likely than black offenders to be sent to psychiatric hospitals, whereas black youth are more likely to be incarcerated.[11] A review of incarceration rates in New Jersey revealed major racial disparities.[12] In 1986, 10% of white juveniles in New Jersey were sentenced for first-degree crimes, as opposed to 31% of black and Hispanic youth. In third-degree crimes, 12.2% of black youth and 14.9% of Hispanic youth were incarcerated, as opposed to 5.7% of white youth. It has also been determined that preadolescents who are treated and followed in mental health programs are likely to be admitted to juvenile detention centers as adolescents, in lieu of receiving psychiatric treatment.[11]

The Washington, DC, mental health experience with jailed adolescents supports these findings; juvenile court judges routinely refer adjudicated youth for psychiatric and psychological evaluations that may be performed by private practitioners or those who work in the Youth Forensic Mental Health Division. Of 50 youth referred by the courts for psychiatric assessments in 1989, 10 had a history of psychiatric hospitalization and/or use of psychotropic medications.[13] Diagnoses included major depression, dysthymia, sexual paraphilias, bipolar depression, schizophrenia, obsessive-compulsive disorder, borderline personality disorder, posttraumatic stress disorder, seizure disorders, and organic mood disorders. Psychological testing frequently determines these youth to be impulsive or depressed, or to have low self-esteem or paranoid features.

Conduct disorder is the most common mental health diagnosis applied to incarcerated adolescents. This diagnosis describes the offense but provides no physical, psychological, or neurological information about the offender. It ignores underlying pathology and offers no assistance in the diagnosis and treatment of the problem. Mental health examinations suggest that acute and chronic depression are more accurate diagnoses than conduct disorders. They address underlying pathology (i.e., the causes of the behaviors) and offer direction for the treatment of the problem. Conduct disorder is usually associated with behavior that is aggressive and difficult to control. Other behavioral control diagnoses include oppositional defiant disorder and impulse control disorder. Thyroid, renal, liver, and collagen diseases may present as aberrant behavior, as may genetic disorders

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(e.g., Klinefelter's syndrome and Fragile X syndrome). In utero exposures to alcohol and drugs may also create neurological problems that lead to maladaptive, negative, and aggressive behaviors.

Many psychiatrists believe that the conduct-disordered adolescent is the child with attention deficit disorder (ADD), only older. The symptoms of ADD include poor sustained attention, lack of concentration, diminished impulse control, hyperactivity, and impaired regulation of activity level to situational demands. These same behaviors often appear in incarcerated youth. There may be a history of ritalin or dexedrine use. The incarcerated youth generally will not report a history of ADD, but will describe placement in a special education class.

Several epidemiological and clinical studies indicate that approximately 25–40% of ADD children will engage in antisocial behavior and be diagnosed with conduct disorder during adolescence.[14,15] A Madison, Wisconsin, survey suggests that the child with a diagnosis of ADD is more likely to engage in antisocial behavior if there is great family adversity, low verbal intelligence, low reading ability, and early childhood aggression.[16] Other information suggests that the more severe a child's ADD, the more likely the child is to be diagnosed with conduct disorder.[17] Finally, another report indicates that ADD adolescents are more likely to commit a theft, assault someone, or use a weapon.[18] However, it has not yet been determined whether ADD and conduct disorder are the same condition or overlapping ones.

The high incidence of learning disorders among youth in custody makes diagnosis even more difficult. The term *learning disturbed* refers to individuals suffering from a group of cognitive impairments that affect their ability to learn reading, arithmetic, spelling, and writing skills. Learning disturbances are commonly found in children with ADD. These children tend to have lower grades, lower achievement scores, more grade repetitions, and more special education. Learning disabilities are present in more than 50% of incarcerated youth in Washington, DC.[19] Psychological testing often reveals disparities between verbal and performance IQs that are consistent with learning disorders in a number of different populations and persons. Many incarcerated youth have such differences between their verbal and performance IQs.

Many detained juveniles have ADD and learning disabilities that have never been diagnosed. These are young people who have experienced school failure and have seen themselves as

underachievers since early in life. They have become frustrated by and disinterested in school, making them more susceptible to adopting antisocial behaviors.

A biochemical link between ADD and delinquency may exist. Zametkin et al. have recently published data demonstrating a link between ADD and low glucose metabolism in various areas of the brain.[20] In 1990, Wisconsin researchers published findings indicating that sucrose ingestion improves behavior in juvenile delinquents.[21] The implication is that glucose metabolism may be a factor in both ADD and delinquency.

A major health problem among juvenile offenders is substance abuse. The incidence of substance abuse among juvenile offenders exceeds that in nondetained adolescents. In recent national surveys, 63% of incarcerated youth admitted to the regular use of drugs.[22] Of these, 32% were under the influence of alcohol at the time they committed an offense. Another 39% admitted to being under the influence of some other mind-altering agent.[1]

An association between substance abuse and criminal behavior has been demonstrated. In addition, it has been noted that a conduct-disordered juvenile who has a diagnosis of ADD is more likely to be a substance abuser.[23] The major substances abused by offenders, in the order of prevalence of use, are alcohol, marijuana, and cocaine.

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When asked how these substances make them feel, youth often provide poignant responses: "They [drugs] give me a feeling of happiness I've never had before." "The marijuana made me laugh and laugh and laugh... I used it every day... it made me feel so different from how I usually feel." These responses convey deep pain and sadness that seem to permeate the adolescents' lives. Some delinquent youth have learned to anesthetize their pain by using drugs. More disturbed youth often have histories of substance abuse beginning in preadolescence or early adolescence. These individuals show signs of organic mood disorder or organic psychosis by age 15 or 16, characterized by hallucinations, delusions, poor memory, labile affect, and flashbacks. Organic mood disorder and organic brain syndrome are frequent diagnoses in this group of adolescents. Treatment usually includes psychotropic medications.

Hallucinations occur frequently among incarcerated youth, with an incidence of 15–20%.[24] They usually occur in the late

Hallucinations occur frequently among incarcerated youth, with an incidence of 15–20%. They usually occur in the late evening when...the youth is alone in his or her room.

evening when all is quiet and dark and the youth is alone in his or her room. Youth often describe hearing someone call their name. Or they may hear a voice reprimanding them for their behavior and warning them of future negative consequences. The youth describe seeing shadows and faces on the wall. The face may be that of a dead friend or a feared foe. They describe frightening dreams in which someone is chasing them, shooting at them, threatening them, or trying to hurt them. Dreams rarely involve their trying to hurt anyone.

These dreams and hallucinations are probably anxiety related. They usually do not occur during the day or in the company of others. Stress hallucinations usually disappear within a week or two of admission to a detention facility and rarely require medication.

▶ Other incarcerated adolescents describe... "command hallucinations" that direct the adolescent to engage in antisocial behaviors.

Other incarcerated adolescents describe hallucinations of a different nature. These hallucinations began prior to detention and may occur at any time, even in the presence of people and light. They tend to be "command hallucinations" that direct the adolescent to engage in antisocial behaviors. Youth may describe sights and sounds associated with devil worship; they may report seeing Satan or the letter "D." Adolescents usually have refused to tell anyone about these hallucinations because of fears that they would be perceived as "crazy" or that no one would believe them. Also, hallucinations represent an unmanly experience to adolescent males.

One example of an adolescent experiencing hallucinations is "Clinton," who killed two other adolescents when he was 15 years old. At age 16, he came to therapy cheerfully, boasting of his latest adventure. "I waited outside the bar, and hid behind the car. They came out and I shot them. I got them good...no regrets...sometimes I feel like I *am* the devil. Sometimes I just look at people and hate them. You think I'm the devil, really? At night, I think I see the devil in my room . . ."

The presence of hallucinations of any type should alert the psychiatrist to the potential of serious emotional vulnerability. Appropriate evaluation will be necessary to rule out organic causes (e.g., brain tumors, sequelae of brain injury, chemical imbalance). Psychotic depression and severe posttraumatic stress disorder may also be the cause. Human immunodeficiency virus (HIV) testing should be ordered, with proper consent and pretest and posttest counseling. The HIV virus may cause either direct damage to brain cells or indirect damage through the develop-

ment of cerebral opportunistic infections; the HIV-positive person may display signs of mental illness secondary to either of these processes. Neurological consultation is also essential to rule out nervous system disorders.

Depression is probably the most common mental health problem among incarcerated youth. Major depression has been found in 20% of incarcerated youth.[8] In one study, clinical depression (either major or minor depression) was found in 11% of detained adolescents, as opposed to only 4% of adolescents in a family practice.[25] Juvenile offenders may have vegetative signs, but many do not. Nor are they likely to perceive themselves as depressed. Angry, hostile feelings and aggressive, belligerent behaviors represent sadness and hopelessness in these youth. Usually the youth have had few resources to allow them to process their bad feelings. Having an adult actually listen to them and express interest in their feelings is usually a welcome surprise, though sometimes met with suspicion. The adolescents' depression may also be expressed in low IQ scores. Scores may even fall into the mental retardation range.

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One youth, "Fred," liked to "talk tough." "Please" and "thank you" were not part of his vocabulary. This 16-year-old enjoyed portraying himself as streetwise and invulnerable. Fred also liked to read. His Wide Range Achievement Test (WRAT) reading score was at the third grade level, yet he could read and understand everything. Repeat testing within a few weeks of the original test revealed a WRAT at the ninth grade level. Fred explained that he was angry on the day of the original testing and had felt that the test was a waste of time.

Too often, juveniles are judged to have low intelligence rather than be depressed. Assuming a tough facade and adopting an intimidating countenance and manners are often the juvenile's way of masking depression. The psychiatrist should order thyroid function studies for the chronically and/or seriously depressed juvenile.

Suicidal gestures, thoughts, and attempts are also common occurrences. They may result from anger at a judge, counselor, or family member; an effort to leave detention through hospitalization and/or release; or feelings of sadness and aloneness. Adolescents may have learned to express feelings and needs through aggressive, attention-getting means. Unaddressed childhood episodes of abuse and neglect engender feelings of

When anger and hopelessness combine, [some] youth may act impulsively and turn to suicide, usually by hanging. . . . Suicide assessments help alert mental health staff to the need for therapeutic intervention.

revenge and retaliation. "An eye-for-an-eye, a tooth-for-a-tooth" may be the only form of redress known to these youth, with disastrous consequences. Negative sanctions usually prevent assaults on counselors or peers, so residents can discharge angry feelings only upon themselves. When anger and hopelessness combine, the youth may act impulsively and turn to suicide, usually by hanging.

A suicide assessment survey should be administered to all youth in custody, whether they are in adult jails or juvenile facilities. Rates of suicidal activity are higher for juveniles detained in adult jails. Suicide assessments help alert mental health staff to the need for therapeutic intervention. They also provide disturbed youth with the opportunity to request assistance. Responses should be reviewed on a regular basis to monitor the efficacy of the survey instrument. All adolescents who attempt suicide should be referred to psychiatric staff for further assessment and disposition.

The most important parts of an assessment are the physical examination, the mental status examination, and the history (both family and social). Careful history-taking will often reveal physical, sexual, or emotional abuse. A striking feature of conducting interviews with incarcerated youth is that they usually do not understand that the childhood experiences they relate are abusive or neglectful. In some cases, the adolescents do realize that they have lived in abusive environments and are embarrassed about having done so. They will deny their experiences out of shame for themselves and their parents. Numerous studies support the relationship between maltreatment and the subsequent development of antisocial, aggressive behaviors.[26,27] One youth stated:

> My mother was a drug addict and she couldn't take care of us. . . we went from relative to relative. . . my brother and I stayed with my dad and his girlfriend, they had a nice place and everything. . . but he used to beat us. . . one time he put us out of the house in the wintertime. . . it was terrible. . . I was 11. . . then I just didn't care anymore. . . I started to do everything and anything. . .

Sexual identity problems are another outcome of child abuse and neglect. There is an increased incidence of inappropriate sex play and practices among incarcerated juveniles.

Sexual identity problems are another outcome of child abuse and neglect. There is an increased incidence of inappropriate sex

play and practices among incarcerated juveniles. Within a detained population, sexual assault is not uncommon. Several young men may attack one or two younger, smaller boys. Fellatio, sodomy, and the introduction of objects into the rectum are the usual occurrences. An abused youth may experience some confusion regarding his own sexual preferences.

Self-mutilation, practiced by many jailed adolescents, is another result of child abuse and neglect.[28] These youth cut, burn, slash, bang, and pick themselves to the point of bleeding and leaving marks. Self-mutilation is defined as deliberate harm inflicted upon the self without a conscious suicidal intent. Tissue damage is usually the result. Youth in detention will use anything from an eraser to the edge of a fork to etch designs, initials, etc., on their bodies. Self-injurious behavior of this type correlates with impulsivity, chronic anger, somatic anxiety, severe character pathology, aggression, sexual feelings, desire for control, self-hatred or guilt, and pursuit of euphoria. There is some support for the idea that serotonergic dysfunction facilitates self-mutilation.[29] Aberrations of serotonin function have also been associated with aggression and impulsivity.[30]

◀ Self-mutilation, practiced by many jailed adolescents, is another result of child abuse and neglect.

Warm, supportive, consistent, and clear interactions between the parent and the growing, developing child create healthy intrapsychic structures. Parents who behave abusively to children, who fail to provide a safe, secure emotional and physical environment, and who absent themselves from children's lives prevent the development of a sense of self-worth. Inconsistency and rejection by the parent evoke intense rage and insecurity. The child grows up feeling unprotected and unimportant. The result of aberrant and absent parenting is the development of a damaged psyche that manifests itself through depression, character disorders, and narcissistic rage. Many delinquent youth have lower levels of ego development than do nondelinquent youth.[31] They tend to be immature and self-centered. There is a lack of sensitivity to the needs and feelings of others.

◀ The result of aberrant and absent parenting is the development of a damaged psyche.... Many delinquent youth have lower levels of ego development than do nondelinquent youth.

Family traits that correlate with adolescent misbehaviors include parental criminal behavior, maternal depression, parental disinterest, and poor family management practices (e.g., providing no limits, structures, or expectations).[31] Some parents of incarcerated youth have expressed the opinion that the antisocial acts committed by their boys represent normal

and expected phases of development (parents do not generally express these views regarding their female children). Parents admit to requiring less of male children in terms of household chores, schoolwork, and participation in family life.

More and more parents are absent due to incarceration. The incarceration rate has risen for mothers. Drug abuse has also increased for mothers, making them less available for parenting and leaving their offspring feeling abandoned. It is a striking reality that too many incarcerated youth have no visitors and receive no letters.

▶ The absence of fathers is a major factor in the creation of delinquent behaviors.

The absence of fathers is a major factor in the creation of delinquent behaviors. Family histories reveal fathers who are absent or uninvolved. They may have been present early in the child's life and then have disappeared. Young men may have lost their fathers to incarceration for criminal offenses, or to death, often violent in nature. Mental health assessments frequently fail to examine children's feelings and experiences in relation to not having a functional, present father. The assessment usually centers upon children themselves and their relationships with their mothers.

Youth may express angry, hostile, and resentful feelings about their absent fathers: "I guess he didn't want me... he takes care of his other kids but not me... I used to want to see him but not anymore... he left us when I was little... my mother does everything for me... I don't know why he doesn't call or come over... he hasn't done anything for me."

▶ gang members function as each other's fathers.

The impact of absent fathers reveals itself in the attraction of fatherless youth to gangs. The old explanation is that the gang represents and replaces the family. More specifically, gang members function as each other's fathers. The gang offers camaraderie, leadership, validation, and challenge. Frequently, an older male friend introduces a young person to the drug culture. In the Washington, DC, area, there are now many more youth selling drugs than using them. The majority of buyers are adults. The drug dealer is revered and honored as a neighborhood "Robin Hood." The gang confers status, success, and security.

Incarcerated youth have not progressed along normal lines of growth and development. Abuse and its sequelae of psychological impairment and neurological deficit lead to low self-esteem and lack of concern for others. Abused, poorly parented youth are unable to achieve the healthy attachments and autonomy

that create fulfilling lives. Instead, they adopt negative behaviors that seem to meet their needs and provide them with a sense of control and self-worth.

Incarcerated youth require intensive, focused programs that introduce new opportunities for growth and development. An intensive, weeklong assessment process—addressing medical, psychiatric, psychological, neurological, and educational issues—will inform the creation of a child-specific treatment plan. The plan should include a 24-hour/7-day cycle and a point/level system, allowing the youth to earn his or her departure from the center. All staff, including security personnel, should be screened, trained, oriented, and monitored. A parallel program should exist for the child's family. A youth who has developed self-esteem should have the opportunity to return to a functional family.

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An intensive, weeklong assessment process—addressing medical, psychiatric, psychological, neurological, and educational issues—will inform the creation of a child-specific treatment plan.

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9

Sexuality and Sexually Transmitted Diseases

Mychelle Farmer, M.D.

"Even 'normal' adolescent sexual behavior appears to be quite complex [and] incarcerated adolescents are known to engage in [more] high-risk sexual behavior."

MANY FACTORS PLACE INCARCERATED youth at high risk for acquiring sexually transmitted diseases (STDs). The circumstances surrounding their early sexual encounters are often disturbed, involving childhood sexual abuse, exploitation, and sexual assault. This chapter examines the sexual behavior of incarcerated adolescents as it occurs in the chaotic environment of drug addiction, dysfunctional families, and homelessness. Comparative data that contrast normal adolescent sexual experiences to those of youth in detention are presented and discussed.

ADOLESCENT SEXUAL BEHAVIOR IN THE UNITED STATES

Adolescence is a period of great developmental and sociocultural transition, a time of personal growth and awakening. Sexual curiosity and experimentation are common during adolescence, a fact which has recently been substantiated by the Youth Risk Behavior Survey.[1,2] This study, conducted by the Centers for Disease Control, evaluated health risk behaviors of adolescents in grades 9–12 throughout the United States and its Caribbean territories. The survey indicated that within American society, most adolescents have sexual intercourse at least once prior to high school graduation. Seventy-two percent of 12th graders indicated having prior intercourse. Among

racial groups, African Americans most frequently had prior sexual experience, followed by Hispanics and whites (72.3%, 53.4%, and 51.6%, respectively).

The median age at first intercourse for the adolescents surveyed through the Youth Risk Behavior Survey was 16.1 years. However, the population surveyed was a national sample of youth who attend schools. In studies of urban populations, the median age at first intercourse has been reported as low as 13 or 14 years.[3] The Youth Risk Behavior Survey revealed some disturbing trends in adolescent sexual practices. Twenty-seven percent of the males and 11.8% of the females had had four or more lifetime sex partners. Of the adolescents surveyed, only 44.9% reported using a condom during their most recent sexual encounter.

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As more data are collected through such studies as the Youth Risk Behavior Survey, even "normal" adolescent sexual behavior appears to be quite complex.[4-6] American adolescents generally initiate sexual intercourse during their high school years; many will have multiple sexual partners during the years following their sexual debut. For most adolescents who have sex, condom use is not a priority. That condoms are not widely used by most adolescents implies that they may have difficulty accessing condoms when they are needed. The problem of condom accessibility is probably multifactorial, complicated by impulsive decisions to have sex, failure to negotiate with partners about condom use prior to sex, and sociocultural norms pertaining to condom use within American society.

Sexual Behavior of Incarcerated Youth: An Overview

Incarcerated adolescents are known to engage in high-risk sexual behavior. A cross-sectional study was undertaken in San Francisco, comparing acquired immune deficiency syndrome (AIDS) knowledge and risk behaviors of adolescents attending public schools and adolescents confined to a detention facility.[7] Among the adolescent detainees, 99.1% had previously engaged in sexual relations, and 84.4% had had three or more sexual partners since their sexual debut. Only 28.6% reported consistent condom use. Thus, in comparison to adolescents of the same age who attend public school, incarcerated adolescents more frequently report previous sexual intercourse, intercourse with multiple sexual partners, and inconsistent condom use.

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As a result of their higher lifetime numbers of sexual partners and their failure to use condoms, adolescents in detention have higher rates of sexually transmitted diseases. Most studies of sexually transmitted diseases among incarcerated adolescents have been cross-sectional in design, to quantitate the prevalence of sexually transmitted diseases within this high-risk population.

Many of these earlier studies focused upon genital infections identified in incarcerated adolescent females. In a Wisconsin study, 226 of 1,899 (11.8%) incarcerated adolescent females were culture positive for *Neisseria gonorrhoeae*.[8] While this study did not present data on the prevalence of other sexually transmitted diseases occurring within this population, it clearly demonstrated that adolescent females in detention are at high risk for such infections. A significant proportion of these females were pregnant at the time of admission to the state facility, suggesting poor use of pregnancy prevention methods.

