National Center for Education in Maternal and Child Health

MCHB Maternal and Child Health Bureau

Health Care of Pregnant Incarcerated Women

Report from the 1991 Tri-Regional Workshops

148081

Health Care of Incarcerated Youth

Report From The 1991 Tri-Regional Workshops

Health Care of Incarcerated Youth

Report From The 1991 Tri-Regional Workshops

Edited by Paula M. Sheahan

Sponsored by the

Maternal and Child Health Bureau
Health Resources and Services Administration
Public Health Service
U.S. Department of Health and Human Services

Published by the

National Center for Education in
Maternal and Child Health
Washington, D.C.

Cite as:

Sheahan, Paula M. (Ed.). (1991). *Health care of incarcerated youth: Report from the 1991 tri-regional workshops.* Washington, DC: National Center for Education in Maternal and Child Health.

Published by:
National Center for Education in Maternal and Child Health (NCEMCH)
38th and R Streets, N.W.
Washington, DC 20057
(202) 625–8400

Single copies of this publication are available at no cost from:
National Maternal and Child Health Clearinghouse (NMCHC)
38th and R Streets, N.W.
Washington, DC 20057
(202) 625–8410 or (703) 821–8955 x 254

The National Center for Education in Maternal and Child Health (NCEMCH) provides information services, educational materials, and technical assistance to organizations, agencies, and individuals with maternal and child health interests. NCEMCH was established in 1982 at Georgetown University, within the Department of Obstetrics and Gynecology. NCEMCH is primarily funded by the U.S. Department of Health and Human Services, through its Maternal and Child Health Bureau.

This publication was produced by the National Center for Education in Maternal and Child Health under its cooperative agreement (MCU–117007) with the Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.

Contents

III. State Action Plans

IV. Appendices

National Planning Committee

Robert W. Deisher, M.D.

Carolina M. Endert, M.S.W., L.C.S.W.

Juanita Evans, M.S.W., L.C.S.W.

James A. Farrow, M.D.

Ronald Feinstein, M.D.

Richard Freedman

Mary Gardner

Bernard Guyer, M.D., M.P.H.

Laura M. Kruse, M.P.H., R.D., L.D.

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

Foreword

Over half a million children and adolescents are housed in juvenile and adult correctional facilities in the United States. With increases in gang activities and drug-related crimes, more and more underprivileged minority youth are being incarcerated. In addition, changing social conditions in the past two decades have produced a growing subculture of alienated youth with major lifestyle disturbances (runaways, juvenile prostitutes, "street kids"). The children who come to correctional institutions are often from chaotic family backgrounds with histories of multiple divorces and separations, from families who often abuse alcohol and drugs, and who often have abused their children, and lack roots or a sense of belonging. The families are often poor, with medical care, by necessity, low on their list of priorities.

The health problems of incarcerated youth have been statistically characterized in several studies. These youth have higher rates of untreated chronic illness, respiratory infection, and respiratory disease, because they begin smoking early, suffer other environmental

risk factors, are exposed to violence and trauma at greater rates, and have a variety of serious psychiatric disorders.

The Maternal and Child Health Bureau has long had an interest in the health of high-risk children and youth. Children in the juvenile justice system are a particularly vulnerable segment of this population, and they present significant health concerns and health-care delivery challenges.

The Maternal and Child Health Bureau developed and sponsored three regional workshops in 1991 on the health care of incarcerated youth. These represent one step in MCHB's overall strategy to mobilize both the public health sector and the juvenile justice community to initiate or upgrade physical and mental health services for this growing class of "forgotten children." In the past, the Maternal and Child Health Bureau has dedicated funds to special projects of regional and national significance which focused on this group, and has sponsored two national conferences to promote interagency collaboration and to highlight the health needs of incarcerated youth (Baltimore, 1988, and San Francisco, 1989). This volume recapitulates the reports from the 1991 Tri-Regional Workshops on the Health Care of Incarcerated Youth, held in San Diego, Philadelphia, and Birmingham.

The purpose of these workshops was to solidify interagency collaboration in addressing the health

needs of incarcerated youth. All states were represented at these working conferences, and each developed a state action plan, which are included in this monograph. The Maternal and Child Health Bureau believes that these regional workshops are a logical next step in implementing change and in promoting closer working relationships within states, between juvenile justice professionals and health care specialists.

We commend the planning committees, who worked diligently to develop the three regional workshops, for their ideas and enthusiasm. The high level of commitment shown by state representatives derives directly from their involvement in this effort. It is our continued hope that state and regional leaders in maternal and child health programs, juvenile justice advisory groups, and juvenile justice agencies will now continue this initiative, and improve the delivery of health services to children and youth in the juvenile justice system. This report is an essential resource toward that end, and a reminder to states about their future obligations to these young people. The Maternal and Child Health Bureau will continue its efforts in the future, to promote the health of this forgotten population, and urge all of those who read this monograph to continue the effort at the local level.

VINCE HUTCHINS, M.D., M.P.H.
Director
Maternal and Child Health Bureau

Workshop Overview

James Farrow, M.D.
Regional Coordinator, Western Workshop

Ronald Feinstein, M.D.
Regional Coordinator, South/Central Workshop

Bernard Guyer, M.D., M.P.H.
Linda Thompson, Dr.P.H., M.S.N.
Regional Coordinators, Eastern Workshop

The Maternal and Child Health Bureau (MCHB) has been supporting initiatives which promote interagency collaboration in addressing the health needs of high-risk children and youth for many years. Meeting the health needs of children in the juvenile justice system, a subset of this group, has been a focus of MCHB over the past five years. MCHB has sponsored several activities to initiate collaboration between child advocates and key state policymakers in the child health and juvenile justice systems. Initially, two national conferences were held entitled "The Forgotten Child in Health Care: Children in the Juvenile Justice System" during the summers of 1988 and 1989 on the east and west coasts. The confer-

ences brought together representatives from both the juvenile justice and health systems to receive an update on the health needs of incarcerated youth, related health issues, and available resources, and to promote interdisciplinary collaboration in providing health care to this population. These conferences were summarized in the MCHB publication *The Forgotten Child in Health Care: Children in the Juvenile Justice System.*

To follow up "The Forgotten Child in Health Care: Children in the Juvenile Justice System" conferences, MCHB convened a national planning committee during spring 1990 to plan the "Tri-Regional Workshops on the Health Care of Incarcerated Youth." This planning meeting brought together representatives from the federal Maternal and Child Health Bureau, Johns Hopkins University's Department of Maternal and Child Health, University of Washington's Division of Adolescent Medicine, and the University of Alabama at Birmingham School of Medicine's Division of Adolescent Medicine. As a result of this meeting the workshops were scheduled to be held in San Diego, Philadelphia, and Birmingham, Alabama, during spring 1991.

The tri-regional workshops brought together key professionals in maternal and child health and juvenile justice to share current information on health needs, resources and issues in health delivery, and to promote collaborative planning at the local, state and regional levels. Each workshop brought together sixty to eighty invited participants including representation from both

the public health and juvenile justice sectors, who could influence health policy concerning incarcerated youth in their states. Regions I, II and III met in Philadelphia; Regions IV, V, VI and VII met in Birmingham; and Regions VIII, IX and X met in San Diego. Participants of the three workshops are listed alphabetically in appendix D beginning on page 265 of this report. Please refer the the Federal Administrative Region map on page 157 to locate the states that were represented at your workshop.

Each workshop was planned and coordinated by a regional coordinator and a regional planning committee. The format for the three workshops was the same and included a historical overview, presentation of workshop goals, and a keynote speaker who focused on a unique aspect of the adolescent in custody.

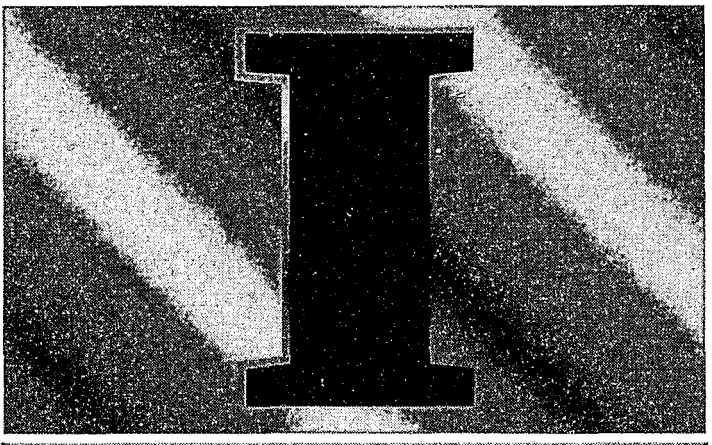
A panel of five short presentations on the topics of standards for health care, coalition building at the state level, financing health care for incarcerated youth, mental health and substance abuse issues, and academic and university involvement with adolescents in custody followed. Participants were then split into small focused discussion groups, each moderated by a facilitator, to begin talking about programs and problems related to the health care delivery system for incarcerated youth in their states.