More recent studies of adolescent females in detention suggest continued high prevalence of sexually transmitted diseases.[9] One hundred females committed to the King County juvenile detention facility in Washington State were evaluated for sexually transmitted diseases upon admission. All of the female detainees included in this study were sexually active. In this population, 18 of 98 (18%) were culture positive for *Neisseria gonorrhoeae*, and 17 of 86 (20%) were culture positive for *Chlamydia trachomatis*. Only 8 of the 100 women studied were without genital complaints. A subsequent study conducted in this facility reported high rates of penicillinase-producing *Neisseria gonorrhoeae* (PPNG) among adolescent prostitutes who were admitted.[10] Twenty-five percent of all cases of PPNG among the women of King County were identified in adolescent prostitutes. This supports the observation that high rates of many sexually transmitted diseases, including resistant strains of certain pathogens, are commonplace among adolescent women in detention. Two cross-sectional studies conducted on adolescents residing at a juvenile detention facility in New York City revealed rising rates of gonorrhea. In 1975, 3.5% of the males and 14% of the females within this facility were infected with gonorrhea. Nine years later, the proportion of infected detainees remained stable for the young men (3.04%) but had increased to 18.3% among young women.[11,12]

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These studies reveal that incarcerated adolescents have high rates of sexually transmitted genital infections. Incarcerated adolescent females, in particular, comprise a special group of high transmitters of such infections. For this reason, incarcerated adolescents should be targeted for intensive surveillance of sexually transmitted diseases. They will also need careful instruction and motivation to adopt appropriate STD prevention strategies.

Wanted: Health Care Resources for Incarcerated Youth

One of the great difficulties in effectively evaluating the prevalence of sexually transmitted diseases among incarcerated adolescents is the lack of available staff to provide medical attention to this population. A national American Medical Association study of 614 juvenile detention facilities revealed that 40% had no ability to conduct an initial medical assessment on newly admitted adolescents; 20% did not provide acute care on a regular basis.[13,14] These shortcomings in the level of health care available to institutionalized youth represent serious neglect of their basic needs. Without proper attention to their health care needs, many incarcerated youth will remain in poor health, and they will continue to harbor untreated sexually transmitted diseases.

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Many deficiencies within the health care system for youth in detention are rooted in the failure to address the complex medical and psychological problems common to this special population.[15-18] Many of these health concerns are closely linked to sexual behavior exhibited by this population. Funding is frequently cited as the primary cause of inadequate health services for incarcerated adolescents. However, even an adequately funded program may not take into account the complex sexual histories common to these youth.

Sexual Abuse as Initiation to Risky Sexual Behavior

Exposure to deviant sexual behavior may begin in early childhood, since many incarcerated adolescents have been sexually abused at a young age.[19] This is especially true of youth who, upon admission to a juvenile detention facility, are found to have a sexually transmitted disease. A retrospective case-control study was undertaken to determine the association of gonococcal or syphilis infection with a history of sexual abuse within a popu-

lation of youth admitted to the New York City Juvenile Detention Center. The study was conducted through review of the medical histories taken on all youth at the time of admission to the detention center.[19] The histories included information on age at first intercourse, pregnancy status among female detainees, and prior rape or sexual abuse. The presence of gonorrhea or syphilis on admission was significantly associated with a history of sexual abuse (*OR*=3.43).

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This study emphasizes the central, historical role of sexual abuse for youth at highest risk for acquiring a sexually transmitted disease. Sexual abuse may contribute to high-risk sexual behavior, which includes multiple sexual partners, inconsistent use of barrier contraceptives, and the use of drugs or alcohol in conjunction with sexual encounters.[20] This study estimates that at least 17% of females in juvenile detention facilities have a history of sexual abuse.

In addition to increasing one's risk of acquiring a sexually transmitted disease, a history of sexual abuse during adolescence or childhood also appears to be associated with a myriad of delinquent and aberrant social behaviors. In this sense, sexual abuse is a disturbing psychological event that may deeply influence adolescent psychosocial development. It predisposes many youth to subsequent troubled life experiences, including illegal activities. Some of these adolescents are incarcerated as a result. Many become part of a larger "subculture" of disenfranchised youth such as runaways or "street youth," adolescent prostitutes, and hustlers.

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Prostitution: A Tragic Sequela of Sexual Abuse

Prostitution during adolescence is a dramatic example of the sequelae of sexual abuse, placing youth at increased risk for sexually transmitted diseases. A study of juvenile prostitution in 1978 resulted in an estimate that 600,000 female prostitutes were younger than 18 years of age.[21] Young men may also engage in prostitution, although it is believed that fewer males than females engage in this type of behavior.[22,23]

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Adolescent prostitutes manifest a number of risky sexual behaviors. Many of them begin having sexual relations during late childhood; previous studies suggest the median age at first intercourse for this special population is 12 years.[24] Most are

introduced to prostitution by age 15, often through a complex series of life events including sexual abuse during childhood, alcohol and drug dependency, and mental health concerns.[25]

Prostitution remains a destructive influence on the sexual development of adolescents. Because many adolescent prostitutes are runaways or homeless, they are deeply enmeshed within a street subculture, resulting in considerable sexual victimization.[26] Sexual favors may be used as currency for securing shelter, food, or drugs. Sexual encounters are disconnected from any sentiment of sexual attraction or commitment. Instead, prostitution provides adolescents with a necessary survival skill, without which they could not support themselves.

Sexual victimization may begin through sexual abuse in early childhood. However, abusive sexual relations continue as the adolescent adopts the lifestyle of a prostitute. Fifty-eight percent of female prostitutes report being raped at least once.[24] Many adolescent prostitutes are abused by their pimps or lovers, which, in the case of female prostitutes, may cause them to mistrust men and have negative attitudes toward them.

Over one-third of adolescent prostitutes identify themselves as homosexual or bisexual.[22] In the case of male adolescent prostitutes, previous studies suggest that only 15% perceive themselves as heterosexual.[22] Most of the sexual encounters of adolescent prostitutes relate to trade for survival rather than to sexual attraction or pleasure. Thus, gender identity issues can be addressed only in light of the complex sexual experiences that pervade their young lives.

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Due to their promiscuous sexual behavior, adolescent prostitutes represent an important reservoir of sexually transmitted diseases. They have numerous sexual partners, many of whom are essentially unknown to them, and few consistently use barrier contraceptives.[25,26] Drug and alcohol abuse is commonplace among this population, a factor which compounds their risk for exposure to infection.

Adolescent prostitutes have high rates of infections with gonorrhea, chlamydia, and trichomoniasis,[9] and a recent study in New York City suggests high rates of human immunodeficiency virus (HIV) infection.[27] When compared to other incarcerated youth, adolescent prostitutes may not have significantly higher rates of these diseases, however.

While adolescent prostitutes may be arrested or placed in institutions for adolescents, they do not constitute a significant

proportion of incarcerated youth. Studies indicate that over 1 million adolescents are involved in juvenile court cases each year, and 500,000 of them are admitted to juvenile detention facilities. Most of these young people are male, and most (69%) are detained for property or personal offenses.[28] Less than 10% of adolescent detainees have been convicted of prostitution.

These figures indicate that the high rates of sexually transmitted disease observed among adolescents in juvenile detention facilities reflect risky behavior in the delinquent population as a whole. Adolescent prostitutes may be at high risk, but incarcerated youth not involved in prostitution are likely to have similar risks for genital infections. This fact further supports the theory that incarcerated adolescents represent an important reservoir of sexually transmitted diseases, indicating a strong need for careful screening of this population, both at the time of admission to a detention facility and following discharge.

"Sex-for-Drugs" Trade

The "sex-for-drugs" trade plays an important role in the transmission of sexually transmitted diseases among incarcerated youth. Adolescents involved in sex-for-drugs transactions are at high risk for sexually transmitted diseases. Adolescents involved in sex-for-drugs exchanges do not always consider their behavior equivalent to prostitution. In order to ascertain the contribution of sex-for-drugs trade to high rates of genital infections, studies have evaluated such behavior independent of the label of prostitution.

A prospective case-control study was undertaken in San Francisco to determine the extent to which crack cocaine-related transactions—specifically, sex-for-drugs trade—were responsible for the rising rates in gonococcal infections.[29] In San Francisco, adolescents experienced an 11% increase in the number of gonorrhea cases between 1986 and 1988. Adolescents with gonococcal infections were compared to age-matched controls residing in the same areas of San Francisco but not reported to have gonorrhea.

Comparative data revealed a striking contrast between female cases and controls. Adolescent women with gonorrhea had significantly higher rates of prior sexually transmitted diseases, and they had higher numbers of sex partners. Among the

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women reported to have gonorrhea, 69.7% had a prior history of placement in a juvenile detention center, compared to only 9% of female controls. Thirty-two percent of the women with gonorrhea had a history of receiving drugs or money for sex, while none of the controls reported such behavior.

In a review of data on adolescent males in this study, there were fewer contrasts between the cases with a history of gonococcal infection and the controls. As with the women in the study, a significantly higher proportion of the men with gonorrhea had a prior history of sexually transmitted disease (53%, vs. 14% in the controls). For the remaining characteristics and risk behaviors explored, there were few differences between the male cases and the controls. Male controls had had significantly higher numbers of sex partners in the past 30 days than the male cases (3.1 vs. 1.9, respectively). A similar proportion of cases and controls had previously spent time in a juvenile detention facility (33% of cases compared to 45% of controls). An equal proportion of cases and controls had a history of offering sex or money for drugs. Among males, controls had higher rates of crack cocaine use than did cases (25% versus 15%, respectively).

This study suggests that sex-for-drugs transactions place young women at high risk for acquiring gonorrhea. It also shows that a previous history of a sexually transmitted disease is an independent risk factor for gonorrhea in this population of adolescent men and women.

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Both the cases and the controls included in this study reported high rates of illegal activities, suggesting that both cases and controls share many characteristics and behaviors of incarcerated youth. Large proportions of these adolescents have abused drugs; in fact, the male controls have higher rates of substance and alcohol misuse than do the male cases. Over one-third of all male cases and controls evaluated had spent some time in a juvenile detention facility. For the women in this study, reported drug use exceeded national norms for high school students, particularly for cocaine and crack. Thirteen percent of all males evaluated had offered money or drugs for sex, and 32% of female controls had accepted such offers. Such transactions appear to be commonplace in adolescent populations with high rates of substance abuse.

Careful attention must be given to incarcerated adolescents with a history of engaging in sex-for-drugs transactions. They

may represent the group at highest risk for acquiring a sexually transmitted disease.[30-32] This appears particularly true for young women who accept drugs or money for sexual favors. Health providers who evaluate incarcerated youth must pay close attention to the sexual behavior of this group. In addition to treatment for substance abuse, counseling about risky sexual encounters would benefit these adolescents.

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These studies of adolescent prostitution and sex-for-drugs transactions indicate that youth in detention have complex medical and social histories prior to incarceration. Therefore, their risks for and rates of sexually transmitted diseases cannot be viewed in isolation. The sexual behavior of these young people is largely a reflection of their life experiences. Sexual acts may be used as a commodity to purchase shelter or other essentials. Emotions typically associated with sexual involvement, such as affection, sexual attraction, and arousal, may be replaced by violence, coercion, and altered mental states that are drug induced. Given this complex interplay of sex and survival within the lives of incarcerated youth, the relationship between sexual behavior and other social or health behaviors common to adolescent detainees requires further study.

Important Relationships for Incarcerated Youth: The Role of Sexual Behavior, Substance Abuse, and Risks for HIV

One recent study of 224 adolescents in a Maryland detention center described their risks for acquiring sexually transmitted diseases, with particular emphasis on their risk for and knowledge about HIV infection.[33] In addition, the study evaluated the relationship of sexual behavior to drug and alcohol abuse. The mean age of the population surveyed was 16 years, and 74% were black. The study required that participants complete a 78-item questionnaire read to them by instructors at the detention center. The questionnaire was broad based and included questions regarding previous sexual experiences, willingness to adopt STD prevention strategies, prior substance use, and attitudes toward HIV/AIDS and AIDS prevention programs.

Ninety-six percent of the population studied had previously engaged in sexual relations, and most reported having multiple sex partners. These adolescents had had an average of 14 partners in the past year, suggesting high rates of promiscuity.

Seventy-seven percent reported little or no condom use (36.8% reported never using condoms). Two percent of the surveyed population identified themselves as gay or bisexual; however, 19% reported having rectal intercourse, and 51% reported having oral-genital contact.

Given the high rates of multiple partnerships in this population, the reluctance to use condoms, and the high incidence of both oral and anal intercourse, the population is at extremely high risk for all sexually transmitted diseases, including HIV infection. Approximately one-fifth of those surveyed reported having at least one sexually transmitted disease in the past. Data regarding the presence of a sexually transmitted disease upon entry into the detention center were not included in this study. Seroprevalence of HIV infection was also not ascertained.

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Many of the youth surveyed indicated a history of drug or alcohol use prior to sexual encounters; 24.8% used drugs and/or alcohol before having sex at least half of the time. This suggested that the youth frequently used illicit substances in conjunction with sexual experiences. Having sex while under the influence of drugs or alcohol increases the likelihood of unsafe sex practices.

The results of this study suggest a need to incorporate substance abuse prevention components into strategies to reduce the rates of sexually transmitted disease among incarcerated adolescents. In order to achieve the desired benefit of an STD prevention program for these young people, messages about drug abuse and safer sex practices must be merged.

Other studies of a general adolescent population indicate that sexually experienced adolescents have higher rates of drug and alcohol use than virginal youth.[34] In this study, students from junior and senior high schools in Baltimore, Maryland, completed a self-administered questionnaire regarding sexual experiences and substance abuse. Responses from this group suggested that adolescents who had sexual relations were significantly more likely to have used drugs or alcohol in the past. This study did not determine the extent to which substance use occurred in conjunction with sexual relations, so one could only conclude that both behaviors occurred in a subset of the population surveyed.

An effort is currently being made to develop integrated AIDS and substance abuse prevention programs, targeted toward school-age populations. Such programs will seek to reduce rates of unsafe sex practices and alcohol and substance abuse among

adolescents. Clearly, such programs should be designed for detained youth as well.

Recent seroprevalence studies indicate that adolescents admitted to juvenile detention facilities may be at increased risk for HIV infection.[27] Of the adolescent populations surveyed, 4.2% of all incarcerated youth were HIV positive. Only homeless and runaway youth had a higher prevalence of HIV infections, with 6% of homeless and runaway youth seropositive for this infection. It is presumed that homeless youth have high HIV infection rates due largely to their involvement with intravenous drug users, their own personal use of drugs, and prostitution or sex-for-drugs transactions.

Few studies have specifically examined the sexual practices of adolescent runaways and homeless youth.[24,25] Most reveal sexual experiences such as involuntary sexual encounters (rape and sexual abuse), homosexual experiences, and multiple anonymous sex partners. Such practices place these youth at high risk for all sexually transmitted diseases, with HIV risk of particular importance. Reports of these high-risk behaviors among runaway and homeless youth are consistent with their high rates of HIV infection.

A national longitudinal evaluation of the prevalence of HIV infection among incarcerated youth would enhance one's ability to determine rates of HIV seroconversion over time. Such a study would enrich our understanding of HIV infection within this needy group of adolescents. Those incarcerated populations having the highest rates of this infection might then be targeted for intensive HIV counseling, expanded HIV prevention programs, and aggressive condom promotion. If possible, homeless and runaway youth should be included in such an evaluation, due to their reportedly high rates of HIV infection.

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HIV infection is associated with many complex consequences that, superimposed upon a population of incarcerated youth, constitute a medical nightmare. Few studies have been done on cohorts of incarcerated adolescents. However, the pathophysiologic relationships observed in other studies are probably applicable to incarcerated youth.

Many studies have been conducted to evaluate the relationship of other sexually transmitted diseases to the transmission of HIV. Striking data from two studies indicate that infection with genital ulcer disease significantly increases one's risk of

contracting HIV infection.[34,35] Both these studies were prospective evaluations of high-risk populations. While adolescents were not included in either study, evaluation of HIV seroconversion among homosexuals and female prostitutes was performed. In both studies, those who had a history of syphilis or other ulcerative infection had significantly higher rates of seroconversion than those who did not.

Other studies have explored the role of subsequent, concurrent sexually transmitted infections in the progression of HIV disease. Few of these studies indicate a potential relationship between HIV and other sexually transmitted diseases, however. Among homosexual men who are HIV positive, progressive generalized lymphadenopathy occurs more frequently in those men who have a recent history of a sexually transmitted disease.[36] The Multicenter AIDS Cohort Study found that those who developed AIDS within three years of becoming HIV positive were 3.4 times more likely to have a history of syphilis than HIV-positive individuals who failed to develop AIDS in the three years following seroconversion.[37] Other studies have failed to show a significant relationship between genital infections (including genital ulcer disease) and the progression of HIV infection. Given these data, there is no conclusive proof that sexually transmitted disease influences the progression of HIV infections.

Recent studies of adolescents in detention have not found high rates of genital ulcer disease.[9,12] Most studies have been based upon historical data rather than upon culture or serology. Thus data regarding rates of genital ulcer disease among detained youth are lacking.

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Incarcerated youth in certain regions of the country are at increased risk for HIV seroconversion. However, specific factors contributing to this increased risk have not been correlated through well-controlled studies. Sex-for-drugs transactions are associated with increased risk of gonorrhea in adolescent women, many of whom have a history of being in detention.[29] The HIV status of these youth was not included in this study, so it is not possible to quantitate their HIV risk.

Most studies regarding HIV risk among incarcerated youth have been based on surveys of knowledge, attitudes, and behaviors. Prospective studies that track STD rates and HIV seroconversion rates are needed to enhance our understanding of incarcerated adolescents. These studies should be comprehensive in nature, and they should include both historical data and those obtained

from health examinations of incarcerated youth. The results of cultures and serologic studies are needed to confirm diagnoses.

Most studies of incarcerated youth fail to include an adequate sexual history. It would be useful to have information regarding patterns of partner switching—that is, the extent to which this group engages in serial monogamy. Some of these adolescents may have multiple sex partners within a given time period; this type of behavior also needs to be described.

The relationship of risky sexual encounters to social events has been examined in previous studies. This relationship requires further scrutiny, however. Sexual experiences may occur in conjunction with drug or alcohol use, or sex may be used to secure financial support and shelter. It would also be useful to understand how such activities differ from those of adolescents who have not been incarcerated.

Conclusions

Incarcerated adolescents have complex sexual histories that include sexual debut at an early age and promiscuous sexual behavior. Many of them have a history of childhood sexual abuse, and they may have been victimized sexually during their adolescent years. Their risks of contracting sexually transmitted diseases are compounded by their failure to use appropriate barriers to prevent such infections.

Given these multiple concerns, the incarcerated adolescent has complicated sexual involvement with both peers and adults. These relationships are largely unstable, and they are frequently short-lived. Sexual encounters may occur on impulse, and adolescents may have only a superficial sexual attraction to their partner or partners. Such experiences increase the instability of the lives of these youth, rather than offering true sexual satisfaction or pleasure.

Incarcerated youth represent a heterogeneous group that includes many subpopulations experiencing disturbed sexual relationships. Adolescent prostitutes and hustlers are usually not incarcerated, but they have many characteristics in common with incarcerated youth. Like incarcerated adolescents, prostitutes have high rates of sexually transmitted diseases, and they often have histories of sexual abuse and incest. Prostitutes, especially adolescent males, have higher rates of homosexual and bisexual tendencies.

Incarcerated adolescents include a number of youth who abuse alcohol and drugs. Nearly 10% of detainees have been convicted of illicit drug use, and roughly one-fourth of the youth in detention have used alcohol or drugs in conjunction with their involvement in other criminal offenses. Thus, drug abuse and addiction strongly influence their behavior in general. Their sexual behavior is also affected by drug abuse and addiction, given the high rates of drug or alcohol use reported in conjunction with sexual encounters.

Sexual relationships of juvenile offenders overlap considerably with those of adolescent drug addicts who may escape incarceration. Reports of sexual conduct of adolescents who abuse crack cocaine indicate that their sexual histories are similar to those of incarcerated youth, including initiation of intercourse at an early age, multiple sex partners, and prior history of sexually transmitted diseases. This group also reports the disturbing practice of exchanging sex for drugs, a practice likely to be responsible for increased rates of certain sexually transmitted diseases in regions where crack cocaine use is endemic.

These disorganized, complex sexual experiences common to incarcerated youth impair their ability to sustain satisfying intimate relationships. Such experiences adequately explain their increased risks for sexually transmitted diseases. Without aggressive prevention strategies, it is likely that the STD and HIV infection rates for this group will continue to rise, presenting a risk to the adults and peers who engage in sexual relations with them.

Such risks will be significant for communities in which large numbers of incarcerated youth reside. In Washington, DC, for example, nearly half of all males (both adolescent and adult) are incarcerated, on probation, or on parole.

Such risks will be significant for communities in which large numbers of incarcerated youth reside. In Washington, DC, for example, nearly half of all males (both adolescent and adult) are incarcerated, on probation, or on parole. They are therefore likely to be at high risk for genital infections, putting their community at risk. Similarly, communities with high rates of drug abuse and addiction will likely have high rates of genital infections, presumably due to their propensity to engage in high-risk sexual encounters.