On the final day, participants got together by state to develop state action plans outlining strategies for collaborative efforts to improve the health care of

incarcerated youth in their state. Since some states were represented by only one or two individuals, the action plans may reflect some regional initiatives. Each meeting culminated in a presentation of state action plans and a commitment for future evaluation and follow up.

We would like to give a special thanks to the national planning committee, regional planning committees, speakers, facilitators, recorders and participants for their hard work, enthusiasm, and cooperation which helped to make the workshops so successful.

Section



The Forgotten Child Past and Present

1 Historical Overview

The Forgotten Child in Health Care

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

Background Providing adequate health care to America's children and youth increasingly concerns both policymakers and lay people. The growing number of high-risk children and youth intensifies this concern. These high-risk children, often called the "forgotten children," are those involved with the juvenile justice system.

These are the children who live in high-crime areas, areas where gangs and drugs are rampant, and health, educational, and social service needs remain at least partially neglected. But they also live in privileged suburbs, where their mental illnesses or emotional disturbances have received insufficient attention, leading them to acts of violence. Essentially, they could be anyone's children: but because of the fear they instill in us, they become no one's children. They experience

high rates of illness, impaired health status, and chronic emotional, physical, and psychological problems. For many of these young people, contact with the juvenile justice system may represent their only hope for reasonable and adequate health care services.

Characteristics of Youth in the Juvenile Justice System

Each year, juvenile justice agencies in the United States arrest close to 1.3 million adolescents between 10 and 18 years of age. The typical arrested suspect is a minority male, 14–17 years old.

The great majority of these suspects are charged with property crimes (theft or vandalism), or with status offenses such as truancy, running away from home, or being "beyond the control of their parents." Fewer than one-fifth are held for crimes of violence.

Health Issues for Incarcerated Youth

Predictably, delinquent youth suffer a higher incidence of health problems than their non-delinquent peers. The reasons for this higher rate of illness are predictable. Confined juveniles are more likely to smoke, or use illicit drugs or alcohol, behaviors that may compromise their health through increased risks of disease and shortened life expectancy (Kovar, 1979; Thompson, 1985). Their aggressive behavior is associated with an increased risk of injury, with subsequent disability or mortality (Johnson et al., 1972; Velcek,

1977). Confined youth offenders are also typically from lower-class families, who may have failed to provide adequate health care and supervision. Finally, confinement may exacerbate pre-existing health problems, or contribute to new ones. For example, juveniles may suffer injuries because of fights or self-mutilation. Staff attempts to "control" youngsters through restraints, or excessive medication, may lead to health problems. Physical and psychological abuse may occur in correctional facilities. Since these young people are wards of the state, the juvenile justice agency confining them has an obligation to provide adequate health care. Despite the documented need for health care, services for detained and incarcerated youth remain inadequate or unavailable in many instances.

Maternal and Child Health Involvement in the Juvenile Justice System

The Maternal and Child Health Bureau funded two national conferences to address the need to improve health care for incarcerated youth. The conferences, collectively called "The Forgotten Child in Health Care: Children in the Juvenile Justice System," represented an initial attempt to encourage collaboration between child advocates and key state policymakers in child health and juvenile justice. The assumption underpinning this attempt was that the needs of young people who come in contact with the juvenile justice system are complex. Therefore, no single program compo-

nent, no matter how well designed, can fully serve the needs of this population. Instead, a unified approach, involving all the agencies serving children, must be designed, to address their individual needs.

The tri-regional workshops taking place in San Diego, Philadelphia, and Birmingham represent the action phase of the process: designing and planning collaborative programs for incarcerated youth. These workshops need to evolve coordinated strategies among professionals in child development, child health, juvenile justice and child advocacy, to improve the health and well-being of this vulnerable population.

Where Do We Go From Here?

The health and social problems faced by today's incarcerated youth population cry out for new solutions. Relying on a single established approach will no longer do. Professionals in health, education, and juvenile justice must instead forge a shared mission and strategy to prevent and treat the problems plaguing our youth. Only by wholehearted and intelligent cooperation can the tragedies in store for these children be averted. The series of conferences and workshops represent the initial steps in forging this shared mission.

A Time For Change

The time is ripe for change. The depth and breadth of the change, however, will depend largely on the willingness and commitment of this group to advocate

for youth. As leaders in your fields, you are in key positions to make necessary changes so that we will not "forget" our children any longer. We can no longer close our eyes to the conditions of our incarcerated children.

As I close, I offer the following challenges to this group:

1. Find new solutions, not old ones. Improving the health of vulnerable populations requires creative thinking and fresh ideas. Plans must be designed to ensure that adequate resources exist to meet standards for health, education and safety.

2. Network to build effective coalitions and advocacy for troubled youth.

3. Begin to expand education and training of professionals in medicine, nursing, law, education and public safety.

4. Conduct research and develop demonstration programs to identify services that are both effective and efficient.

My sincere hope is that as you meet in your small groups, you bring into focus your vision of the ideal system of services for our children in the year 2000. Do not be satisfied with anything less.

2 Keynote Address

The Forgotten Child in Our Midst

Rebecca A. Craig, R.N., M.P.A.

Scenario I: *My name is Robert. When I was very little, I remember waking up in the middle of the night and hearing my mother pleading, "Stop, don't hit me, please don't hit me." I remember worrying that something was happening to Mommy, and when I would try to get out of my room the door was locked, so I would just lie there, scared, afraid that something awful was going to happen. And pretty soon I'd hear my father screaming terrible things and then everything would be quiet.*

In the morning, Daddy would be gone and Mom's face would look really bad. It was blotchy red, and all out of shape. When I would ask her, she would say there was nothing wrong and I shouldn't worry. Then one night my Daddy came into my room while Mommy was screaming and crying. He took me out of my warm bed and into the kitchen. I was really scared and crying. He hit me and told me to shut up. He said I was going to get

to see what this bitch was really like and how a man should treat a woman. Then he tied me in my high chair and made me watch while he cut my mother to pieces. At first she screamed, and then she was real quiet.

He took her head and put it on the sink. I remember that real clearly, and I still have horrible nightmares. Then I don't remember very much, except a real loud noise from his gun, and he was on the floor, but he didn't have a face anymore. I tried to get down, but I couldn't move. I sat there, and finally I remember seeing the sun, and then the neighbors came and the police, I couldn't stop crying.

I'm 32 years old now, and serving a life sentence. I know I shouldn't have killed her, but I couldn't stop. I'd been following her for days but she got angry. I guess this is where I belong, just like my daddy. At least here, maybe I won't hurt anybody anymore.

Scenario II: *My name is Jane. One of the first things I remember was my mother's boyfriend coming into my room when I was trying to sleep. He used to do things to me that hurt. I tried to tell my mother, but she just got angry and said he was nice to us, and that I was a liar and shouldn't say such things. Then one day he went away. My mom and me, we did things together, then, and were real happy, but she kept saying I needed a daddy.*

Then she brought home a different man, and said he was really special and would be around for a long

time. He did seem nice; we went on picnics, to the park, and after awhile I began to think he really was nice. He was my special friend. Then, one night it started all over again. I think I was 11. I remember I had just started to get my period and my breasts were beginning to grow. He told me I needed to learn about men and what would happen to me when I was grown. He began to touch me all over. I told him to stop. I didn't like what he was doing to me, but he didn't stop and he only laughed at me. I tried to tell Mom, but she really thought he was wonderful, and told me I was lying. He kept telling me this is what everyone did.

Finally, it got so bad. Every time my mother was gone he would find me and start in again. I knew he would never stop, and she would never listen to me, so I ran away to Los Angeles. In the bus station, a man told me he would take care of me. I went with him and he gave me food and a place to stay. All I had to do was be nice to his friends, you know what I mean. I made lots of money and he gave me really great drugs. When I take cocaine, nothing hurts anymore. It feels so good. See my mom? Why? She never listened to me and she doesn't really give a damn.