Gender identity issues will be of significant concern, particularly for adolescent prostitutes who are incarcerated. A significant proportion of male prostitutes consider themselves homosexual or bisexual; many young female prostitutes express negative attitudes toward men. There is a higher proportion of homosexuals and bisexuals among adolescent prostitutes.

True expression of gender identity may be delayed until adulthood in many normal individuals. However, sexual experiences in childhood and adolescence clearly play an important role in the final determination of gender identity. As incarcerated adolescents explore various forms of sexual expression, they will develop preferences. Their gender identity will be strongly influenced by these preferences.

For many incarcerated adolescents, sexual activities are merely skills they have developed to use as commodities in exchange for sustenance or drugs. Sexual pleasure and preferences may be of less concern than the desire to secure shelter, food, or drugs. Gender identity issues become enmeshed in the trade of sex, making the sexual orientation of these youth of secondary concern.

Clearly, the youth become victims of a society that places a higher priority on secondary and tertiary prevention than on primary prevention of health problems. Given their complex sexual histories, it is unlikely that they will extract themselves from disturbed sexual relationships on their own. Instead, an aggressive and comprehensive health strategy is the only hope of reversing these destructive aspects of their lives. Their risks of contracting sexually transmitted diseases are not a priority for them when a risky sexual encounter can be bartered for shelter or food. It is imperative that health providers gain greater knowledge and greater skills in addressing the health needs of incarcerated youth. Particular attention must be paid to providing care that will enhance the sexual and reproductive health of these youth. Longitudinal health care strategies will also be needed to ensure long-term interventions for this needy and vulnerable population of adolescents.

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Clearly, the youth become victims of a society that places a higher priority on secondary and tertiary prevention than on primary prevention of health problems.

Recommendations

In order to address the health problems presented by the sexual behavior of incarcerated youth, a broad-based strategy will be needed. Listed below are some recommended steps to treat—and in some instances to prevent—high-risk sexual behavior.

1. Provide counseling services for adolescents with a history of sexual abuse, rape, or prostitution. These youth are particularly vulnerable to health problems that result from unsafe sexual practices. Counseling may provide needed therapy

for adolescents damaged by previous sexual experiences. It may enhance healthier coping skills for victims of sexual assault.

2. Conduct comprehensive medical evaluations for new admissions to juvenile detention facilities. While the majority of these facilities provide initial medical assessments, 40% do not provide comprehensive medical evaluations upon admission. Twenty percent do not provide ongoing acute care. Initial health examinations should include reproductive health evaluations, HIV counseling, and, if desired, HIV testing.

3. Provide prevention services that target the reduction of unsafe sex practices. Many juvenile offenders begin illegal activities prior to initiating sexual relations. Efforts should be made to identify adolescents who are virgins or who have only recently begun to explore sexual relationships. These adolescents would benefit from motivational discussions and counseling that encourages safer sexual behavior. This counseling would be particularly beneficial to adolescents involved in the drug trade, given the close link between drug abuse and risky sexual practices.

4. Offer early intervention services for homeless and runaway youth. Homeless adolescents have special reproductive health needs that are not met by conventional health programs. Health care must be available in urban areas where homeless youth cluster, and the care should include evaluation for sexually transmitted diseases and contraceptive services.

5. Conduct health policy review to determine those deficits in the health system that obstruct reproductive health care for incarcerated adolescents. A significant number of adolescents in detention do not receive health care services, and those who do may not receive comprehensive reproductive health services. Health policy should be developed to ensure that these high-risk youth receive medical services both during and after incarceration. Policies should also be developed to identify youth at risk prior to incarceration, in order to reduce the number of American youth admitted to detention facilities.

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10

Substance Abuse Programs

Jana Ewing, Ph.D., M.A.

"In the criminology literature, trends in treatment programs reflect two simple concepts—nothing works, and anything is possible."

ALTHOUGH THE PREVENTION OF drug and alcohol abuse has been of public concern since the 1960s, only in the past 10 years has that concern been directed toward juveniles in correctional facilities. This previous lack of attention resulted partially from a debate about whether drug use should be dealt with as a medical/public health problem or as a criminal/corrections problem. We now have some key pieces of knowledge about the juvenile offender population. First, juvenile offenders are likely to be drug and alcohol users and abusers as well as to suffer from serious emotional disturbance or mental illness. Second, they are likely to have received little or no evaluation, assessment, or diagnosis. Third, these youth are likely to have had no appropriate interventions or to have failed in a number of interventions that were not culturally, socially, psychologically, educationally, economically, or developmentally appropriate. Fourth, the families of the youth are not likely to have been involved in any treatment planning or consultation. Fifth, there are no quick fixes. Knowledge concerning the relationship between substance use, substance abuse, and criminality remains quite limited.

Programs currently treating incarcerated substance users reflect multiple treatment and prevention approaches based on varying assumptions. This chapter will

review continuing areas of dialogue concerning the treatment of incarcerated populations including the identification of problems in treatment application and barriers to the delivery of adequate care. The most recent research findings regarding incarcerated substance users, including treatment approaches and outcomes, will be cited. Existing prevention programs in the corrections setting will be identified. New areas for program development will be discussed.

Current Controversies that Affect Implementation of Appropriate Services

The debate regarding the prevention and treatment of substance use in incarcerated adolescents continues. The discussion centers upon the association between substance intake and criminal behavior, the effects and implications of substance use in incarcerated adolescents, evaluation unique to the juvenile justice system, and the prevalence of dual diagnoses in incarcerated adolescents. While each of these controversies contributes to a general lack of consensus on treatment approaches, each highlights the fact that treatment of incarcerated substance users must take into account diverse usage patterns and contributing factors.

Association Between Substance Intake and Criminal Behavior

▶ Some researchers adamantly hold that there is no causal connection between substance abuse and criminality....others maintain that substance use and gender best predict certain criminal behaviors.

The relationship between substance use and crime is still hotly debated. Some researchers adamantly hold that there is no causal connection between substance abuse and criminality.[1] Others maintain that substance use contributes to some criminal acts but not to others.[2,3] Some researchers believe that only certain substances contribute to some criminal acts.[4,5] Yet others maintain that substance use and gender best predict certain criminal behaviors.[2,6,7] Farrow (see chapter 12, page 195) and others in this volume point out that street drug cultures distinguish themselves by high rates of assault, robbery, and homicides; both users and dealers are continuously victimized by their peers and rivals. Research suggests a major role for substance abuse in conduct disorder, antisocial personality disorder, and other psychiatric disorders.[8–12] Some researchers view substance use as an indicator of a generalized social deviance syndrome, which might include psy-

chiatric disorders.[13-17] Many believe that both criminality and drug abuse/addiction are manifestations of a deviant lifestyle in which drug use is a form of socialization.[1]

Each of these positions suggests a different treatment perspective. For example, treatment providers who view substance abuse as part of a generalized deviant behavior pattern may treat drug and alcohol use as they do other forms of norm-violating behavior, with the expectation that once the drug and alcohol use cease, so will the criminal behavior. The teaching and reinforcement of prosocial behaviors are emphasized in this approach; one example is the "Teaching-Family Approach."[18] In contrast, treatment programs such as Alcoholics Anonymous may isolate one substance (such as alcohol) and specifically target behaviors (abstinence) related to that substance. This approach does not claim to affect any behavior other than the dependency or use, emphasizing that the responsibility for substance use as well as for other destructive conduct rests with the individual. Another viewpoint is that treatment of adolescents must address substance abuse and other underlying problems in the context of concurrent psychiatric diagnoses, learning disorders, family interactions, internal conflicts, and developmental issues.[19]

Only a few studies provide data on a wide range of attitudes and behaviors relating to substance abuse and criminality in adolescents of both sexes, different ages, and varied ethnicity.[20-22] This perspective suggests the use of a variety of "continuum of care" mental health services available in some states. Research clearly establishes that association, attachment, commitment, and other dimensions of bonding to delinquent friends are related to involvement in delinquent behavior and drug use. Developmental studies suggest that understanding the stages and characteristics of adolescence and substance use are necessary.[23,24] Several authors have described adolescent substance abuse patterns in terms of disruptions in the developmental tasks of identity formation and independence definition, in the attainment of educational skills, and in the cohesion of roles of family systems.[25,26] Others describe relationships between substance use patterns and specific adolescent psychiatric syndromes.[27-29] Studies employing a delinquent peer bonding measure in addition to conventional bonding measures have nearly always found the delinquent peer measure to be the strongest single predictor of delinquency—that is, a pat-

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tern of relationships with delinquent peers can mediate the total influence of conventional bonding, whereas the reverse is not true.[13,30-38] The social-developmental context of substance use may be more significant than what substance is used in what quantities and for how long.

Effects and Implications of Substance Use in Incarcerated Adolescents

The hypothesized relationship between drug abuse and criminality invites continued discussion among researchers interested in adolescent populations. Most of the corrections research describing drug use onset in adolescents is done retrospectively, with adults. In most of these studies, gender and age significantly affect criminal behavior.

In many studies of drug use and abuse in incarcerated females, the temptation is to conclude that the more involved a female is in the use and abuse of drugs, the more her criminal activities (e.g., prostitution, theft, and sale and delivery of drugs) center upon the support of her habit.[39,40] While this belief may have some validity, it may reflect some mild sexism that assumes that females are of a "gentler nature" and that even drug-using females are less likely to be violent than drug-using males. This position does not seem credible in light of recent research indicating that age is at least as significant a factor as gender or amount of drug use in understanding criminal offense patterns. Evidence shows that females who use drugs heavily tend to be younger. Females who use drugs lightly are more likely to be older. Treatment providers who assume that a youth's "violence potential" increases with heavier drug use ignore the fact that violent crimes against persons (homicide) predominates in the older, light user groups, while property and drug offenses predominate in the younger, heavier use groups. The propensity to commit offenses against persons seems to increase with age but decrease with drug use. While most studies of incarcerated male substance users describe heavy substance use as highly associated with violent crime, that association does not seem to apply to females. The assumption that female users are less likely to be violent than male users is also inaccurate. On the basis of some research, only heavier-using younger females are less likely to be violent. Some research explains this by stating that among females, lighter drug users are likely to be more impulsive—and

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therefore more violent—than heavier users, who tend to plan more before committing an offense. On the basis of this conclusion, nonviolent offenses may simply be easier and less risky than crimes against persons for heavier drug users.[2]

Many studies have found that violent criminals drink before their crimes more often than property criminals.[41–44] The reasoning underlying much of the discussion of the alcohol-crime link is that while crimes against property are utilitarian and rational, crimes of violence are the result of loss of self-control. Alcohol is thought to play an important role in the genesis of violent crime because of its "disinhibitory" qualities. (This disinhibitory process is not generally cited in relation to female offenders.[45–47]) A number of studies, however, do not support the disinhibition theory of drug and alcohol use and violent crime.[41,48] Systematic differences not related to aggressiveness are often found between offenders who drink before committing crimes and those who do not. These differences include race (whites are reportedly more likely to drink in connection with committing a crime), recidivism (repeat offenders are more likely to drink in connection with committing a crime than are first-time offenders), type of offense (burglary, forgery, and arson are associated with alcohol use more frequently than are other crimes), and education (less educated violent offenders were less likely to drink prior to their crimes).[3,49,50]

Many studies have found that violent criminals drink before their crimes more often than property criminals.

Evaluation Unique to the Juvenile Justice System

There are a number of research questions unique to substance-using incarcerated populations. In one study, the use of alcohol and drugs was examined with respect to quantity, frequency, and immediacy to the criminal act for which the inmate was convicted.[3] Inmates jailed as criminal suspects and awaiting adjudication were not included in the study. Nor was criminal behavior that did not result in conviction. From the study, inferences were drawn about the role of alcohol and drug use in criminal behavior. However, the elimination of jailed suspects from the study and the use of conviction records as the sole indicator of criminality may have introduced bias. It can be assumed that many adults commit crimes for which they are not convicted; when they are convicted, it may be for crimes lesser than those with which they were originally charged. Conclusions about the role of drug and alcohol use in criminal

behavior may not be accurate if they are based on data that use convictions as the only indicator of criminal behavior.

A similar bias is found in much of the research done on the juvenile justice system; as in the adult system, official records on juvenile crime reflect only a small portion of the offenses that are discovered, reported, and recorded, and the probability that a given offense will be detected and recorded can vary over time and between jurisdictions.[8,51] Those familiar with the legal system know that both arrests and charges are more a reflection of legal discretion than of actual behaviors. In juvenile populations, arrests often occur without subsequent convictions or detention stays. Realistically, substance-abusing youth who are arrested may not be willing to volunteer the full range, chronicity, or extent of their drug use, especially if they believe that this information will either create new charges or lengthen their sentences. Reporting by youth is also affected by the the phenomenon of "shopping for services." Youth familiar with the system and facing lengthy detention stays will often modify their use history to qualify them for treatment programs that will take them quickly. For example, if a youth becomes aware of a bed available in an alcohol program, he or she may emphasize or exaggerate an alcohol problem and disguise serious poly-substance use.

▶ Increasingly, youth who become involved with the criminal justice system are those with serious and chronic health and mental health needs as well as multisystem involvement. Growing numbers of incarcerated youth have been rejected from mental health and community-based health and social programs because these programs could not meet their needs or contain their seriously disturbed behaviors. One recent Australian study noted the general trend to divert substance-dependent people into the criminal justice system.[52] In this study of 189 sentenced prisoners in Melbourne, Australia, a diagnosis of chronic abuse of alcohol and/or illicit substances occurred in 69% of the sample. This study noted that in the prison psychiatric unit, 36% of the sample had a lifetime diagnosis of psychotic disorder, 2% had a probable lifetime diagnosis of major depression, 60% had a lifetime diagnosis of substance abuse, and 15% were currently psychotic. The trend to divert substance-dependent people into the criminal justice system is observed increasingly with juveniles in the United States.

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Sensitivity to age, gender, and ethnic differences is critical when research, assessments, evaluations, and programs include youth involved in the criminal justice system. Minorities are more likely to be overrepresented in juvenile facilities, as they are in adult correctional facilities, due to socioeconomic factors.[38] Younger youth are less likely to manifest pathological behaviors such as chronic drug and alcohol abuse/addiction or affective or personality disorders. Younger youth, on the other hand, may exhibit more impulsive behavior, consistent with fetal alcohol syndrome or attention deficit disorder. These factors may affect the youth's interaction with or involvement in the criminal justice system and treatment programs.

In urban areas, attempts are made to divert younger youth from locked facilities and to place them into programs providing more supervision. These efforts may not be reflected in arrest records, and urban youth may appear less criminally involved than they actually are. Where there are fewer resources, there may be more arrests and detention stays. There are often fewer resources for females in both urban and rural areas; thus more females may be committed for less serious crimes (e.g., prostitution or theft).

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Prevalence of Dual Diagnoses in Incarcerated Adolescents

The comorbidity of substance abuse and depression or other serious psychopathology has only recently been documented for the adolescent offender population. The rate of substance abuse in the population of diagnosed depressed offenders is generally estimated at about 90%. Conduct disorders and antisocial personality disorders have long been associated with substance abuse. In one study of adolescents seen in a general hospital emergency room for psychiatric evaluations, almost half of those substance abusers with elevated blood alcohol levels had at least one psychiatric diagnosis; the most common diagnosis was depression.[53]

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Another research group interviewed 100 adolescent substance abusers in a drop-in counseling center for youth. The researchers found that 16% showed evidence of *double depression*—a major depression superimposed on a dysthymic disorder.[26] In a study of symptom frequency and severity in depressed adolescents, the excessive use of alcohol was associat-

ed with the psychotic subtype of depression, suicidal plans or attempts, phobia with avoidance, and conduct problems and disorders.[8] Other researchers document the progression of substance abuse with minor mood swings to full-blown bipolar disorder in 39% of juvenile offspring or siblings of adult bipolar patients.[54] Conduct disorder, major depression, and the combination of attention deficit disorder and impulse disorder were the most prevalent diagnoses among 57 adolescents referred to an inpatient setting for substance abuse treatment following detoxification.[29]

In one study, 22% of the juvenile offenders reported being under the influence of alcohol at the time of their crimes, and 71% reported serious adverse effects from the consumption of alcohol.[55] In the early stages, the effects of problem alcohol use included peer and family turmoil. As usage became more extensive, biomedical complications began to appear, followed by school problems. One researcher reported that active depressive disorders in incarcerated juvenile delinquents frequently occurred secondary to substance abuse or alcoholism, and that the agitated subtype of depression occurred significantly more often in the incarcerated sample than in the inpatient sample.[56] The study also noted that the frequency of substance abuse and affective disorders did not correlate with specific types of conduct disorders or with measures of criminal behavior. Many studies document a prevalence of major psychiatric disorders in adolescent offender populations.[26,57-59] Other research indicates that the coexistence of mental disorders and substance abuse detracts from accurate assessment of either condition.[60,61]

Substance Abuse Treatment Programs

▶ **criminology literature . . . [reflects] two simple concepts—nothing works, and anything is possible. [Reviews] have failed to identify any single treatment as effective for all offenders.**

In the criminology literature, trends in treatment programs reflect two simple concepts—nothing works, and anything is possible.[62,63] A major difficulty in implementing treatment programs is the lack of strong empirical evidence supporting any particular form of treatment for offender populations. The successes and failures of well-defined prevention and treatment interventions do not reflect so much a need for more or different programs as for better aligning client needs with existing programs, and for providing an array of services to clients who need them.

Major literature reviews of treatment for the abuse of alcohol and other drugs have failed to identify any single treatment as

effective for all offenders.[64-69] This is not surprising given the heterogeneity of the population of substance-abusing offenders, which is often ignored in research design.[70]

Treatment programs available to incarcerated adolescents are predominantly 12-step Alcoholics Anonymous models and drug-specific education. Such approaches are based on a persistent assumption: Substance abuse is an underlying problem rather than a symptom, and that all addictions are the same and treatable with basic education.[71,72] Though valuable, 12-step programs or basic education alone do not necessarily alter high-risk behaviors.[60] The general consensus is that there are multiple types of alcoholics and drug abusers, and multiple patterns of drug and alcohol use, requiring a broad spectrum of therapies and approaches.[73,74]

Short-term detention (jail) facilities housing adult offenders have limited drug treatment programs.[75] Drug treatment programs are more likely to be reported in large jails where there is a continuum of services. These services include screening, urinalysis, and collection of assessment data for residents, as well as employee assistance programs for staff. Youthful offenders housed in short-term detention centers generally must rely on educational models and 12-step programs because they are seen as the only models appropriate for a short-term, high-turnover, recidivist population. A few short-term detention facilities (such as the King County Detention Center in Seattle, Washington) have broadened educational programs to include aspects of social learning theory and affective education (also called humanistic education) used in longer-term therapeutic community (TC) programs.[76,77] There is considerable evidence in adult populations that TC programs based on social learning theory may be the most effective with offenders whose drug-dependent lifestyles have evolved over long periods of time.[78-81] Model demonstration TC programs for adults include a Pima County program (Tuscon, Arizona), a Hillsborough County program (Tampa, Florida), a Cook County program (Chicago, Illinois), Oregon's Correctional Residential Treatment program, New York's Stay'n Out program, and Delaware's Key program.[75,82,83]

◀ Youthful offenders housed in short-term detention centers generally must rely on educational models and 12-step programs because they are seen as the only models appropriate for a short-term, high-turnover recidivist population.

The Paradigm Program (Seattle, Washington) selects youthful male offenders who are detained pending final adjudication of their charges. These offenders live in a "Straight Ahead Unit," separate from other offenders. This separation is key to more

intensive programming since it provides youth with some protection from the corrections "subculture" that considers active involvement in treatment "weak." The program involves an intensive approach to education and focuses upon the development of self-esteem through values clarification and the enhancement of interpersonal skills and decision-making techniques. It also targets general life skills relevant to the use and sale of drugs, including financial aspects, family effects, and the risk of HIV infection.[67,84-86] Youth receive individual and group education as well as drug and alcohol counseling, drug and alcohol assessment, and access to onsite mental health, health, and HIV services.

The TC model is unique in that it provides individuals in short-term facilities with services that are generally offered only in longer-term correctional facilities. In the Key program, the primary staff members are recovering addicts who have been rehabilitated in that program. In the Paradigm program, staff are professional drug and alcohol counselors or trained juvenile child care staff. In both the Key and the Paradigm programs, the primary goal is to change negative patterns of behaving, thinking, and feeling that predispose one to use drugs. The overall goal is a responsible drug-free lifestyle. The results of this intensive prevention strategy indicate that in the short-term, many youth adopt constructive attitudes or behaviors. Unfortunately, nearly all of the youth relapse on release because of insufficient individualized services to meet their needs. In most cases, educating youth without meeting broader needs or increasing individual and family support cannot overcome the tremendous influence of the drug culture.

▶ In both the Key and the Paradigm [TC] programs, the primary goal is to change negative patterns of behaving, thinking, and feeling that predispose one to use drugs.