Scenario III: *My name is Jason. When I was 12, I watched my mom cry at the end of every month when she would tell us kids that there was no more money or food. There were five of us. My oldest brother had been killed on the street. We would be so*

hungry for a few days, and then there would be food again. One day a guy told me he would pay me if I just stood on the corner and told him if I saw any cops coming. I did what he said and he gave a twenty dollar bill. It was so easy. After several weeks of doing this, he seemed to really like me, and he asked if I wanted to make more money. "Sure," I said, and he told me to take this package to some guy and bring back the money. I did it, and he gave me lots of money.

I'm pretty smart, so I began to watch closely, and I figured out that everyone really wanted these drugs. I knew I could have this kind of money if I had my own route. After several months I convinced him I could get more customers for the stuff. I lined up several guys to do what I had been doing, taking orders, getting deals lined up. I went back to the guy and told him how much I needed to supply my "clients" (that's a word he taught me) and he told me we could do business. Like I said, I'm smart, so I began to figure and plan, and I knew I was never going to be hungry again.

Does what I do hurt anybody? I don't make anybody buy the stuff. They want it. My Mom? What does she think? At first she believed me, that I was selling newspapers, but then I had better clothes, and lots of money. She cried a lot, said I should go to school and get good grades—but what difference does that make? The teachers don't have as much money as I do. Not even my lawyer has as much money as I do. The people that have the money, that have great cars and clothes,

they're all doing what I do. The rest of the world are suckers! They really believe that crap, that if you work hard you get ahead, but they don't have any money.

The judge tried to tell me I was smart and could really be somebody if I used the time in youth authority to learn and make something of myself. I asked him if he had a chauffeur waiting to drive him anywhere he wanted. Then I asked him how much he earned. I bet I make more in a week than he does in a whole year.

I'll do my time. I talked to some of the other guys who have been here and they told me what I need to do, who to see. Besides, this will give me connections to expand my business when I get out. Do I think that I'm going to die on the street? Hey, everyone dies sometime. At least I won't be some poor sucker who thinks that working hard gets them something, cause that's just so much shit.

These are true stories from individuals in the criminal justice system. They are representative of the lives of many inmates. I spend 50–80 percent of my life on the road, evaluating the health care provided in jails and juvenile halls. As part of this process, I talk with hundreds of inmates and youth. Daily, I am struck by the reality of life as they know it: the abuse, the assault on lives, and the poverty.

Let me give you an idea of the magnitude of the problem. There are nearly 200,000 persons incarcerat-

ed in California. There are approximately 1 million persons incarcerated in the United States. In 1989, there were 2.3 million bookings into California county jails; that means 24.2 of every 10,000 residents of that state spent some time in jail. Of these, the majority have spent some time in juvenile hall or the youth authority. More than 1.3 million delinquent and status-offense cases were handled in 1984 by the juvenile court system. Of these cases, more than 500,000 were admitted to public detention or correctional facilities and 100,000 were admitted to private facilities.

It costs $76,000 to construct a single jail cell and $28,000 to incarcerate each person. In just four years of operation, staff cost will exceed construction costs in a given correctional facility.

On a given day in 1987, the average population of juveniles in public correctional facilities averaged 53,503—up 10 percent in four years. But the proportion of juveniles held in custody to the total population increased from 116 per 100,000 to 208 per 100,000 during the same span of years. This proportion is increasing daily. Some studies indicate that 25–35 percent of current adolescents will have committed a legal offense by the age of 19. This rate is greater for selected populations, such as those with learning disabilities, who are adolescent parents, youth who abuse drugs or alcohol, and youth who have been physically or sexually abused.

Boys make up 85 percent of the incarcerated population and over half are from racial or ethnic minori-

ties. The average age of first arrest for a juvenile in state institutions is 12.8 years—not yet a teenager. The average age of incarcerated youth is 15.4 years, not yet old enough for a driver's license. Approximately 95 percent are in custody for a legal offense (44 percent have committed property crimes; remaining offenses include status offenses/running away from home, abuse or neglect, and voluntary admission). Overall, 90 percent of the boys are cases of delinquency, and 50 percent of the girls are status offenders.

Overall, approximately 40 percent of youth referred to juvenile court are repeat offenders. These are youth who commit more serious crimes (burglary, motor-vehicle theft, or robbery). Boys tend to commit more serious crimes than girls in this population. Finally, these youth tend to be younger at the time of their first offense than the average first offender.

Physicians know that health problems abound in this population. The first and most comprehensive study evaluating these youth was published in 1974 by Drs. Litt and Cohen. The study found that girls in this population become involved in sexual behavior at earlier ages than the general population, and exhibit a higher incidence of sexually transmitted disease. In a recent study, 81 percent of the girls in a detention setting complained of a vaginal discharge. Gonorrhea was diagnosed in 18 percent, and chlamydia in 20 percent.

A significant percentage of these youth have long-term health problems as a result of drug and alcohol

abuse. In a 1988 survey by the Bureau of Justice, 63 percent of those interviewed used drugs regularly, 32 percent were under the influence of alcohol when they committed their offenses, and 39 percent were under the influence of another drug. The only study which related liver function tests to drug use was conducted in 1974. This study found that 20 percent of the youth abused drugs to the extent that one-third of the drug abusers had abnormal liver functions. Later surveys did not include such laboratory tests, but we can infer that approximately 20 percent of all incarcerated youth have liver damage, given that 63 percent report regular use of drugs.

Mental health professionals will tell us that psychiatric disorders, such as learning disabilities, conduct disorder, and depression appear to be significantly more prevalent than expected among incarcerated youth. Studies show past or present symptoms meeting a diagnostic criterion for major depression in approximately 20 percent of juveniles interviewed. One study of the clinic population in the open community, by contrast, found approximately 4 percent were clinically depressed. Between 20 percent and 40 percent of incarcerated youth have serious mental health problems, ranging from self-destructive behavior and suicidal ideation, to other clinical psychosis conditions.

Many of these children receive medical, dental and mental health services only through incarceration. This is particularly true for repeat offenders. In general, the

percentage of youth regularly seeking medical or mental health services, and who are taking prescription medications, ranges from 20–40 percent—depending on whether they have been sentenced or are being held at a local juvenile hall.

In brief, these youth come to the facilities with substantial pre-existing physical and emotional problems. These include past physical or psychosocial insults, poor lifestyle habits, and lack of prior health care. Their behavior often draws attention away from their basic health care needs.

Many of these youth have faced such destruction and abuse that the anger continues over their lifetime. Typically, abusers have been abused as children. In the adult system, over 90 percent of prisoners on death row were either physically or sexually abused as children.

The professionals working in the criminal justice setting are some of the best and most courageous people I have ever met; they deal daily with the throwaways of our society. How well is their role understood? They are probation staff attempting to make a difference. They are doctors facing the frustrations of trying to work in a system that turns a deaf ear to their efforts to arrange for continuity of care with their colleagues in the community. They are nurses who feel obliged to say they work for the health department, because their professional friends disapprove of nurses who would work in such institutions as our juvenile

corrections facilities. These professionals see first-hand the throwaways of our society.

Why stay in this environment? Every professional I have asked has answered the same way: "I stay because maybe I can make a difference." They deal with the pain, anger and rejection these youth face in society. These are professionals committed to making a difference. They work to affect these youth; they listen to their pain. These professionals try to see through their acting-out of pain, the rejection, and the fear these children face on the streets—and in the institutions—and the rage these children feel at the lack of fairness they see in our society.

Financing of Health Services

Today, health care workers in this setting compete for ever-scarcer resources. One of the greatest dangers I fear is community and state officials striking comparisons between the juvenile justice setting and youth in the community.

Individuals responsible for distribution of funds say that these youth have more access to health staff and care than youth in the community. While some of this is valid, there are two facts that people forget when they make these assertions. First, these *are* the youth from their own community. The money spent in this setting serves their own youth; it should not be an us versus them concept. These are our children. Second, these youth are at the highest risk, and need the ser-

vices *now*. These children will be returning to the community, and should not be seen as separate from it.