In the past, refusal or decision-making skills, originally developed as part of the antismoking campaign, became the basis for widely publicized and federally endorsed antidrug programs.[87-91] Typical programs are those such as Reducing Adolescent Drinking/Drugging and Driving (RADD); WHOA, A Great Way to Say No; and Just Say No.[87,92-94] The focus on refusal skills reflected a shift of attention to the social influences that promote drug use and to broad life or coping skills. The social influence strategy commonly centered upon awareness of the social pressures to use drugs, representation of true social norms (it's not true that "everybody's doing it"), engagement in a public commitment not to use illegal drugs ("friends don't let friends drink and drive"),

▶ In the past, refusal... skills, originally developed as part of the antismoking campaign, became the basis for... antidrug programs.... The focus on refusal skills reflected a shift of attention to the social influences that promote drug use and to broad life or coping skills.

development of problem-solving and decision-making skills, improvement of self-control and self-esteem through goal setting, development of coping and interpersonal skills, and development of specific refusal skills.

In general, models focusing upon decision-making skill improve drug knowledge and perceptions of peer attitudes toward substance use; however, in most programs of this type, positive effects are not maintained one year later.[67,86] In most studies, youth feel that assertiveness becomes more difficult as they grow older, even with participation in programs for a number of years. One review of 15 substance abuse programs found that 9 of them reported significant increases in drug use among participants and a significantly more liberalized attitude toward drugs.[66] Some programs appeared to have a negative effect even while the participants were in the program. No follow-up studies were conducted to see if the negative effect persisted. The programs reviewed included a full range of prevention approaches, raising concerns about possible negative outcomes.

◀ In . . . studies, youth feel that assertiveness becomes more difficult as they grow older, even with participation in programs for a number of years. One review of 15 substance abuse programs found that 9 of them reported significant increases in drug use among participants and a significantly more liberalized attitude toward drugs.

Beyond education, 12-step, and decision-making approaches, two types of general strategies appear to dominate most of the prevention literature. The first strategy is an integrated intervention (single program) approach that recognizes the multiple needs of the client and attempts to address those needs. The treatment group home is an example of this approach. The second strategy is a multiprogram/multiagency approach that recognizes that no single program can address the full range of needs of any single client. Clients participate in a number of approaches and a number of programs.

An example of an integrated intervention or single-program approach is the "Teaching Family" program, used with juvenile offenders placed in the community in a group home setting.[18] This program was developed under the assumption that the risk factors for delinquency are similar to those for drug abuse, and that positive effects in one domain carry over to the other domain. Results of the Teaching Family approach indicate that drug and alcohol use decrease while youth are in the group home, and that treatment seems to improve prosocial behavior—more so than in a set of comparison groups homes. However, neither the Teaching Family program nor the comparison group homes appeared to have a posttreatment effect.[95]

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Another type of integrated approach involves parents in prevention and intervention. The goal is to improve parenting and family management skills of the parents or families of offenders. The desired effect is an increase in family bonding and a decrease in the influence of destructive family modeling with respect to both criminal and drug abuse behaviors.[51]

▶ The Mister program . . . targets adolescents as parents rather than as children, treating criminally involved black adolescent fathers. . . . Successes are numerous. . . .

The Mister program, which has an integrated approach, targets adolescents as parents rather than as children,[96] treating criminally involved black adolescent fathers. Parenting, pregnancy, and prevention issues are the focus of an intensive, individualized, interagency approach. Successes are numerous and include youth who complete their high school education, gain employment, and take a more responsible parental role with their children, including spending time with their children or contributing financially to their care. A major emphasis of the Mister program is to find economic alternatives to selling drugs.[97]

▶ [multiprogram/multiagency] programs. . . educate parents and encourage feedback on intervention projects. . . .

The multiprogram/multiagency approach that recognizes that no single program can address the full range of needs of any single client is reflected in a number of initiatives. Several states have carried out planning efforts for appropriate drug, alcohol, and mental health services for youth. Successful programs, such as Soul-O House, Oakland Parents in Action, the Willie M. Program, and the Parents Resources and Information of Drug Education coalition, educate parents and encourage feedback on intervention projects, increasing the sense of accountability and modes of action for entire communities.[97] North Carolina's Willie M. network, the Alaska Youth Initiative, and the Ventura County Program (California) have developed a multiagency approach carried out in a coordinated, collaborative, and flexible way to meet the individual and comprehensive needs of the adolescent or child and their families. The Ventura County Program includes outposting trained staff in juvenile justice and child welfare agencies; developing day treatment programs jointly operated by mental health, drug and alcohol, and education agencies; and developing a number of other services along a continuum of need. The Alaska Youth Initiative is a highly individualized service model designed for rural environments. In areas with few formal agency resources, individualized services "wrapped around" the youth become critical. Case managers are responsible for developing, organizing, and implementing an array of services and forms of support for the child—a family to live with,

drug and alcohol treatment, education, and daily ongoing support.

It is important to note that both integrated and multiagency approach programs are moving away from generic prevention approaches that teach single skills or rely on unitary assumptions. Even in nonoffender populations, generic prevention and treatment do not work.

◀ Even in nonoffender populations, generic [prevention approaches that teach single skills or rely on unitary assumptions] do not work. . . . a youth involved in theft, drinking, and driving under the influence of alcohol is different from a youth involved in gangs.

Most programs for juvenile offenders are beginning to suggest guidelines for specific age ranges or for specific types of clients, based on kinds of deviancy.[98,99] For example, a youth involved in theft, drinking, and driving under the influence of alcohol is different from a youth involved in gangs. From this perspective, treatment must be tailored to the individual. The social organization of drug use and drug dealing among urban gangs is complex. Individuals are involved in gangs to different degrees; there are variations in types of gangs, gang activities, levels of drug use, delinquency of individual gang members, and associations between various activities.[100] Newer treatment models are based on a concept of health that recognizes the subjective experience and social context of any individual.[101] The most effective approach must involve a comprehensive system of intervention, closely coordinated from education to treatment to follow-up. Collaboration among community organizations, agencies, institutions, and individuals is essential.

Hodgins and Lightfoot may have said it best: "The failure to find effective treatment interventions may be largely attributed to the indiscriminate application of specific treatment interventions to an extremely heterogeneous offender population."[103] Given the large population of incarcerated adolescents with histories of drug and alcohol abuse, it is likely that the population will be heterogeneous in terms of strengths and deficits and unlikely that a single treatment approach will meet the needs of all members of the population. Treatment efficacy can be maximized by matching clients with specific needs to treatment interventions with specific capabilities. A number of studies have demonstrated that improved outcomes are observed when individuals are matched with treatments on the basis of personality and cognitive variables; treatment program setting, modality, and philosophy; and culturally relevant goals.[104–106] Ineffective treatment interventions can harm clients. For example, offenders with negative self-images had more reconvictions

and committed more severe offenses after receiving group therapy than after receiving regular institutional care.[104] Indiscriminately applied treatment may not only be ineffective, but can actually have negative effects on the well-being and future behavior of participants.

Identification of Problems and Barriers to The Delivery of Adequate Care

Research on criminally involved youth encompasses a number of disciplines, each offering wide and varied perspectives. However, this broad perspective has not prepared the criminal justice system or institutions housing criminally involved youth to deal with the prevalence of drug and alcohol use. Underestimates of the proportion of youth who are seriously involved in substance use has resulted in institutions that are unprepared for the health and mental health risks associated with serious abuse. Institutions have inadequate health and mental health screening, inadequate assessment and treatment protocols, and a lack of effective evaluation and treatment programs to deal effectively with the broad range of issues raised by incarceration and antisocial behaviors in general.

There is a deficiency in basic information about the successes or failures of various treatment programs. Three general factors account for this phenomenon:

1. *Assuming homogeneity in the incarcerated population perpetuates homogeneity in treatment approaches.* A preponderance of research on incarcerated substance users relies on faulty distinctions between types of crimes to serve as indicators of behaviors of incarcerated persons. For example, there is a false assumption that those who are convicted of violent crimes are violent and that those who are convicted of property crimes are nonviolent. This is a dangerous assumption for researchers to make. Looting, for example, is a violent property crime and can indicate serious aggression. Faulty groupings fail to take into account more revealing patterns of behavior and more complex individual profiles.

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There is also too much variability in the legal system for criminal arrests or convictions to serve as accurate indicators of behavior. In research samples, the use of facts pertaining to incarceration, court referrals, or arrests for particular

crimes can create biases. There is a lack of important information such as the number and timing of arrests, the seriousness of offenses, the circumstances of crimes, the extent of physical injury or potential loss, the victim-offender relationship, the number of convictions, and the amount of detention and/or commitment time served. Additionally, official statistics often reflect political biases that may affect the choice of measures of crime and their interpretation. Populations in short-term detention facilities may be quite different from those in longer-term commitment (state) correctional facilities. Legal/criminal guidelines vary greatly between adult and juvenile systems and from region to region. The juvenile system is largely discretionary at all levels, including the arrest, charges, and whether or not disposition of the case involves commitment time. Little is known about the reliability and validity of self-reported criminal behavior among the psychiatrically impaired.

Assuming homogeneity of incarcerated groups perpetuates a false notion that understanding incarcerated groups will illuminate substance use patterns. Incarceration does not simplify substance abuse prevention or treatment approaches. If anything, it complicates them and tends to minimize and obscure the effects of multiple interactive physiological, psychological, sociocultural, and situational factors. For example, the comorbidity of substance abuse and other psychiatric disorders in adolescents is an important factor in the improved assessment of incarcerated adolescents.

2. *Institutional and systems responses to multiproblem juvenile offenders are confused.* Delivering treatment and prevention services to juvenile offenders involves the collaboration and cooperation of a number of systems, including judiciary systems, mental health systems, and drug and alcohol systems (which in most states are separate from mental health systems). Additionally, there is variation from state to state in legislative motivation to provide services in a youth's best interest as defined by juvenile justice codes. For example, the majority of states contain a "purpose clause" in their preamble to juvenile justice codes (the preamble provides a statutory rationale to aid courts in interpreting legislation). The purpose clauses emphasize rehabilitation and individual

supervision of juvenile offenders. Other states have redefined the purpose of their juvenile justice system, deemphasizing the role of rehabilitation and elevating the importance of public safety, punishment, and individual accountability. Not only do treatment orientations vary based on levels of sophistication in assessing needs, but the systems may not agree that treatment needs are a priority (in many states, punishment is the priority for incarcerated youth). Or systems and agencies simply may not know how to coordinate the delivery of services and may therefore divert resources away from incarcerated youth. Criminally involved youth who need treatment for substance use or other problems do not fit neatly into known or familiar programs or systems.

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systems may not agree that treatment needs are a priority (in many states, punishment is the priority for incarcerated youth).

3. *There is a profound absence of basic information or sensitivity to culture and families with respect to the many complex issues discussed.* A number of professionals argue for a major reexamination of the entire professional training and human resources development area, based on the changes in the nature of the youth population that must be served and based on systems that are culturally destructive and result in large numbers of youth who remain unserved in spite of multiple system involvement.[107-110] The lack of appropriate services for incarcerated youth is underscored by the paucity of substance abuse treatment research on providing services outside of traditional mental health settings, working with culturally diverse populations, and treating incarcerated youth in cooperation with their families. Substance use or abuse treatment of criminally involved youth cannot continue to ignore the real issues affecting treatment and prevention. Designing treatment programs without input from and participation of families is a recipe for failure.

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Family issues are also changing. Consideration must be given to family dynamics that include the effects of adoption, foster care, physical and sexual abuse, multigenerational criminality, substitute families such as transient/homeless groups or gangs, and incarceration of single adolescent parents. Many youth in the criminal justice system are parents, and family issues must involve parenting approaches as well. Treatment in cooperation with families is virtually unrecognized, often because the family does not fit traditional con-

cepts. Treatment demands cultural competence and must involve families, systems, agencies, and practitioners with the capacity to respond to the unique needs of populations of varying cultures.

RECOMMENDATIONS

In order to serve the population of potential and actual substance users, an understanding of a number of factors is needed. General recommendations are suggested in the areas of programs, research, and training.

Programs

1. Culturally sensitive programs that include parental involvement should be developed. Programs should incorporate information about legal and family problems relevant to their clients, including the presence of multiple psychological disorders, the developmental stage of the client, and the response of clients under conditions in which physiological, social, environmental, situational, and psychological factors interact.

2. Programs must be increasingly sensitive to differing developmental issues of youth as well as to possible developing or existing comorbid psychiatric disorders. Most juvenile facilities house residents ages 9–18. Program developers must select youth who are developmentally compatible and psychiatrically suited for treatment, and must be prepared to justify their selections.

3. Programs should be designed around information based on appropriate standardized and sensitive assessment efforts. Treatment typology instruments should be encouraged. Efforts at measuring key variables have been begun in adults; these variables could be predictive of differential treatment effectiveness in adults. An interview format used in the Federal Bureau of Prison's program addresses drug use, employment, treatment history, criminal history, family and other individual characteristics.[112–115]

4. Program evaluation should be initiated. Institutions rarely have evaluations to assess program effectiveness or utilization. Current program evaluations are superficial at best.

5. Programs must reflect flexibility and a capacity to reach out and form linkages with systems outside the normal service delivery system. Positive treatment outcomes for substance-using juvenile offenders will be achieved if there are efforts to make services fit the client rather than to make the client fit the services. Programs such as home-based models identify the needs of the family and then seek to meet those needs. Advocacy may be an appropriate service requirement and the most profoundly effective preventive tool, especially for minorities whose basic needs may need to be met prior to more sophisticated treatment interventions.

Specific and adequate care will exist only if further research provides more information about the specific needs of this at-risk population and if formal guidelines and training regarding the recognition of symptoms of mental illness or drug and alcohol effects are implemented. Following guidelines and standards suggested by the National Commission on Correctional Health Care, the National Juvenile Detention Association, and the Office of Juvenile Justice and Delinquency Prevention is suggested. The effect of underestimating the proportion of youth who are seriously involved in substance use and suffering from a number of other seriously impairing forces—such as mental illness, economic hardship, family dysfunction, violence, and physical and sexual abuse—has resulted in a number of negative consequences. The consequences include institutions unprepared for the health and mental health risks associated with serious abuse, inadequate health and mental health screening, inadequate assessment and treatment protocols, and a serious absence of effective treatment programs that work effectively for the broad range of issues related to incarceration and antisocial behaviors. Based on current information, success in the prevention of substance abuse among juvenile offenders will rely more on the systematic approach to the complexity of the problem than on finding an ideal treatment program. This systematic approach must include offering a system of service delivery that provides an array of services tailored to the individual and the family.

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11

Violence

Janice Hutchinson, M.D.

" Children and adolescents often are unable to express their sadness, so they express anger instead. Youth are likely to manifest their sad/angry feelings as hyperactivity, fire-setting, muteness, destruction of the self and others, and reckless driving."

DOES ANYBODY REMEMEBER Stokeley? In 1968, black activist Stokeley Carmichael stunned America with the comment that "violence is as American as apple pie." His comment would be less controversial today, with violence a major public health issue affecting the lives of millions. The violence of youth is well documented. Headlines and commentators tell the story: "Teen Arrested After Month of Violence,"[1] "Kids Who Kill,"[2] "Sex Offenses by Juveniles Rise,"[3] "Today a 15 Year Old Teenager Shot and Killed Two Other Teens in a High School,"[4] "Students in Cokeville, Wyoming Hold 'Drop and Cover' Drills,"[5] "Two 11 Year Old Boys Rape 11 Year Old Girl."[6]

In 1986, 1 of every 20 persons arrested for a violent crime was less than 15 years old.[7] Odds are that one-fifth of adolescent males in communities of 100,000 or more will belong to a gang. In 1986, the California State Task Force estimated 50,000 gang members in Los Angeles, responsible for 5,119 violent crimes in the city and 13,222 in the county.[8] These numbers are comparable to those in other areas of the United States. The National Adolescent Student Health Survey reported in 1989 that 20% of boys and 4% of girls had brought a knife to school at least once.[9] Over 2,000 weapons were taken from New York students in 1989.[10] The adolescent murder rate in the United States

has tripled since 1975.[7] Rapes committed by adolescents have doubled, and the number of adolescent robbers has grown five times. There are reports that 35% of high school girls are treated violently by their boyfriends.[11] Since 1980, the number of juvenile sex offenders has grown by 50% in Virginia, 36% in Maryland, and 90% in the District of Columbia. The FBI reports that in 1991, one in every five rapes was committed by a child.[12]

When Stokeley Carmichael made his remark, few believed that youth were implicated in violence to any significant degree. Children had been victimized for centuries; the role of perpetrator was a new one. Now the question is: "Who are these violent young people and how did they get that way?"

Opinions on the origins of youth violence cite factors such as poverty, unstructured environments, school failure, incomplete parental bonding, drugs, media violence, and dysfunctional families. The reality is that all of these factors may contribute to violence. Each is an example of abuse and/or neglect. Any abusive and neglectful experience—either personal or community-based—in conjunction with paranoia, neurological impairment, or low verbal competence may create a violence-prone individual. Neurological impairment, sexual abuse, child abuse and neglect, family problems, poor impulse control, and paranoia do not usually cause aggressive behavior unless they are present in some combination. (To date, little attention has been given to the influence of neurological impairments.) Violence is a merging of neurological and psychosocial problems.

Any abusive and neglectful experience. . . in conjunction with paranoia, neurological impairment, or low verbal competence may create a violence-prone individual.

Current research has identified neuroanatomic and neurochemical substrates—secondary to prenatal insults (e.g., maternal substance abuse) or acquired brain disorders—that are associated with the expression of severely aggressive acts. Neurophysiological research implicates the hypothalamus and limbic system in the mediation and display of aggression.[13] Animal studies have revealed several different sites in these areas that can increase, decrease, or modify aggression. Stimulation of the limbic system can alter human emotions. The amygdala, a part of the limbic system, can play either an excitatory or an inhibitory role. Different routes of neural activity exist between the amygdala and various portions of the hypothalamus. Different feelings will stimulate one pathway or another, with either a calming or exciting effect. The cingulate gyrus is part of the limbic system. Its removal in humans seems to have a calming effect. It is hypothe-

brain disorders... are associated with the expression of severely aggressive acts. Neurophysiological research implicates the hypothalamus and limbic system in the mediation and display of aggression.

sized that discharges in the brain that affect these structures (i.e., the limbic system and portions of the hypothalamus) can lead to disorders producing violent behavior.

Episodic dyscontrol is thought to be common but underreported.[14] It is often identified as a personality problem. The person affected is perceived as having a quick temper. A person with this disorder will show explosive rage upon trivial or impersonal provocation. There may be a history of childhood temper tantrums or a history of brain trauma. Assaults may occur suddenly or follow a period of irritability. Small quantities of alcohol may trigger these episodes, because of alcohol's disinhibitory effect. The affected individual loses control and is difficult to stop. Physical assaults, impulsive sexual assaults, traffic violations, and serious automobile accidents may ensue.[15] Brain insults, including encephalitis, tumors, meningitis, stroke, hypoglycemia, or head trauma associated with a loss of consciousness, can cause episodic dyscontrol. Carbamazepine (tegretol) is the treatment of choice. Clonidine is considered an effective alternative.

◀ A person with [episodic dyscontrol] will show explosive rage upon trivial or impersonal provocation.

"David" was nine years old when he was asked to leave his public school. He was usually a pleasant, engaging child. The teachers reported that he would suddenly become hostile and aggressive, with little or no stimulus. He would fight, hit, scream, throw objects, and threaten to kill. The physical force of grown men was required to subdue him. Electroencephalogram results were normal; episodic dyscontrol was diagnosed. Improvement occurred when tegretol was administered three times per day.

Partial complex seizures have also been associated with aggressive behaviors. Electrical discharges from different sites in the brain—not just the temporal lobe, as was once believed—seem to affect the limbic structures. Consciousness is influenced, and aggressive activity is carried out in a confused, disorganized way. A third of patients with partial complex seizures have other psychiatric symptoms that may be brief (lasting a few days) or prolonged (lasting a few months). The seizures may involve automatisms. Again, the treatment of choice is tegretol.

◀ Partial complex seizures have also been associated with aggressive behaviors.

There is strong evidence that neurotransmitters initiate and control aggression through inhibitory and excitatory stimulation. Norepinephrine, acetylcholine, and dopamine seem to

People who commit impulsive crimes such as arson or the murder of strangers tend to have low serotonin levels. Those who commit premeditated murder tend to have normal serotonin levels.

enhance aggression. Lithium, a popular antiaggression agent, inhibits norepinephrine and reduces aggression in children and prisoners. Benzodiazepines (e.g., valium) and serotonin have antiaggressive properties. People who commit impulsive crimes such as arson or the murder of strangers tend to have low serotonin levels. Those who commit premeditated murder tend to have normal serotonin levels. It is possible to raise serotonin levels with medication. Alcohol and amphetamines can also affect serotonin levels. An occasional drink raises serotonin levels for a brief time, while more frequent alcohol consumption lowers levels. Among incarcerated youth, alcohol is the most popular mind-altering substance. It is also perceived as a stimulant to aggressive behavior.

A disposition to high or low neurotransmitter levels may depend on one's environs. For example, when mice are isolated at certain critical stages of development, there is a drop in their levels of serotonin, a neurotransmitter.[16] Low serotonin levels in both animal and humans are associated with hyperaggressiveness. Low levels of brain serotonin in humans have been associated with violent behavior toward others as well as toward the self. Serotonin has been shown to exert an influence during critical stages of development. When serotonin is absent in mice during certain stages of growth, aggressive behaviors develop as the mice mature to adulthood.

▶

Males have higher levels of hormones known as androgens (e.g., testosterone). These... affect parts of the brain that are linked to the development of aggressive behaviors.

The role of testosterone and other hormones remains unclear because current data are conflicting. Males have higher levels of hormones known as androgens (e.g., testosterone). These hormones affect parts of the brain that are linked to the development of aggressive behaviors. In fetal development, androgens sensitize those parts of the brain that are related to aggression. Males seem to have a greater capacity to secrete large amounts of androgens in the brain in response to stress. Males commit violent acts at rates that far exceed those of females. This is true regardless of cultural or ethnic background, socioeconomic grouping, or age. The XYY chromosomal abnormality has been associated with tall stature and extreme aggressiveness. However, most XYY individuals live outside of prisons and mental hospitals.

Neurological findings in violent juveniles have included abnormal electroencephalograms, abnormal head circumference, absence spells, dents in the skull caused by fractures, Babinski signs, choreiform movements, mixed dominance, clumsiness,

saccadic eye movements in pursuit, focal brain injury, history of grand mal seizures, and abnormal psychological testing results.[17] A study comparing extremely violent boys with less violent boys found more major and minor neurological abnormalities, paranoid thoughts, and rambling associations among the more violent boys.

While biochemistry, neuroanatomy, and prenatal insults may make a child more prone to violent behavior, the environment may serve as the trigger. Numerous studies show that childhood victimization greatly increases one's risk of later delinquency, adult criminality, and violent behavior.[18] Abused and neglected children have higher rates of arrests for violent crime. Although the exact process whereby early abuse results in aggressive, acting out behaviors is unknown, a review of the early environments of violent youth may offer some clues.

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Youth tend to be victims as well as perpetrators. Adolescent females are twice as likely to be raped as older women, usually by a person of the same race.[19] Almost half the victims of domestic abuse are adolescents.[20] The leading cause of death among young black males is homicide.[21] Young white males are more often victims of suicide and automobile accidents, with alcohol often a factor. Native American youth have the highest rate of auto fatalities (89 per 100,000).

A National Institute of Mental Health study has revealed that children are exposed to more community and personal violence than had been realized.[22] It is estimated that 3.3 million children in the United States witness spousal abuse each year.[23] The Los Angeles Sheriff's Department estimates that children witness 10–20% of homicides.[24] The victim is often a parent. Children are present 50% of the time when a rape occurs in the home, and 10% may witness the assault as it is occurring. Recent interviews of Washington, DC, school children revealed that 32 had witnessed severe violence (shootings or stabbings). A Maryland adolescent clinic reported that 50% of patients had seen a shooting, and 25% had seen a stabbing or a murder.[25] Interviews with children's parents or guardians revealed that very few recognized that their child had been exposed to a traumatic event, nor did they understand how emotionally traumatic the event had been for the child. No supportive intervention had been offered, and the child did not have an opportunity to express his or her feelings about what had occurred.

◀ It is estimated that 3.3 million children in the United States witness spousal abuse each year.

◀ A Maryland adolescent clinic reported that 50% of patients had seen a shooting, and 25% had seen a stabbing or a murder.

No one was available to help the child make sense of the event or to reassure the child that he or she was not to blame. Posttraumatic stress disorder (PTSD) is likely to result in such situations. PTSD usually goes undiagnosed and untreated.

Children and adolescents often are unable to express their sadness, so they express anger instead. Youth are likely to manifest their sad/angry feelings as hyperactivity, fire-setting, muteness, destruction of the self and others, and reckless driving.

▶ **Despite the frequent and severe level of trauma often experienced by children and adolescents, few consider applying this diagnosis [of PTSD] to them.**

PTSD has been widely described in Vietnam War veterans and rape victims. Despite the frequent and severe level of trauma often experienced by children and adolescents, few consider applying this diagnosis to them. Rather, the child is more likely to be diagnosed with "adjustment disorder." How one is expected to "adjust" to a violent experience such as rape or murder is unclear. Sooner or later, depending on the severity and duration of the trauma and the child's proximity to it, the child will develop signs of PTSD.

After experiencing an unusual event that would be traumatic for anyone, the child may relive or reenact the events through dreams, nightmares, or intrusive and distracting recollections. There may be a psychic numbing in which the child retreats from family and friends and loses interest in usual activities. The child may also enter a state of hyperalertness and easy arousal. Sounds may remind the child of the event, sleeping disturbances may occur, and the startle response may be exaggerated.

▶ **Scientists have found that catastrophic events change the brain chemistry, making it more sensitive to adrenaline surges days, months, and years after the initial trauma.**

The basis for these responses may be found in the biochemistry of the brain. Again, neurotransmitters and the limbic system play a key role. Scientists have found that catastrophic events change the brain chemistry, making it more sensitive to adrenaline surges days, months, and years after the initial trauma. Changes occur in the manner and rate of production of stress-related chemicals in the brain. Three sites are known to be affected. The locus ceruleus secretes too many catecholamines (hormones that mobilize the body for an emergency). The opioid system (amygdala, locus ceruleus, and hypothalamus) secretes too many endorphins (substances that blunt pain). Levels of corticotropin-releasing factor (CRF) increase, alerting the body to emergencies that do not exist. (CRF levels are mediated by the hypothalamic-pituitary axis.) These physiological changes seem to parallel the PTSD behaviors of those who have been exposed to abusive and neglectful environments.

Nearly all child sex offenders have been sexually abused at least once themselves. The sexually abused child reexperiences the event through dreams, nightmares, flashbacks, and other psychological phenomena. The terror and humiliation felt by a child during an assault may lead to chemical changes that keep the child in a state of anxiety and tension, fueling feelings of anger, resentment, and retaliation. The abused child may attempt to relieve his or her sense of vulnerability and hopelessness by achieving power and control over a smaller, weaker person—by definition another child. There is a lack of empathy that characterizes the assault of one child upon another. The sexually abused children dissociate themselves from the pain, fear, shame, and degradation of smaller and more vulnerable children.

Nearly all child sex offenders have been sexually abused at least once themselves.... The abused child may attempt to relieve his or her sense of vulnerability and hopelessness by achieving power and control over a smaller, weaker person—by definition another child.

One day "Mrs. G." noticed that her four-year-old son, "E. J.," was trying to put his penis into the buttocks of a doll. She was quite alarmed and asked her son what he was doing. She learned that the family's 10-year-old foster son, "Jeremy," had tried to put his penis into E. J.'s rectum a few days before. When Jeremy was confronted about this, he admitted that he had tried to have anal intercourse with E. J. An older boy had had intercourse with him in his previous group home placement.

A 1987 study describes the link between sexual abuse and the processing that leads to antisocial, aggressive behaviors.[26] The delinquent or criminal behavior of 17 boys who had been victims of long-term sexual abuse was compared to that of 13 classmates who had not been abused. The findings are as follows: Nearly all of the sexually abused group had been arrested, destroyed property, participated in acts of violence, physically assaulted someone without provocation, used a weapon, or participated in breaking and entering. Among the control subjects, not more than four boys committed any of these acts, and none of them used a weapon or physically assaulted someone without provocation. Another group of boys came from stable, supportive families and had been abused for a limited time. They did not show increased aggressive behaviors. The boys who had been abused over a long period of time without the support of a nonblaming family were the ones who became abusers.

"Steve" was 13 years old when he was committed for two years on a charge of raping and sodomizing three young cousins, two girls, ages 4 and 10, and a boy, age 7. He had been

asked to babysit these children. When left alone with them, he had vaginal intercourse with the 10 year old and made her put objects into the vagina of the 4 year old. He put his penis into the boy's mouth. He later revealed that he had been angry for a number of years over his sexual abuse by his stepfather. While he was abusing these children, he explained, he felt angry and was flooded with memories of his own abuse. He had never discussed his abuse with anyone.

▶ Males who are sexually abused are more likely to sexually abuse other children.... Girls are more likely to perceive themselves as vulnerable and helpless, and are more accepting of a passive role.

Males who are sexually abused are more likely to sexually abuse other children, male or female. Males are typically more aggressive and more compelled to reestablish roles of superiority and dominance. Girls who are sexually abused tend to engage in multiple sexual encounters, align themselves with abusive men, have early pregnancies, and be unable to protect their offspring from abuse. Girls are more likely to perceive themselves as vulnerable and helpless, and are more accepting of a passive role. Abused females are more likely to become suicidal, drug and alcohol addicted, and nonemployable. Girls are more likely to internalize guilt and feelings of responsibility for sexual abuse, regarding themselves as unworthy individuals. Young men in detention often report brothers who have been incarcerated and sisters who have experienced early pregnancy. This is consistent with findings on the impact of violence on males and females. Female behavior may be changing, however, with more females being arrested for violent crimes.

▶ Nearly all adolescent murderers have been exposed to extreme violence that has had a severely traumatic effect.

Nearly all adolescent murderers have been exposed to extreme violence that has had a severely traumatic effect. These children are hyperalert and hypervigilant. Young men often say that they thought their victim was going to shoot them, whether or not the person had a gun. A look or a word may literally provoke a "killing" response. The gun is perceived as the ultimate protection. There is little or no remorse: "It was them or me" or "I don't feel anything about it" are common sentiments among these youth. Juvenile murderers often have great emotional distance from their victims. Violent children have usually learned that actions speak louder than words and that behaving violently is an appropriate way to express feelings.

Kids who kill have become the subject of the 1990s. They have been diagnosed with a multitude of problems.[27] These problems include psychomotor epilepsy, electroencephalogram abnormalities, and neonatal deficits. Kids who kill have poor psy-

chological controls, criminally violent families, increased gang membership, severe educational difficulties, substance abuse, suicidal tendencies, and parental psychiatric illness.

Among Washington, DC, juveniles who have killed, there are several outstanding features. In one study of 20 males 13–19 years of age, all of whom had committed one or more murders in the past fours years, each youth had previously witnessed a murder at close range (within six feet).[28] Second, in these witnessed murders, they knew either the victim or the perpetrator, often both. Third, a therapeutic intervention had never taken place. Finally, no one recognized how traumatic the event was for the juveniles, and no one talked with them about their feelings.

One day when "Jack" was seven years old, he went with his father to answer the doorbell. When his father opened the door, a man was standing there with a gun. The man shot Jack's father. Blood ran from Jack's father's chest wounds onto Jack's feet. Other family members pulled Jack away, and they never discussed his father's shooting with him. But Jack never forgot what had occurred. When he turned 13, he and his brother began to search for their father's killer. They subsequently murdered this killer and two other people. Jack said that one of these people had said something to him that made him angry.

One type of escalating youth violence that has not been widely acknowledged is assault on parents and guardians. More youth are violently attacking their parents with guns, knives, fists, and any other available weapon. Studies estimate that as many as 2.5 million parents are struck by their children each year. Boys tend to assault parents more often than girls do, and mothers are a more likely target than fathers.

Little "Christopher" was eight years old when he started to attack his grandmother. His mother was a drug addict, his father had disappeared, and Christopher lived with his grandparents. He was frequently truant from school and had been observed selling drugs. He had gone to live with his grandparents after authorities found him beaten and abandoned by his mother. One day when his grandmother insisted that he stay in the house, Christopher became angry. He went into the kitchen and picked up all the knives, chasing his grandmother to her room. She remained there for hours, afraid to emerge.

Youth often join each other in committing acts of violence. They refer to these acts as "fun" or "wilding." Several years ago,

Youth often join each other in committing acts of violence. They refer to these acts as "fun" or "wilding."

New York adolescents ages 14–20 attacked a lone female jogger. She sustained permanent injuries. The youth randomly attacked several other people in the park that evening. The incident was remarkable in the almost total collusion among these young men to commit acts that were life-threatening to other human beings. The excitement generated by the assault superceded sensitivity to victims' pain and devastation. Perhaps the attackers attempted to relieve or overcome feelings of emotional emptiness with stimulation that was excessive to a degree that could have caused death. The degree of support and approval that they offered each other was yet another sign of their desperate need for fathering.

While childhood victimization plays a dominant role in the etiology of youth violence, media presentations also contribute. Movies, advertisements, videos, and music glorify and glamorize violence. Many media images link sex and violence. The latest media event that celebrates violence is wrestling. Decorated, macho-looking characters strut and parade around the ring to the delight of cheering men, women, and children. The wrestlers wear leather, chains, whips, and other pain-inducing equipment. There is no regard for standards of sportsmanlike conduct. Rules and regulations are flagrantly ignored. The more vicious and aggressive the wrestlers, the more the crowd applauds. This hyperviolent exercise is presented as a sports event. Though no causal relationship between viewing wrestling and adopting violent behavior has been demonstrated empirically, clinical evidence does exist.

▶ Movies, advertisements, videos, and music glorify... violence. Many media images link sex and violence.

"Larry" was 11 years old, with a diagnosis of attention deficit disorder. He was a bright child, with sad, angry feelings following his mother's rejection of him. He began to behave like his favorite wrestling characters. At school, he tried to put other students into various wrestling positions and dominate them. He eventually adopted a wrestling name that described him as a person to be feared. His parents said he was absolutely addicted to television wrestling programs.

Conclusions

Youth are entitled to a violence-free childhood. A child should be able to experience growth and development leading to a positive sense of self. In order for this to happen, the following conditions must occur:

1. Parents must love and accept their children from birth.
2. Children must be provided with environments that are safe and secure.
3. Adults must respond to children's needs to be listened to, touched, and comforted.
4. Situations and people that are abusive and neglectful to children must be recognized and interrupted.
5. Children must be encouraged to discuss events that are traumatic, without blame or negative sanctions.
6. Children must learn nonviolent responses to situations that evoke anger.
7. Underlying physical/neurological disorders must be diagnosed and treated.

Recommendations

When youth have had violent childhoods and have adopted aggressive behaviors, interventions must occur. An intensive treatment program, in which a juvenile offender can spend several years, must be implemented. The treatment program should offer (1) structure; (2) accountability; (3) appropriate and challenging education; (4) issue-specific psychotherapy; (5) vocational training; (6) opportunities to raise self-esteem; (7) training in nonaggressive coping skills; (8) victim empathy groups; (9) sex offender treatment when appropriate; (10) low-dose tegretol, lithium, or other psychotropics when indicated, and (11) a program for parents that offers skills training, group therapy, parenting therapy, and social support interventions as needed. Many believe that the way to stop violence among our youth is to build more prisons and detain more youth. However, increasing evidence suggests that if we do not stop the violence committed against our youth, they will continue to commit violence against us.

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12

Homeless Youth

James A. Farrow, M.D.

"The majority of adolescent females on the streets ultimately become involved in juvenile prostitution.... For those... not involved in prostitution, a criminal lifestyle is often promoted by panhandling, solicitation of money using strong-arm tactics, and drug dealing."

AS NOTED BY THOMPSON AND Farrow in Chapter 1, substantial numbers of America's youth are incarcerated each year, with a significant impact on the health and well-being of our adolescent population. A subset of this population, primarily in urban centers, is caught up in the revolving door between correctional institutions and the streets. These young people—now numbering well over a million in the United States—pass freely from institutional, correctional, and foster care programs into the often chaotic and dangerous life on the streets.[1] Their increasingly conspicuous presence challenges the commonly held belief that street people constitute an undifferentiated reservoir of the aged and unstable. These homeless and runaway youth may not exhibit the degree of emotional debility and physical illness characteristic of older veterans of street life, but in studies of their physical and mental health needs, there is disturbing testimony of their inadequately addressed health problems.[2]

Runaways and street youth interface with the juvenile justice system in many ways. In a number of states, runaway behavior, truancy, and parent-child alienation are considered status offenses. The juvenile justice system is used as a tool for controlling these youth. Even in jurisdictions where status offenses no longer exist as a classification of delinquent behavior, soc-

ial service agencies may use court-ordered interventions to engage the adolescent and family. Many youth are arrested because of criminal activity resulting from the lifestyles they have adopted in order to survive. The violence of urban street life promotes assaults—often involving weapons—and fosters theft as a means of survival or of purchasing illicit substances; the majority of adolescent females on the streets ultimately become involved in juvenile prostitution, an illegal behavior in almost all jurisdictions.[3] For those young people not involved in prostitution, a criminal lifestyle is often promoted by panhandling, solicitation of money using strong-arm tactics, and drug dealing. Young adolescents initiating gang activities or working as runners for drug dealers are often the most vulnerable to entering the juvenile justice system. In most cases, these "minutemen" (as they are often called because they are in detention for only a short time) are marginally involved in illegal activities that offer them a strategy for survival on the streets.[4]

▶ the majority of adolescent females on the streets ultimately become involved in juvenile prostitution.... For those young people not involved in prostitution, a criminal lifestyle is often promoted by panhandling, solicitation of money using strong-arm tactics, and drug dealing.

The homeless child on the streets who becomes temporarily incarcerated has the opportunity to receive a number of health and social services. This chapter discusses preventive services for homeless youth who enter the juvenile justice system: Health services (physical, mental, screening, and outreach), prevention of prostitution, shelter services and family reconciliation, drug abuse prevention and treatment, and gang intervention services.

Health Services

Many homeless youth live in a state of perpetual crisis. When these crises are health-related, adolescents most frequently seek services in busy emergency rooms or public health clinics, or not at all. When they are incarcerated, their health problems become the responsibility of the detention facility. These adolescents have a greater number of serious, acute, and chronic medical and mental health problems than other adolescents, even those in the nonhomeless delinquent population.[5,6] Many have chronic medical problems such as asthma, epilepsy, or diabetes that are aggravated by erratic hours, lack of sleep, and living in a survival mode.[7] They are rarely in a position to take good care of themselves. Their health problems are often secondary to substance abuse, poor nutrition, violence and injury, and sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) disorders.[7,8] They have multiple combined risks for poor health outcomes.

▶ When [homeless youth] are incarcerated, their health problems become the responsibility of the detention facility.... Many have chronic medical problems such as asthma, epilepsy, or diabetes that are aggravated by erratic hours, lack of sleep, and living in a survival mode.

A substantial proportion of young women arrested for prostitution activities are pregnant. In a study by Deisher et al.,[9] the majority of juvenile prostitutes became pregnant at least once during their time on the streets. These young women are in extremely high-risk situations and tend to be relatively young. A majority of them have been involved with child welfare services at younger ages. Many have been in multiple foster placements, have run away from home, and have become involved with the juvenile justice system because of multiple minor infractions of the law. Many are quite transient and have unstable living situations. Some live with pimps or boyfriends. It is not uncommon for their pregnancies to be detected during a brief stay in a detention facility. Condoms are not used consistently by these young women or street youth in general. As a result, the sexually transmitted disease rate and, in some urban localities, the HIV positivity rate, are disproportionately high.[9,10] For the general homeless youth population, there is a need for health screening, reassessment and treatment of chronic illness, STD/HIV screening, and pregnancy services. In addition, if the youth are in detention facilities for any length of time, important health education services may be provided.

In a study by Deisher et al., the majority of juvenile prostitutes became pregnant at least once during their time on the streets.

◀ the . . . homeless youth population... [needs] health screening, reassessment and treatment of chronic illness, STD/HIV screening, and pregnancy services.

Pregnancy-related services should consist of diagnosis, substance detoxification, medical care, referral to community prenatal care clinics for high-risk obstetrical services, confidential HIV testing, and screening and treatment for sexually transmitted diseases. Because street youth incarcerated in secure facilities generally have shorter stays than youth arrested for felonies, these screening and treatment services must be designed for implementation within 72 hours of incarceration.

These young people have multiple mental health needs as well. Although chronic mental health disorders are not as common among adolescents as among the adult homeless population, homeless youth suffer from a wide range of painful and debilitating mental health problems, often coexisting with physical and substance abuse problems. Some studies report high rates of depression, suicide attempts, physical and sexual abuse, and other mental health problems.[6,11] Rates of psychiatric hospitalizations in this population are significantly higher than those of their nonhomeless peers.[12] Rates of defined disorders, including major depression, conduct disorders, and posttraumatic stress (often as a result of exposure to violent living situations) were at least three

◀ homeless youth suffer from a wide range of painful and debilitating mental health problems.

times higher in homeless youth than in a nonhomeless comparison group.[12] A "dual diagnosis" of major depression and alcohol/drug abuse has been seen in a number of homeless adolescent populations. Difficulties related to struggles with sexual orientation are especially high among homeless adolescent males.

Homeless youth are often arrested and jailed in various states of intoxication with alcohol and drugs. Although alcohol and other drugs may play a "functional" role in helping homeless youth survive on the streets, they also destabilize their lives further, not only promoting delinquent behavior but making it more difficult for youth to utilize available services. The longer adolescents remain homeless, the more likely it is that they will become involved in substance abuse.[13] Alcohol and drug abuse may also increase a street youth's risk of developing physical and mental health problems, especially trauma from accidents and injuries, acute infections, and sexually transmitted diseases.

▶ The longer adolescents remain homeless, the more likely it is that they will become involved in substance abuse.

These morbidities demand improved screening, prevention, and treatment services in detention facilities, but since youth are often in custody only temporarily, follow-up and outreach are critical. Though medical and mental health outreach may not be perceived as part of the core mission of the detention facility, outreach and follow-up relationships may be developed with community agencies that work regularly with homeless youth. No young person receiving health screening and initial treatment in detention should be sent back to the streets or to a shelter without appropriate medical or mental health follow-up. Outreach becomes especially challenging with youth who have no permanent home, keep late hours, and are transient. Multiservice centers operating in many urban localities have developed special health outreach services for homeless adolescents or have mobile services. Outreach workers provide services to youth in the field and within institutions to ensure completion of medical treatment and follow-up for medical and mental health diagnoses.

▶ No young person receiving health screening and initial treatment in detention should be sent back to the streets or to a shelter without appropriate medical or mental health follow-up.

Recommendations for Improved Health Screening Services and Outreach

The juvenile justice system has a significant opportunity to screen youth and address many of the health problems previously enumerated. Specifically, detention facilities can provide the following services:

1. Basic physical and mental health screening at the time of admission.
2. More extensive health screening for preadjudicated youth through the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT).
3. A standard of care as developed by the National Commission on Correctional Health Care[14] and a facility health services accreditation.
4. Formal relationships with a local health department to provide enhanced screening for sexually transmitted diseases, including HIV.
5. Formal relationships with local youth shelters and service centers to provide onsite and offsite outreach services to runaway and homeless youth in order to better ensure follow-up of medical/mental health problems.
6. Develop education on sexuality and general health for all youth confined in correctional facilities.

Juvenile Prostitution

National estimates of numbers of youth involved in prostitution range from 90,000 to 900,000.[15] Adolescent prostitutes cannot be stereotyped. They are both boys and girls who receive food, lodging, and clothing in exchange for sexual favors. They work in bars as dancers, waitresses, or waiters, serving sex as well as drinks for a price. They are involved in the pornographic film industry and are forced by pimps (sometimes their parents) to have sex in exchange for money. And while adolescent males do not generally work for pimps, escort services hiring these young men flourish in many cities. Regardless of their particular prostitution lifestyles, almost all these adolescents come from dysfunctional families. Most of the young women are victims of childhood sexual abuse. Silbert and Pines[16] found that 60% of the female juvenile prostitutes they studied had been sexually abused, and James and Meyerding[17] found that 86% of the male prostitutes they studied in Boston had a history of being sexually abused. Runaway and homeless youth make up approximately 75% of all youth involved in prostitution.[15] These young prostitutes, who live predominantly on the streets or with "clients" or pimps, have few marketable legitimate job skills and turn to a variety of illegal activities. Most

◀ almost all [juvenile prositutes] come from dysfunctional families.

Most [juvenile prostitutes] sell sexual favors not for profit but for survival.

of these young people sell sexual favors not for profit but for survival. Though these youth are often arrested for prostitution, which is illegal in most jurisdictions, they are in a sense victims of sexual exploitation. Their prostitution activities entail high risks of being physically assaulted, contracting various sexually transmitted diseases (including HIV), and developing substance abuse problems.

A recent study by Yates et al. compared the health risks of homeless youth involved in prostitution with those of homeless youth not involved in prostitution.[18] Given the substantial number of young prostitutes, both male and female, who find themselves in secure facilities, these medical diagnoses are worth noting. In the Yates study, there were significant differences between prostitutes and nonprostitutes with respect to a list of lifestyle-related medical and mental health diagnoses. Among homeless young prostitutes, drug abuse, the need for contraceptive services, sexually transmitted diseases (including HIV), other infectious diseases, and pregnancy were significantly greater.

As previously mentioned, youth involved in prostitution are more than five times as likely to report homosexual or bisexual identities, a finding substantiated in the Yates study. The study also notes that the age of first sexual encounter was younger in the juvenile prostitute group and that these youth had been sexually abused three times more often than homeless adolescents not involved in prostitution. In addition, physical abuse was twice as likely and satanic abuse more than three times as likely to be disclosed by the prostitution-involved youth.

▶ sexual exploitation is clearly defined as including prostitution as a form of child abuse that must be reported.

Since 1978, states have been encouraged to incorporate the term *sexual exploitation* into their legal lexicons; sexual exploitation is clearly defined as including prostitution as a form of child abuse that must be reported.[3] All jurisdictions have child abuse and neglect laws mandating that certain professionals report suspected child abuse to appropriate state agencies. Each state defines the types of abuse that must be reported. Sexual abuse is often included in these definitional provisions, but until recently the term as defined in state laws included only sexual contact between a child and a parent or caretaker. Sexual contact was not reportable if it occurred between a child and a third party with the encouragement of a parent or caretaker. In spite of this trend, juvenile prostitutes are regularly involved in the juvenile justice system as offenders and receive few services that might protect them from sexual exploitation and victimization.

Recommendations

1. Adolescents incarcerated for activities related to prostitution should receive enhanced physical and mental health services, including general health screening, pregnancy detection, screening, and treatment for STDs, including HIV.
2. In states that allow reporting to child protective authorities (through their broader definitions of sexual exploitation), this reporting should be carried out so that the youth may be transferred to protective custody.
3. Formal relationships should be developed with community prostitution prevention organizations and shelters to provide onsite and postdischarge services.
4. Specialized sex education groups should be developed within juvenile detention facilities to cover the following subjects: medical aspects of sexuality, sexual exploitation, positive expressions of sexuality, sexual normalcy and stereotypes, and sex and drugs.[19] These programs should be especially sensitive to issues of sexual orientation and female sexual victimization. Juvenile justice systems and even some public social service agencies have traditionally failed to address these problems. Services must be intensified and prioritized for youth who have experienced these problems, especially when the youth enter the juvenile justice system. The corrections system and the child welfare system should work together to improve the well-being of homeless youth who survive prostitution.

Shelter and Family Reconciliation Services

For all of its faults and lack of rehabilitative orientation, the juvenile justice system often provides basic food and shelter for homeless young people. Homeless and runaway youth, desperate for the basic necessities of life, tired of inclement weather, and afraid of violence in their environments, often commit relatively minor crimes in order to gain entrance into the justice system for temporary shelter and sustenance. These youngsters may become dependent on the juvenile justice system to serve their basic needs. They are less in need of secure custody than of food, shelter, remedial education, job skills, and medical and legal assistance. A number of cities, large and small, have devel-

◀
For all of its faults and lack of rehabilitative orientation, the juvenile justice system often provides basic food and shelter for homeless young people.

oped centers that provide multiple services for runaway and homeless youth, obviating the need to sort through often petty delinquencies in juvenile court. Some of the shelter services are closely linked with social service agencies and with family reconciliation services for those runaway youth who may benefit from returning to their homes. Often it may be inappropriate for adolescents to return to their homes, due to abusive environments or parents who have literally thrown their children out into the street. The first contact these youngsters have with the juvenile justice system may offer an opportunity to divert them for appropriate social and shelter services. Continued association with tougher juvenile offenders who are not victims of homelessness may serve to exacerbate their delinquent behavior. In spite of the change in many state laws eliminating status offenses, long-term juvenile correctional facilities are replete with homeless youth who are basically social misfits who have become dependent on the state for their needs.

In the United States, services for runaway and homeless youth are less comprehensive than they are in parts of Europe, but model outreach and service delivery models exist.[20] Secure juvenile facilities that regularly come into contact with runaway and homeless youth should have formal relationships with such services. These service agencies may be either public or private, but exemplary services share a number of guiding principles:

▶ model outreach and service delivery models exist. Secure juvenile facilities that regularly come into contact with runaway and homeless youth should have formal relationships with such services... exemplary services share a number of guiding principles....

1. They adapt services to the adolescent rather than expecting the adolescent to adapt to the services.
2. They provide local integrated and coordinated services.
3. They recognize the multiple needs of youth and ensure comprehensive services and holistic care.
4. They draw on the resources of a community or work in coordination with other programs to provide a range of services, either in-house or through interagency agreements.
5. They provide services in an environment and a manner that enhance the self-worth and dignity of adolescents, respecting their wishes and goals.
6. They maximize opportunities for youth self-determination in the planning and delivery of services, and foster a sense of personal efficacy that encourages youth to effect change in their lives.

7. They serve all runaway and homeless youth or provide and track referrals for those youth the program is unable to serve.
8. They provide services that are visible, accessible, and attractive to youth.
9. They incorporate flexibility in service provision and funding, which supports individualized services.
10. They work to provide culturally competent services.
11. They recognize the pivotal role that families play in the lives of high-risk adolescents, and they involve family members when appropriate.
12. They affirm the strengths of youth and their families and don't focus on deficits.

Recommendations

The juvenile justice system can play a key role in intervening with homeless youth to prevent further homelessness:

1. Juvenile corrections personnel should receive special training regarding the factors leading to and promoting homelessness within their own jurisdictions. Specifically, juvenile probation officers responsible for community supervision should be fully aware of resources for community-based shelter and foster care. These individuals should bring family reconciliation services to bear on the resolution of parent-child conflicts that have promoted runaway behavior.
2. Detention facilities should have relationships with multiservice centers for runaway and homeless youth so that the outreach services of those agencies can be available to youth in detention.
3. Local and state juvenile justice professionals should work toward diverting status offenders to the social service system as opposed to the juvenile corrections system.
4. The juvenile justice system should develop special programs for juveniles who have committed only minor offenses, in order to keep them out of the corrections system. They should recognize that much of the juveniles' behavior has little criminal intent and is motivated by desperation and survival needs.

Drug Abuse Prevention and Intervention

As previously noted, the abuse of alcohol and other drugs appears to be a pervasive problem among homeless youth. This abuse results from their homelessness and adds to their risk of developing problems. Alcohol is the substance most commonly used and abused by homeless youth. Among youth residing in 16 shelters located throughout the country, 79% reported using alcohol—60% on a regular basis.[21] In a New York City study, 20% of youth shelter dwellers reported using alcohol to the point of intoxication at least once per week, and the most disturbed youth were significantly more likely to report getting drunk weekly.[22] The majority (69%) of runaway youth seen in an outpatient medical clinic in Los Angeles reported recent use of alcohol.[23] The prevalence of substance abuse among nonhomeless youth is more limited. In a study conducted in Hollywood, California, more than one-third of homeless youth met diagnostic DSM-III criteria for substance abuse, a rate five times higher than that for the nonhomeless.[12] Among homeless youth seen at an outpatient medical clinic in Los Angeles, 53% reported marijuana use, 32% reported stimulant use (cocaine and amphetamine derivatives), and 9% reported the use of narcotics within the previous six months.[23] In a study of the detention population in Seattle, Washington, 90% of the adolescent IV drug users were female, a finding related to the relationship between female prostitution and IV drug use.[24]

In a New York City study, 20% of youth shelter dwellers reported using alcohol to the point of intoxication at least once per week, and the most disturbed youth were significantly more likely to report getting drunk weekly.

Drug-abusing youth have a number of health needs, some of which are evident when they are arrested and incarcerated. Medical personnel in detention facilities need to be aware of problems associated with acute intoxication, withdrawal, and detoxification. If the facilities cannot provide the youth with the intensive, short-term medical treatment they need, the youth will have to be transferred for hospital care. For the pregnant adolescent addicted to intravenous substances such as heroin, special obstetrical consultation is needed.

Detention-based substance abuse assessment and education programs are becoming more commonplace. When conducted by staff credentialed in adolescent substance abuse assessment and treatment, they can be an effective first step in engaging the youth in needed treatment. In some jurisdictions, the juvenile court has the power to legally remand the young person to treatment in lieu of detention time. Court-ordered treatment has not

Court-ordered treatment has not been well evaluated...its efficacy as opposed to volunteer treatment has not been established.

been well evaluated, and its efficacy as opposed to volunteer treatment has not been established. It may be an appropriate option, especially for youth who are heavy users and have adopted dangerous, unhealthy lifestyles.

Recommendations

1. Every juvenile facility should have the capacity to medically evaluate drug-abusing and alcoholic youth.
2. Juvenile corrections officers working in facilities should be trained to recognize the side effects of drug and alcohol intoxication.
3. Juvenile facilities not equipped to closely monitor youth onsite should have formal arrangements with both medical and psychiatric health care providers in the community for referral within 24 hours of arrival.
4. Large facilities should have inhouse drug and alcohol assessment and education programs run by credentialed and/or other qualified substance abuse treatment staff. These programs should be diagnostic and supportive, not punitive.
5. There should be more controlled studies on the use of court-ordered treatment for adolescents, a practice now varying significantly from one jurisdiction to another.

Gang Intervention Services

Both males and racial minority youth are overrepresented in the incarcerated youth population. As indicated in Chapter 1, official crime statistics show that crime rates among blacks have been well above those for whites. One of the major racial differences has to do with inner-city violent crime perpetrated by gang members, who in most urban areas are racial minority youth. A 1984 study suggests that when black and white adolescents commit equally violent acts, whites are more likely to be hospitalized and blacks are more likely to be incarcerated.[25]

Gangs thrive in most cities for a variety of reasons. Young men living in poverty, often raised by a single female parent, need a sense of belonging and build their identities around the status they gain from being members of a gang. The inevitable involvement of gangs in drug-dealing further perpetuates criminal activity and violence. Young minority males not only are

Young men living in poverty, often raised by a single female parent, need a sense of belonging and build their identities around the status they gain from being members of a gang.

drawn into criminal behavior involving weapons but are victimized by violence themselves. Both the emergence of widespread gang affiliation and the explosion in handgun ownership by adolescents have contributed to the steady increase in incarceration rates for young minority males. The violent juvenile crime rate has increased significantly for both individuals and young gang members.[26] The majority of violent criminal offenses committed by juveniles can be attributed to group influence.

All sectors of urban society should play a role in intervening with gang members or preventing children from entering into organized gang activities. It is not the responsibility of only the juvenile justice system to intervene or to break the cycle of children's involvement in such activities. The juvenile justice system does, however, play a major role by virtue of its sustained contact with these youth.

RECOMMENDATIONS

1. Gang affiliations should be addressed within detention facilities through implementation of one of several violence prevention curricula.[27]
2. Alternative recreation programs should be resources for detention facilities—especially those programs run by community recreation and parks departments, boys' and girls' clubs, midnight basketball leagues, etc.
3. Juvenile probation services should be linked with existing adult mentoring programs in the community.
4. Existing gang intervention programs should be closely linked with juvenile detention and rehabilitation services. The outreach services of community-based gang intervention programs should be available to youth while they are in detention.

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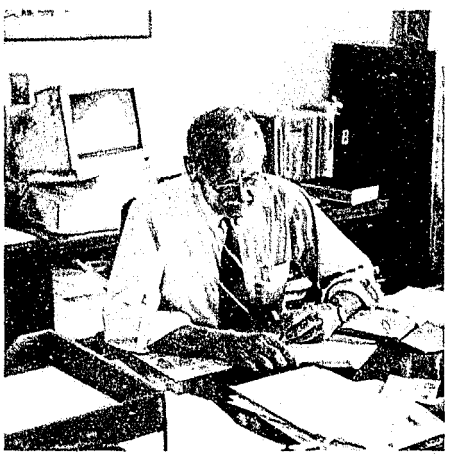
13 Financing



Sue Burrell, M.L.S., J.D.

"While a growing body of work provides health care standards for children in custody, there is precious little guidance on how to pay for it."

ADEQUATE HEALTH CARE REQUIRES adequate funding. This is particularly true when the population to be served is children in the custody of the state, many of whom have already suffered from the medical neglect often accompanying poverty and disruptive family situations. Although the last decade has seen the development of comprehensive standards of health care for incarcerated children, remarkably little attention has been focused upon the financing of such care. This chapter will explore existing practices in health care financing for secure and nonsecure facilities housing delinquent children. It will also discuss potential funding opportunities other than institutional budgets. Finally, it will emphasize the crucial part that health care financing may play in fashioning appropriate juvenile court dispositions.

TYPES OF CONFINEMENT AND LENGTH OF STAY

This country detains large numbers of children for extensive periods of time. Children confined as a result of allegations of delinquent behavior may be held in a broad range of facilities, including detention centers, shelters, reception/diagnostic centers, training schools, ranches/camps or farms, halfway houses/group homes, and other private facilities. This chapter will distinguish between "secure facilities" such as detention centers and train-

ing schools, which rely upon physically restrictive architecture or devices to keep children from leaving, and "nonsecure facilities" such as shelters or group homes, which do not.[1]

The numbers of incarcerated or confined children are staggering. In 1988, 834,985 children were admitted to 3,500 public and private detention and juvenile correctional facilities across the country.[1] On the date of the 1988 one-day census, there were 95,621 children in custody.[1] More than three-fourths of the children admitted to public juvenile facilities were detained in preadjudication status.[1]

The average length of stay for children in short-term public facilities (detention centers, typically holding children awaiting adjudication or disposition) was 16 days; the average stay for those in public long-term facilities (generally used for postadjudication commitments) was 167 days.[1] When training schools (the juvenile system equivalent of prison, typically reserved for postadjudication commitments of the most serious offenders) were separated out from other long-term facilities, the length of stay was even longer, with an average of 200 days for public training schools and 311 days for privately run training schools.[1]

Health Characteristics of Confined Children

As discussed in the chapters by Thompson, Farrow, Owens, and Hutchinson in this volume, detained children have significant medical needs: "Adolescents entering detention and correctional facilities tend to have poorer health histories than their non-incarcerated counterparts and are frequently suffering from significant health problems at the time of admittance."[2] Most court-processed adolescents come from low-income households,[2] and the poor health status of many incarcerated youth is partly a function of their lack of medical insurance. One study found that 34% of adolescent offenders (compared with 8% of nonoffenders) did not have a consistent source of health care.[2] Uninsured adolescents tend to be in poorer health and to wait longer periods of time between physician visits, and they are more likely to be hospitalized.[3] For many of these children, who are disenfranchised from traditional medical services in the community, correctional health care may become the primary source of health services.[4]

One study found that 34% of adolescent offenders (compared with 8% of nonoffenders) did not have a consistent source of health care.

Incarcerated youth suffer from a broad range of preexisting conditions. Studies of adolescents entering juvenile justice facilities have identified substantial nutritional deficiencies and physi-

cal illnesses, sexually transmitted diseases, physical manifestations of stress, dental and skin problems, traumatic injuries, and congenital malformations.[2,4,5] It has been estimated that 15–23% of children entering juvenile justice facilities suffer from mental health problems.[2] For example, approximately 20% of juveniles in correctional facilities currently meet—or have met in the past—diagnostic criteria for major depression, and 63% used drugs regularly before their incarceration. Substantial numbers of detained delinquents are neglected, abused, emotionally disturbed, or mentally retarded.[3,6] Researchers have correlated physical and sexual abuse with delinquent behavior and the use of illicit substances.[7]

It has been estimated that 15–23% of children entering juvenile justice facilities suffer from mental health problems.... Many... suffer additional health and mental health problems as a consequence of incarceration itself.

Many children suffer additional health and mental health problems as a consequence of incarceration itself.[4,5,8] Children in custody experience substantially higher rates of trauma than do nonincarcerated adolescents, including injuries from fights, suicide attempts, accidental self-harm, sports, horseplay, and vocational activities.[8] Unfortunately, confined children may be unable to obtain appropriate medical treatment when they are ill or injured.[2] Thus, delinquent children enter detention with serious health needs that may become greater during confinement.

Legal and Professional Standards on Health Care Funding

Incarcerated children are legally entitled to adequate medical, dental, and mental health care. Institutions failing to provide these services may face lawsuits brought by clients seeking damages or demanding compliance with constitutional and statutory requirements.[9,10] Professional associations in both the medical and correctional fields prescribe standards of health care for confined children.[11–15] However, while a growing body of work provides health care standards for children in custody, there is precious little guidance on how to pay for it. Most published legal cases address funding indirectly, if at all, in measuring adequacy of health care against constitutionally required standards of care.[16]

Of the major standards groups, only the Child Welfare League of America (CWLA), in *Standards for Health Care Services for Children in Out-Of-Home Care*, specifically addresses sources for financing of health care.

Of the major standards groups, only the Child Welfare League of America (CWLA), in *Standards for Health Care Services for Children in Out-Of-Home Care,*[14] specifically addresses sources for financing of health care. These standards govern children in foster care or other nonsecure placement. Several of the CWLA

standards call for collecting eligibility information and maximizing the use of services covered under the state Title XIX (Medicaid) program; Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs; Title V (of the Elementary and Secondary Act) programs; the Vocational Rehabilitation Act; and other funding programs.

Current Practice in Financing Health Services for Children in Custody

The dearth of literature on health care programs in juvenile delinquency systems has been described as appalling.[3,17] The pioneering American Medical Association standards for health care in juvenile facilities, published in 1979, were written without an extensive study of prevailing practice. In 1983, the National Commission on Correctional Health Care undertook such a study, with the goal of developing an accreditation program for health services in juvenile institutions, based on actual practice and objectively identified needs.[18] The survey responses from 215 short-term and long-term public juvenile custody facilities provided the first major examination of health service delivery, including sick call, screening, follow-up treatment, and dental services.[18]

▶ Given the paucity of research on health care delivery, it should come as no surprise that even less has been written on the financing of health programs in juvenile facilities.

Given the paucity of research on health care delivery, it should come as no surprise that even less has been written on the financing of health programs in juvenile facilities. An unpublished survey conducted for the House Select Committee on Children, Families and Youth found that a majority of states rely solely upon state revenues for funding health care of juvenile delinquents; six states use a combination of state and federal money; and two states rely solely on county money. Only nine states reported using state or federal Medicaid funds for children in the juvenile justice system. The survey also found that many juvenile facilities have no separate health care budget, so that requests for health services compete with requests for new beds or water heaters.[19]

A study of 20 short-term regional detention centers in Georgia provides a rare snapshot of the interplay between funding and delivery of health care services.[20] The study determined that there was no standard budget allotment for medical expenses in the juvenile detention centers. In contrast, the adult correctional system allotted 10% of its budget for medical care, averag-

ing $1,600 per inmate per year. The study noted that several other states budgeted $1,500 to $2,000 per juvenile inmate for health services.[20]

Most of Georgia's regional detention centers had the funds to contract with private physicians for physical examinations and sick call. However, hospitalization, even for reasonably common occurrences such as broken bones, appendicitis, complications of pregnancy, or diabetes, were "unplanned expenses" that created chaos in the operating budget. Money for prescriptions and emergency room visits came out of general operating accounts. Policy required parents to pay for the health care of preadjudicated youth and for emergency and elective health care of postdisposition youth, but the actual collection rate was less than 5%.[20]

Funding constraints had an even more direct impact upon the availability of onsite care. Although statewide policy called for 24-hour medical coverage, most of the institutions did not even have a person designated to arrange for such coverage. There was evidence that some youth who became ill or sustained injuries were simply discharged to their parents or guardians.[20]

There has been no comprehensive study of health expenditures in juvenile correctional institutions. In contrast, a 1990 National Commission on Correctional Health Care survey provides cost data on medical, dental, and mental health services for adult prisoners.[21] The cost data includes staffing, specialty care, hospitalization, equipment, supplies, pharmaceuticals, emergency transport, renovations and repairs, and other overhead, but excludes new construction. The annual health expenditure per inmate per year varied from $787 in South Dakota to $3,381 in Alaska, with an average of $1,906 and a median of $1,665.[21] The percentage of correctional expenditures devoted to health ranged from a low of 2.8% in South Dakota to a high of 18.9% in Texas.[21] According to the survey, 4 states decreased their inmate health spending in the 1980s, and 27 increased spending substantially above the rate of inflation. The surveyor believed the increases to reflect a real expansion in staff and services. Texas showed the most dramatic increase in its health expenditures, at time intervals closely parallel to the appointment of a special master for health services in class action litigation (*Ruiz v. Estelle*, 503 F.Supp. 1265 [S.D. Tex.

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There has been no comprehensive study of health expenditures in juvenile correctional institutions. In contrast, a 1990...survey provides cost data on medical, dental, and mental health services for adult prisoners.

comparative data [have] not yet been compiled for juvenile facilities.

1980]) over unconstitutional conditions of confinement in the Texas prison system.[21]

This type of comparative data has not yet been compiled for juvenile facilities. Few juvenile facilities perform any sort of rigorous cost analysis or comprehensive planning for health care needs. Health care, for most facilities confining delinquent children, is treated like any other budget item. The remainder of this chapter will explore funding options and related policy considerations for expanding health care for delinquent children in custody.

The Medicaid Limitations on Institutional Health Care

The Medicaid Program

Medicaid is a program of medical assistance for the poor established by Title XIX of the federal Social Security Act.[22] Under the program, the federal government helps states pay providers for Medicaid services through a matching formula ranging from 50% to 83% that inversely reflects the state's per capita income.[23] Despite chronic complaints from all quarters that Medicaid does not cover needed services, does not sufficiently reimburse providers, and suffers from unbearable paperwork requirements, it remains the most significant public health program available to low-income children.

▶ Despite chronic complaints from all quarters... Medicaid... remains the most significant public health program [for] low-income children.

The importance of Medicaid has increased in recent years because its inclusion of the Early and Periodic Screening, Diagnosis, and Treatment program now entitles Medicaid-eligible children to comprehensive and periodic assessment of health, developmental, and nutritional status, plus diagnosis and treatment of conditions found during assessment.[24] In the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Congress substantially strengthened the EPSDT program by amendments requiring states to provide children with any federally reimbursable, "medically necessary" services needed to treat mental or physical illnesses discovered through an EPSDT screen, whether or not those services would have been covered under the state Medicaid plan.[25,26]

Eligibility for federal Medicaid reimbursement requires children to be dependents in families receiving public assistance (e.g., Aid to Families With Dependent Children [AFDC]); families that have incurred high medical expenses; families who receive

Supplemental Security Income (SSI) for the disabled; families with pregnant women, postpartum women, or children under six years of age, and under 133% of the federal poverty level; or foster families receiving payments under Title IV-E of the Social Security Act.[23] Recent Medicaid amendments call for expanded eligibility for children below the federal poverty level, with successive age groups to be phased in over the next decade.[27] Many detained children fall within at least one area of eligibility.

Medicaid for Delinquent Children in Custody

Ironically, a low-income child who receives health care through Medicaid may lose Medicaid eligibility upon entering institutional custody, even though the child is ostensibly confined for his or her own benefit. The Code of Federal Regulations provides that federal financial participation in expenditures for services is not available to "individuals who are inmates of public institutions as defined in § 435.1009."[28] But, while the federal regulations exclude some institutionalized individuals from eligibility, several categories of children in custody clearly do *not* fall within the exclusions. The definitions in 42 C.F.R. § 435.1009 include several important exceptions to the "inmate exclusion."

Children in Nonsecure Confinement

Children confined in child care institutions as defined in 42 C.F.R. § 435.1009 are not excluded from Medicaid eligibility. Also, § 435.1009 specifically states that children for whom foster care maintenance payments are made under Title IV-E, and children receiving AFDC foster care under Title IV-A, are not within the "inmate exclusion."[29,30]

Delinquent children in nonsecure placement are therefore in roughly the same position as children placed as a result of abuse or neglect. They may qualify for Medicaid in a number of ways. They may be eligible for Medicaid by linkage with AFDC, through Title IV-E foster care funds, through meeting the requirements for being "medically needy" under their state's definition, or through meeting the requirements for some other "categorically needy" qualification.[31] Thus, many delinquent children placed in nonsecure group homes, foster homes, or other residential treatment facilities may be Medicaid eligible and entitled to the benefits of the EPSDT program. In fact, a

◀ Delinquent children in nonsecure placement.... may qualify for Medicaid.... [through] AFDC... Title IV-E foster care funds... meeting... requirements for being "medically needy" under their state's definition, or... some other "categorically needy" qualification.

1985 study of health services for California children in foster care found that Medicaid was the primary source of financing.[32]

Children in Secure Confinement

Even though the exclusion for inmates of public institutions is commonly interpreted as precluding Medicaid eligibility for all children in secure detention, closer scrutiny reveals that the exclusion is not total. For example, the exclusion does not apply if the individual is "in a public institution for a temporary period pending other arrangements appropriate to his needs."[29] This leaves open the possibility of Medicaid eligibility for postdisposition children in secure institutions who will ultimately be placed in nonsecure facilities such as group homes or foster care. In California, for example, postadjudicated minors detained pending "suitable placement" in nonsecure facilities, are considered eligible for EPSDT services.[33] The "temporary placement" exemption to the Medicaid exclusion also suggests eligibility for preadjudication children, since they are "temporarily" detained pending disposition of their case. Because of this exemption, preadjudicated detained minors in Washington State are considered eligible for EPSDT.[33]

▶ [Even for] children in secure detention...[Medicaid] exclusion is not total.

Further, regulations appear to leave open the possibility of Medicaid eligibility for children confined in some private institutions or other facilities. At least one case has concluded that group homes for developmentally disabled persons, administered by a private not-for-profit corporation organized under Indiana law but not administered by any governmental unit, are not public institutions for purposes of the Medicaid restrictions.[34] Thus, despite an awesome maze of definitions, federal regulations leave room for Medicaid eligibility of at least some groups of confined delinquent children.[35]

Systemic Accommodations Allowing Medicaid

A number of juvenile agencies have found ways to successfully qualify detained children for Medicaid. One of the most interesting developments has occurred in Massachusetts, in conjunction with the commonwealth's efforts to deinstitutionalize its delinquency system. Since 1986, the Department of Public Welfare, the agency operating the state Medicaid program, has considered all Department of Youth Services youth eligible for Medicaid, regardless of whether they are in secure confinement.[35]

Since 1986, the [Massachusetts] Department of Public Welfare... has considered all Department of Youth Services youth eligible for Medicaid.

The Department of Public Welfare continues to track eligibility for federal reimbursement and absorbs all costs for youth whose placement in state-operated facilities or whose family income levels would otherwise exclude them from federal reimbursement. The Department of Youth Services seeks private insurance information from parents; completes Medicaid applications for every youth; cooperates with the Department of Public Welfare in placing Medicaid recipients in managed care plans; and cooperates in auditing of the system.[35] By using state Medicaid funds to pay for youth who are eligible for federal reimbursement, the state has cut the cost of health care by 50%. Moreover, by using state Medicaid dollars to buy health care for youth ineligible for federal reimbursement, the state ends up paying less—Medicaid pays lower prices for services than what hospitals, labs, or providers would charge the Department of Youth Services. Consequently, although the cost to the Department of Public Welfare has increased, the net cost to the state has decreased.[35]

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The universal Medicaid coverage in Massachusetts represents official recognition that the delinquent children placed through the Department of Youth Services are just as disadvantaged as those placed through dependency proceedings, and that the state has similar responsibilities to each population. There has been strong support for this financing scheme from the Department of Public Welfare, particularly the department's EPSDT program staff. They believe that delinquents are mostly low-income youth who suffer from high sexually transmitted disease and pregnancy rates and are generally at higher risk for health problems than nondelinquent adolescents. It makes sense, both from economic and public policy perspectives, to provide this population with comprehensive health care.[35]

Medicaid regulations permit states to cover persons who, but for their institutional status, would qualify for the program.[36] Also, Section 2176 of the Omnibus Budget Reconciliation Act of 1981 permits states to provide Medicaid through a "waiver" system to individuals who would otherwise be at risk for institutionalization or who are already in institutions and need the services to be able to return to the community.[16,37] Vermont's waiver program, for example, targets emotionally disturbed children in group residential treatment, specialized foster care, staffed apartments, and home-based services.[38]

The Call for Medicaid Expansion

Medical professionals have long acknowledged the absurdity of the Medicaid restrictions for institutionalized youth: "There are federal funds for fighting crime—why not expend them for medical rehabilitation?"[39] Certainly, it makes little sense that a child who is Medicaid eligible (through AFDC or income eligibility criteria) prior to coming into the juvenile justice system may lose that eligibility when the state assumes wardship, supposedly in "the best interest of the child."

Several major policy decisions have called for Medicaid expansion to cover all detained children. "Option 1," presented to Congress in the 1991 Office of Technology Assessment report on adolescent health, was to improve delinquents' access to health care by changing federal regulations so that adolescents in correctional facilities would be eligible for Medicaid.[40] Similarly, the American Medical Association Council on Scientific Affairs has stated:[4]

> The American Medical Association should request Congress to instruct the Department of Health and Human Services to (1) study the issue of funding for health services within juvenile correctional facilities and (2) make recommendations to the Congress regarding such funding, including the role of Medicaid in financing such services.

▶ Policy recommendations . . . note that "regular Medicaid and EPSDT funds could be utilized to assure a broader range of services for these children."

Policy recommendations growing out of recent Maternal and Child Health Bureau (MCHB) conferences have also included the necessity for modification of Medicaid funding policy to permit reimbursement for youth confined in juvenile justice institutions. The recommendations note that "regular Medicaid and EPSDT funds could be utilized to assure a broader range of services for these children."[41]

Advocates have also voiced the need for other Medicaid improvements for children placed out of home, including expanding mental health services, redesigning reimbursement procedures, creating alternative delivery mechanisms (e.g., requiring full EPSDT evaluations within 30 days of court findings), fast-tracking Medicaid applications, developing a special benefit package for Title IV-E children based on EPSDT guidelines, and expanding benefit coverage for drugs, orthodontia, and optometry services. It has also been suggested that Medicaid

waivers be used to create prepaid case-managed systems of care with expanded benefit packages and extended eligibility for foster children.[32]

Funding Opportunities

Health care financing for children in custody need not be relegated to the annual round of institutional budget proposals, to be approved or denied as political tides ebb and flow. Apart from Medicaid, an abundant group of funding sources exist, even in lean fiscal times. Funds may be available from local, state (including statutory children's health programs and other special drug/tobacco/alcohol prevention funds), and federal sources (including Title V, Title XIX, and Supplemental Security Income); hospital and/or medical school services; and charitable groups.[33,42] Existing resources may be stretched further by pooling funds from different agencies.[41] In some systems, seeking reimbursement from private insurance held by the child's parents, or purchase of private insurance for confined children, may be worthwhile. Ongoing services for specialized medical services (e.g., tattoo removal) may be arranged through limited grant applications, contributions from charitable groups, or volunteer physicians. Arrangements with medical schools and community health agencies may result in mutually advantageous programs for confined youth. The possibilities for both public and private funding are tremendous.

◀ Apart from Medicaid, an abundant group of funding sources exist, even in lean fiscal times.

The following is a brief catalogue of public funding sources to be examined as potential resources for providing health care to delinquent children in custody. Some of this money is targeted toward individual children; other funds support broad institutional programs. Some of the funds may be accessible to juvenile facilities only indirectly through contract or interagency agreement with grantees or agencies directly receiving the funds. Some of the sources place restrictions upon eligibility or the type of facilities that may receive funds, but advocates are encouraged to closely scrutinize regulations for ways in which to maximize eligibility and services.

Special Education Funds

A substantial proportion of detained youth are eligible for funding under the Individuals with Disabilities Education Act (IDEA)[43] and its state analogs. Under the federal statutory

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scheme, educationally handicapped children are entitled to a free, appropriate, public education up to age 22, in conformity with an individualized education plan (IEP), regardless of institutional status.[44] Failure to provide special education services to incarcerated youth has resulted in litigation in a number of states.[16]

Under IDEA, children may be eligible for special education funds for mental retardation, hearing impairments, speech or language impairments, visual impairments, serious emotional disturbance, orthopedic impairments, or specific learning disabilities affecting their ability to benefit from educational programs.[45] Once eligibility is established, the IEP developed for the child may include a broad range of instructional and related services, including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities, counseling, and medical services for diagnostic or evaluation purposes. Related services may also include school health services, social work services in schools, and parental counseling and training. Residential treatment found necessary for implementation of the IEP must also be provided, at no cost to the child's parents.[46,47]

▶ But as a practical matter, many necessary education-related services overlap with medical services needed by the child.

Special education funds are not directly available as medical services—42 U.S.C.A. § 1396b(c) (West 1992).[48] But as a practical matter, many necessary education-related services overlap with medical services needed by the child. This is particularly true when the child's educational handicap stems from a physical source such as impaired vision or hearing, or orthopedic problems. Other areas of overlap may occur when the child's educational handicap is a serious emotional problem requiring mental health treatment. Medicaid law specifically permits reimbursement for covered services furnished to a child when the services are required by the child's IEP.[48]

In addition, the federal Chapter I Programs for Neglected and Delinquent Children provide grants to state education agencies to meet the special education needs of children in institutions for delinquents.

Special education eligibility triggers a significant set of due process protections[49] designed to ensure that the child will continue to receive appropriate services in the least restrictive appropriate setting,[50] with full reevaluations every three years or more often if conditions warrant it.[51] These protections make IDEA a particularly attractive health resource for eligible children.

In addition, the federal Chapter I Programs for Neglected and Delinquent Children[52] provide grants to state education agencies to meet the special education needs of children in institutions for

delinquents. These funds are not tied to a particular child. They are appropriated to the education agency based on a statutory formula, to meet the special education needs of educationally deprived children through supplemental education programs.[53] Use of Chapter 1 funds is more limited than under the IDEA, but includes purchase of equipment for special education purposes, employment of special education personnel and school counselors, and a catchall "other expenditures authorized under this section."[54] Thus, a facility that provides health services coinciding with permissible uses for Chapter 1 funds (e.g., mental health or physical therapy programs offered through the institutional school) may be able to take advantage of this additional funding source.

Maternal and Child Health Grants (Title V)

Block grants through state maternal and child health (MCH) programs[55]—sometimes referred to as "Title V" programs—may provide at least some funding for services for institutionalized children. The purpose of maternal and child health grants is to (1) assure access to quality maternal and child health services for low-income persons who live in areas with limited availability of health services, (2) increase the number of adolescents in low-income families who receive health assessments and follow-up diagnostic and treatment services, (3) promote the health of mothers and children, and (4) encourage collaboration and coordination with other agencies to promote health and access to care.[3,56] Thus, MCH block grants provide some funding for direct service programs, including programs for pregnant and parenting adolescents, comprehensive evaluation programs for adolescents with developmental disorders, and nutrition programs.[3] MCH funding is also available through grants for special projects of regional and national significance (SPRANS) that contribute to maternal, infant, and child health.[2,57]

◀ MCH block grants provide some funding for direct service programs.

The Maternal and Child Health Bureau has expressed specific concern for the health care needs of detained delinquents. From 1988 to 1991, MCHB collaborated with the School of Hygiene and Public Health at Johns Hopkins University to present a series of conferences on health care issues related to children in the juvenile justice system.[58] Participants in the conferences called for increased involvement of state MCH programs in health care for delinquents, use of MCH special program

funds for delinquents, and increased collaboration with juvenile justice agencies.[59,60]

The Maternal and Child Health Bureau has a clear interest in juvenile justice health care issues. Institutions may be able to receive maternal and child health money by applying for funding of specific health services through their county maternal and child health programs, or through agreement with other agencies designated to receive maternal and child health grants.

Supplemental Security Income

The Supplemental Security Income program[61] provides cash payments to disabled children, and in most states receipt of SSI funds automatically qualifies children for Medicaid.[31] Residents or inmates of public institutions are not eligible to receive SSI.[62] However, the inmate exclusion does not apply to individuals in a number of different situations, including those confined in various kinds of medical or psychiatric facilities, or in publicly operated community residences housing fewer than 16 people. Also, the exclusion does not apply to persons who were eligible during a prior month or to certain persons institutionalized for less than three months.[63] Therefore, many children in group care or foster homes may qualify for SSI.[31]

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As a result of the Supreme Court's decision in *Sullivan v. Zebley*,[64] the Social Security Administration has published rules substantially broadening children's eligibility for SSI. Children are eligible if (1) they have one of the conditions on the list of impairments developed by the Social Security Administration; (2) their impairment is "functionally equivalent" to a listed illness or condition; or (3) they can prove disability through an "individualized functional assessment," showing that the disability impairs development or makes it harder to engage in age-appropriate daily activities. Older adolescents (ages 16–18) must show impairments that substantially reduce their ability to acquire skills needed to assume roles reasonably expected of adults.[65,66] Thus, children with physical disabilities, developmental disabilities, fetal alcohol syndrome, and emotional disturbance may qualify for SSI.[26]

It may be worthwhile for children to apply for SSI even if they meet Medicaid eligibility requirements through [another] factor.

It may be worthwhile for children to apply for SSI even if they meet Medicaid eligibility requirements through some other factor. The individualized assessment itself might confirm significant health problems and thus may have some impact on long-

term appropriate placement. Also, SSI results in monthly payments made to the child's representative payee, and this money will be available to meet the child's special needs. This may be of particular importance for disabled children leaving custodial status who need basic income for health care, supportive services, or assistance to caretaker relatives.

Funding for Specific Health Services

Pregnancy and parenting

Family planning funds for a broad range of contraception, pregnancy testing, and prenatal services are awarded under Title X of the Public Health Service Act.[67] Most of the money supports the work of several thousand private nonprofit family planning clinics around the country. Title XX of the Public Health Service Act, the Adolescent Family Life Act, provides grants to public agencies and private, nonprofit organizations for services to pregnant adolescents and adolescent parents, and for adolescent pregnancy prevention based on encouraging abstinence from sexual activity.[3,68] In seeking access to Title X and Title XX funds, advocates should realize that substantial restrictions are placed upon the use of funds for abortion and abortion counseling (*Rust v. Sullivan*),[69] and that legislative debate on the extent of those restrictions continues.[2] Probably the best way to access these funds is through affiliation with clinics or facilities directly receiving funds.

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Acquired immune deficiency syndrome (AIDS) funds

A significant proportion of young adults carrying the human immunodeficiency virus (HIV) were infected during adolescence; intravenous drug use and unprotected sexual behavior place many detained children at risk for HIV infection.[70] Treatment for HIV infection is quite expensive, and most detained children are either uninsured or underinsured to cover the costs of treatment. Several funding mechanisms have been set up for financing treatment of HIV-positive individuals. Federal funding is available for the cost of zidovudine (AZT), and treatment is available through federal AIDS demonstration projects and Medicaid.[70] Moreover, with the passage of the Ryan White Care Act of 1990, additional federal funding will be available both to states and to public and private nonprofit entities for a continuum of services for those with HIV disease.[71,72] States vary in the extent to which their Medicaid programs provide

◀ **Federal funding is available for the cost of zidovudine (AZT), and treatment is available through federal AIDS demonstration projects and Medicaid.**

Some states have obtained waivers from the federal government so that they can offer broader services to AIDS patients than are generally available under their state Medicaid programs.

coverage for drugs, mental health services, and nurse practitioner services related to treatment for HIV infection and AIDS. Some states have obtained waivers from the federal government so that they can offer broader services to AIDS patients than are generally available under their state Medicaid programs. The expansion of the EPSDT program under the 1989 amendments may require states to provide expanded coverage for treatment of HIV-positive youth. Treatment may also be available through other state-funded model or demonstration initiatives, or through clinical trials. For example, California Children's Services will pay for HIV diagnostic services regardless of income, and will pay for treatment of HIV-infected individuals meeting financial eligibility criteria. Some adolescents with HIV infection, including those who have been diagnosed with AIDS, are eligible for Supplemental Security Income and thus for Medicaid.[70] Juvenile facilities may be able to access at least some of these funds.

Mental health and substance abuse funding

Many of the public programs discussed in this chapter cover at least some mental health or substance abuse services. Although a major complaint about Medicaid has been the restrictive coverage of mental health services, the EPSDT program may offer an opportunity for expanded services. EPSDT requires the state to provide follow-up, referral, and treatment for federally reimburseable conditions discovered during screening, whether or not the services are covered under the state plan.[2] Regulations have specified that states may cover substance abuse treatment through existing Medicaid programs such as inpatient psychiatric care, rehabilitative services, and clinic services.[31] States may also provide Medicaid for children under age 21 in inpatient psychiatric hospitals.[73]

Although a major complaint about Medicaid has been the restrictive coverage of mental health services, the EPSDT program may offer an opportunity for expanded services.

Children with mental health problems may qualify for special education funds through the Individuals with Disabilities Education Act. For example, the IDEA provides eligibility for children who are seriously emotionally disturbed (SED). Federal regulations define SED as a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, adversely affecting educational performance:

1. An inability to learn which cannot be explained by intellectual, sensory, or health factors;

2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
3. Inappropriate types of behavior or feelings under normal circumstances;
4. A general pervasive mood of unhappiness or depression; and
5. A tendency to develop physical symptoms or fears associated with personal or school problems.

The regulations specifically include children who are schizophrenic within the SED definition, but exclude children who are simply "socially maladjusted."[74] The 1990 amendments to the IDEA created a special program "to establish projects for the purpose of improving special education and related services to children and youth with serious emotional disturbance." The program also provides for grants to education agencies, in collaboration with mental health entities, to provide services to SED children.[2,75] Many detained juveniles meet the statutory definition for SED and may need mental health services to help them benefit from their educational programs.

The Alcohol, Drug Abuse, and Mental Health Block Grants[76] provide funds for prevention, treatment, and rehabilitation services for individuals with substance abuse and mental health problems. These services include the assessment and treatment of severely mentally disturbed children. Funding goes primarily to community mental health centers and may be used only for outpatient services. As a result, these funds are helpful mainly for children in nonsecure shelters and in group or foster care homes.[2]

◀ **The Alcohol, Drug Abuse, and Mental Health Block Grants provide funds for prevention, treatment, and rehabilitation services for individuals with substance abuse and mental health problems.**

In addition to federal programs, a growing number of private and public community mental health and substance abuse programs may be accessible to children confined in the juvenile justice system.[77] Through the use of outpatient services for children in nonsecure custody, or through arrangements for treatment to be provided to detained children at their institutions, these programs can vastly expand mental health and substance abuse treatment resources.

Affiliations with Medical Schools or Public Agencies as a Funding Tool

The administrative structure of institutional health care departments may have a dramatic impact upon the availability

Affiliations with medical schools and training hospitals, for example, offer a rich source of medical expertise, as well as indirect access to other funding sources.

of certain kinds of grants, staff, supplies, and services. Affiliations with medical schools and training hospitals, for example, offer a rich source of medical expertise, as well as indirect access to other funding sources.[78-81] Many city-based juvenile halls have been able to contract with medical schools, nursing schools, and residency training programs to recruit low-cost, high-quality professionals who enjoy working with incarcerated youth.[33]

In Los Angeles County, the Juvenile Court Health Services Division provides health care to incarcerated children under the auspices of the Department of Health Services. Physicians within the division are faculty members at the University of Southern California or at the University of California at Los Angeles School of Medicine. A primary benefit of this administrative structure is that it gives the Juvenile Court Health Services Division direct access to county hospitals and public health clinics. A second benefit is that the arrangement allows the program to receive funds from block grants given by the state to the Department of Health Services.[82]

If the institution does not formally affiliate with hospitals, medical schools, or community health agencies, informed budgeting may best be accomplished by vesting medical professionals with administrative authority for the correctional health system.[11,12] To maximize reimbursement from programs outside the institution, someone in the medical department should be familiar with the intricacies of Medicaid, private insurance, and other health care funding. One way to overcome Medicaid reimbursement bureaucracy is to employ a Medicaid eligibility worker to help children and families determine eligibility and to secure parental releases.[83] Medical professionals may creatively access and use cost-effective contracts for supportive services such as mobile X-ray and lab units, rather than maintaining onsite laboratories.[33]

This is not to say that an abundance of funding is available for every institutional health service. The limitations of funding for adolescent health care are only too well known to practitioners in the field.[84] But few facilities serving juvenile delinquents have begun to explore options beyond their institutional budgets. Thus, a great deal of financial improvement may be realized even within the constraints of the greater health financing system.

Policy Issues

These suggestions for expanded funding assume that adequate funding directly affects quality of care. The purpose of

accessing additional health care funds would be subverted if institutions used them to supplant existing budgetary allocations without improving services.

The purpose of accessing additional health care funds would be subverted if institutions used them to supplant existing budgetary allocations without improving services.

A potentially troubling question is whether increased funding may result in the inappropriate secure placement of delinquent children with chronic illness and other serious or long-term health or mental health problems. However, it is not at all clear that judges make dispositional decisions based on the availability of health care. Also, the legal duty to provide comprehensive care, bolstered by the availability of Medicaid and other funding, might encourage systems *not* to keep children in secure institutional care.

While improved financing may be used to upgrade institutional health care, it may also serve as a much-needed instrument of deinstitutionalization. For children with chronic illness or serious physical or emotional handicaps, health care should be a central component of dispositional planning. It makes little sense to relegate children to institutional settings ill-equipped to meet their health needs. The practical effect of such placement is often physical and programmatic isolation from the general institutional population.

◀

improved financing . . . may also serve as a much-needed instrument of deinstitutionalization.

Moreover, while living arrangements do not always determine the services an individual receives, they may be a primary determinant in shaping access to services. By analogy, funding through Medicaid (and special waivers), special education laws, Supplemental Security Income, Social Security Disability Insurance, and the Medicaid home- and community-based waiver program have had a dramatic effect on the ability of many developmentally disabled persons to live in the community or in small community facilities.[85] The availability of money for early and comprehensive health screening of delinquent children through EPSDT, special education assessments, or SSI individualized evaluations might well establish the necessity for placement in a setting more appropriate to the child's mental and physical needs than a secure facility.

Health care for confined children is an integral part of overall rehabilitation.[2,39,86] Scouting for health dollars for this population demands tenacity, attention to detail, and a sense of adventure. But the potential rewards are great, and we cannot afford the price of failure.

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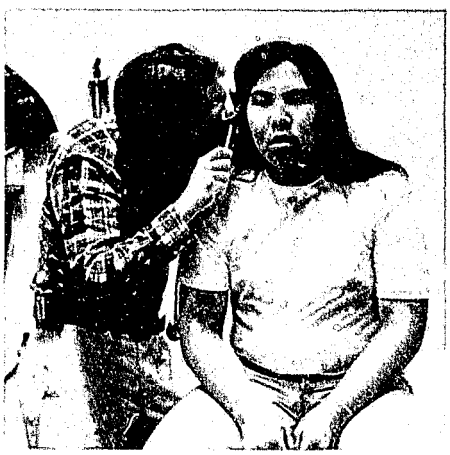
Glossary



acquired immune deficiency syndrome (AIDS): A disorder caused by the human immunodeficiency virus (HIV), resulting in compromise to the immune system and opportunistic infections. Incarcerated youth are at greater risk for acquiring HIV because of their increased drug use and multiple sexual partners.

acute illness: A problem or disease of limited duration, as opposed to *chronic illness*. According to the National Center for Health Statistics, a condition is considered acute if (1) it was first noticed no more than three months before the reference date of the interview; and (2) it is not one of the conditions considered chronic regardless of the time of onset. However, any acute condition not associated with either at least one doctor's visit or one day of restricted activity is considered to be of minor consequence and is excluded from the final data in the National Center for Health Statistics' National Health Interview Survey.

adjudicate: To hear and settle a case by judicial procedure.

adolescence: Definitions of adolescence vary, and many observers agree that a definition based on age alone is not sufficient. Adolescence typically takes place during the second decade of life and is initiated by puberty, although physical and other changes occur (e.g., in height, weight, head size, facial structure, facial expression, and cognitive ability). Adolescence most often refers to the period of life from ages 10 to 18. See also *early adolescence, middle adolescence,* and *late adolescence.*

aggravated assault: See *assault.*

antisocial personality disorder: One of many disorders of personality beginning in childhood or early adolescence and continuing into adulthood. Characterized by patterns of irresponsible antisocial behavior such as lying, stealing, or truancy.

arrest rate: The number of arrests made in a given population per some population base during a given time period.

assault: Unlawful intentional inflicting, or attempted inflicting, of injury upon the person of another. Simple assault is the unlawful intentional inflicting of less than serious bodily injury without a deadly or dangerous weapon. Aggravated assault is the unlawful

intentional inflicting of serious bodily injury or death by means of a deadly or dangerous weapon with or without actual infliction of injury.

attention deficit disorder: Disorder of attention and cognition, usually based on minimal brain dysfunction manifested as a learning disability.

bipolar depression: Depression pertaining to two poles (e.g., manic depression).

burglary: Unlawful entry or attempted entry of any fixed structure, vehicle, or vessel used for regular residence, industry, or business, with or without force, with intent to commit a felony or larceny.

case law: The body of law created by judicial opinions rendered in legal cases in contrast to statutory law generated by legislatures.

choreiform movements: The ceaseless occurrence of a wide variety of rapid, highly complex, jerky movements that appear to be well coordinated but are performed involuntarily.

chronic illness: A problem or disease that is lingering and lasting, as opposed to *acute illness*. For the purposes of the National Center for Health Statistics' National Health Interview Survey, a condition is considered chronic if (1) the respondent indicates that the condition was first noticed more than three months before the reference date of the interview and it exists at the time of the interview; and (2) it is a type of condition that ordinarily has a duration of more than three months. Examples of conditions that are considered chronic regardless of their time of onset are diabetes, heart conditions, emphysema, and arthritis.

conduct disorder: A mental disorder diagnosed on the basis of a pattern of behavior, lasting at least six months, in which a young person violates others' rights as well as age-appropriate social norms and displays at least 3 of 13 specified behavioral symptoms (e.g., truancy, lying, stealing, and fighting).

correctional facility: See *juvenile justice facility.*

custody: The state of being kept under guard.

delinquent behavior: Delinquent behavior includes two types of acts: (1) Acts committed by minors that would be considered crimes if committed by an adult, and (2) status offenses (i.e., acts that are offenses solely because they are committed by a juvenile, such as running away from home and truancy).

depressive neurosis: See *dysthymic disorder.*

detention: The placement of a youth in a restrictive facility between referral to court intake and case disposition.

disposition: A tendency toward certain physical or mental diseases.

dual diagnosis: The occurrence of two psychiatric diagnoses in the same youth (e.g., both chemical dependency and depression).

dysfunctional family: A family that is impaired, disturbed, or abnormal in functioning.

dyslexia: Impairment of the ability to read.

dysmorphic features: The condition of appearing under different morphologic forms.

dysthymic disorder: Another term for *depressive neurosis*, a chronic disturbance of mood involving depression or irritability in children or adolescents.

early adolescence: A period encompassing the profound physical and social changes that occur with puberty, as maturation begins and social interactions become increasingly focused on sex (e.g., on members of the opposite sex). Typically takes place from ages 10 through 13.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program: A federally funded Medicaid program that provides for early screening, diagnosis, and treat-

ment. This program improves the access of children and adolescents to comprehensive medical care as well as specialty services.

felony: Any of several crimes such as murder, rape, or burglary, considered more serious than a misdemeanor and punishable by a more stringent sentence.

foster care: See *social services.*

gender identity: Sexual orientation.

habilitation: Reasonable care and safety. See also *rehabilitation.*

homelessness: The state of being without one's own home—either on one's own or with one's family—and living on the street or in a shelter or other temporary situation (e.g., with relatives or friends). See also *runaway* and *throwaway.*

human immunodeficiency virus (HIV): The virus that causes AIDS. See also *acquired immune deficiency syndrome.*

hyperactivity: Abnormally increased activity. Developmental hyperactivity of children is characterized by constant motion (e.g., exploring, experimenting) and is usually accompanied by distractibility and low tolerance for frustration.

impulsivity: Poor control of immediate behavior.

incarcerate: To put in jail.

injunction: A court order enjoining or prohibiting a party from taking a specific course of action.

institution: An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. See also *public institution.*

jail: A place for confinement of persons in lawful detention.

juvenile delinquent: A juvenile who has committed an act that would be a crime if committed by an adult.

juvenile justice facility: Juvenile justice facilities include (1) juvenile correctional facilities (facilities that hold juveniles after adjudication for long-term commitment or placement for supervision and treatment); and (2) juvenile detention facilities (facilities that are usually called juvenile detention centers or juvenile halls, and hold juveniles pending adjudication or after adjudication and awaiting disposition or placement). Both juvenile correction and juvenile detention facilities can be public (i.e., under the direct administrative and operational control of a state or local government and staffed by governmental employees) or private (i.e., either profit making or nonprofit and subject to governmental licensing but under the direct administrative and operational control of private enterprise). Private facilities may receive substantial public funding in addition to support from private sources.

juvenile justice system: The juvenile justice system includes law enforcement officers and others who refer delinquent and maltreated juveniles to the courts, juvenile courts that apply sanctions for delinquent offenses and oversee the execution of child protective services, juvenile detention and correctional facilities, and, less frequently, agencies that provide protective services and care (e.g., foster care) for juvenile victims of abuse and neglect. The latter agencies intersect with the child welfare or social services system.

larceny: Unlawful taking or attempted taking of property (other than a motor vehicle) from the possession of another, by stealth, without force and without deceit, with intent to permanently deprive the owner of the property. It includes shoplifting and purse-snatching without force.

late adolescence: The developmental period most often occurring from ages 18 to 21 years. This period is marked by concern about academic and vocational plans and requirements for self-sufficiency.

learning disturbance: A group of cognitive impairments that affect ability to learn reading, arithmetic, spelling, and writing skills. Commonly found in children with attention deficit disorder.

middle adolescence: Typically a time of increasing independence. Generally takes place during the period from ages 14 through 17. For those adolescents who do not go on to (and remain in) college, age 17 or completion of high school marks the end of adolescence in social terms.

National Commission on Correctional Health Care: A commission that has developed standards for health services in juvenile detention and confinement facilities and is the accrediting organization for such facilities.

nosology: The branch of medicine that deals with the classification of diseases.

obsessive-compulsive disorder: A condition marked by the compulsion to repetitively perform certain acts or to carry out certain rituals.

parens patriae: Literally "parent of the country." Refers traditionally to the role of the state as sovereign and guardian of persons under legal disability (e.g., minors or adults who have been declared legally incompetent).

paraphilia: Aberrant sexual activity; sexual deviation; expression of the sexual instinct in practices that are socially prohibited or unacceptable, or biologically undesirable.

personal offenses: This category of offenses includes criminal homicide, forcible rape, robbery, aggravated assault, simple assault, and other crimes against persons. Criminal homicide is causing the death of another person without legal justification or excuse. Criminal homicide is a summary category, not a single offense. The term encompasses all homicides in which the perpetrator intentionally kills someone with legal justification or accidentally kills someone as a consequence of reckless or grossly negligent conduct. Forcible rape consists of sexual intercourse or attempted sexual intercourse with a female against her will by force or threat of force.

petitioned cases: Formally handled cases that appear on the official court calendar in response to the filing of a petition or other legal instrument requesting the court to adjudicate the youth a delinquent, status offender, or a dependent child, or to waive the youth to criminal court for processing as an adult.

placement out of home: Cases in which youth are placed in residential facilities that house delinquents or status offenders who have been removed from their homes.

plantar reflexes: Reflexes in the sole of the foot.

prison: A place where persons convicted of or accused of committing crimes are confined; a penitentiary or a jail.

prospective study: A study that looks to the future.

property offenses: According to the FBI, serious property offenses include burglary, larceny-theft, and arson. Minor property offenses include involvement with stolen property.

protective services: An aspect of social services designed to prevent neglect, abuse, and exploitation of children by reaching out with social services to stabilize family life (e.g., by strengthening parental ability to provide good child care). The provision of protective services follows a complaint or referral, frequently from a source outside the family, although the complaint may be initiated by the child as well.

psychotropic: Exerting an effect upon the mind; capable of modifying mental activity. Usually applied to drugs that affect the mental state.

puberty: The period of first becoming capable of reproducing sexually. Marked by maturing of the sexual organs, development of secondary sex characteristics (e.g., breasts, pubic hair), and, in humans and higher primates, the first occurrence of menstruation in the female.

public institution: An institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. See also *institution.*

rehabilitation: The restoration of normal form and function after injury or illness. See also *habilitation.*

retrospective study: A study that looks back to the past.

reward salience: The persistence of behavior in the face of many negative sanctions if intermittent reward is experienced.

robbery: Unlawful taking or attempted taking of property that is in the immediate possession of another by force or the threat of force.

runaway: A child or youth who leaves his or her primary residence to escape family conflict or abuse. See also *homelessness, throwaway,* and *street youth.*

secure facility: A facility that relies upon physically restrictive architecture or devices to keep residents from leaving (e.g., a detention center or training school).

shelter: Place of protection against the elements or danger.

sick call: A certain time of day when individuals suffering from illness or disease can be seen by a health care provider.

simple assault: See *assault.*

social services: Services provided in order to support the functioning of individuals or family units, including (1) supportive or protective services, (2) supplementary services (e.g., financial assistance, respite care, or home aid services), and (3) substitute services (e.g., shelter services, foster care, adoption).

status offense: An act that is illegal solely because it is committed by a juvenile (e.g., running away from home, school truancy).

statutory law: The body of law created by acts of legislature, in contrast to law generated by judicial opinions and administrative bodies.

stereognosis: The faculty of perceiving and understanding the form and nature of objects by the sense of touch.

street youth: A long-term runaway, throwaway, or otherwise homeless child or adolescent who has become adept at fending for himself or herself on the street, usually through illegal activities.

Tanner staging: A standard physical assessment scheme to evaluate sexual maturity of adolescents in puberty.

throwaway: A child or adolescent who has been told to leave the household, who has been abandoned or deserted, or who has run away with no efforts being made to recover him or her.

tort: A private or civil wrong or injury, other than breach of contract, for which the court will provide a remedy in the form of an action for damages. A tort may be (1) a direct invasion of some legal right of the individual, (2) the infraction of some public duty by which damage accrues to the individual, or (3) the violation of some private obligation by which special damage accrues to the individual. Three elements of every tort action are existence of legal duty from defendant to plaintiff, breach of duty, and damage as a proximate result.

tort law: The branch of law pertaining to torts.

training school: Locked and typically large congregate facilities where adjudicated delinquents are placed. Usually operated by the state, they are the most secure facilities for delinquent youth.

violent offenses: According to the FBI, serious violent offenses include murder and nonnegligent manslaughter, forcible rape, robbery, and aggravated assault. Minor violent offenses include assaults without weapons and weapons violations.

ward of the state: See *parens patriae.*

youth population at risk: For delinquency and status offense matters, this is the number of children from age 10 through the upper age of jurisdiction. In all states, the upper age of jurisdiction is defined by statute. In most states, individuals are considered adults when they reach their 18th birthdays. Therefore, for these states, the delinquency and status offense youth population at risk would equal the number of children who are 10 through 17 years of age and living within the geographical area served by the court.

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