Established standards for health service can and do promote fiscal responsibility in this setting. Programs using standards can defend the policies and procedures they develop as a minimum community commitment. The National Commission on Correctional Health Care has developed national standards establishing minimum-level policy and procedures for managing health services in a detention setting. The California Medical Association (CMA) developed state standards combining existing state regulations with a variety of physician- and nursing-practice standards. These standards, specifically geared toward California regulatory and statutory requirements, clearly reflect their community concerns.

CMA became involved in developing standards as an outgrowth of participation in the American Medical Association (AMA), beginning in 1979. The association has continued the program as a service to probation departments, the California Youth Authority, and the health providers. Physicians appointed to a CMA committee choose accreditation team members and set policy. The physicians on the Corrections and Detentions Health Care Committee all practice in either youth or adult detentions. These physicians have fought for resources, and recognize the difficulties faced by those developing programs without guideposts to delineate expected standards of care. Attempting to develop policies and procedures without a community standard

to defend the program, they understand, simply wastes time and money.

Standards establish the framework for discussions, deliberations, and finally decisions, involving probation administration, health providers, and the financial authorities controlling health care funding. Finally, standards establish a basis on which honest health professionals can defend their practices in court.

Public Health and Community Resources

Professionals have the opportunity to educate the population to prevent future illness, working within institutions, placement settings, and community intervention programs. It is also in these settings that health professionals have the opportunity to intervene with drug and alcohol problems, and to identify and treat mental health conditions. These settings should be used and viewed as public health outreach clinics. These youth have limited self-awareness, and minimal to no self-image. They are extremely naive regarding sexually transmitted diseases, pregnancy, parenting, and other concerns that all too often touch their own lives. These youth are at the highest risk of dying from AIDS, drug overdose, and street violence. Workers in these settings have a good chance of teaching and intervening for these high-risk youth.

But nobody will reach these youth unless everyone works together. Maternal/child experts, public health officials, probation and youth counselors, physicians,

nurses, and mental health professionals—both from within institutions and in the open community—must cooperate. With resources so limited, duplication and waste must be minimized. People, programs and resources in general must be shared if we as a society are to effectively react to the poverty, abuse, and rejection currently afflicting our forgotten youth.

Each of you in this room is an expert in your field. You have the experience, expertise and opportunity to develop the framework to make a difference. Use this time well. Share your resources and learn about each others' program needs. This is a time to learn about resources, and to meet others with whom you can work. Return to your community with a knowledge of what is available and what *should* be available, and with a plan to meet the needs of the thrownaway, forgotten children in your community.

Future and Opportunity

The youth are our future; we, as a society, are ignoring their needs. We ignore them, we lock them up, and we execute them. When I began, I gave first-person histories of three people I have talked with. They are adults now, and they are all serving long sentences, and may never be free.

What if we could have intervened? Would they be where they are?

As a society we cannot afford to ignore our youth. We cannot afford to keep locking people up. To reiter-

ate, the average cost in California to build a jail cell is $76,000. The cost per year for incarceration is $18,000–$28,000 per year, and in this state alone we have nearly 200,000 persons locked up.

The anger, pain, violence and poverty these youth know will lead to more of the same "unto the second and third generation." We can stop the cycle. As a society, we must look at the results of *not* intervening.

Section II

Incarcerated Youth: Perspectives on Health Care

3 Model Programs

Los Angeles County Health Care Model

Charles J. Baker, M.D.

In 1976, as a result of a federal lawsuit filed against Los Angeles County by the Western Center for Law and Poverty regarding inadequate medical care for children within Los Angeles County's Central Juvenile Hall, the Board of Supervisors created a task force to study health care services provided within probation facilities. The task force findings prompted the board to order the transfer of health care to the Department of Health Services, with the charge to raise the level of health care to acceptable community standards, and standards developed by the American Academy of Pediatrics.

The board also ordered that an outside advisory council be established. The council would advise and monitor the health care program, ensuring the maintenance of high standards, and recommending necessary

changes to appropriate authorities. The Public Health Commission was selected to be the advisory body, and has served in that capacity since 1977.

The commission has been involved in all matters concerning the physical and mental health of children under the auspices of the Department of Health Services, Juvenile Court Health Services Division. During the commission's tenure, there have been significant improvements in the health care program to benefit these unfortunate children. (The program consists of a health assessment, physical examination, R.N. clinic, M.D. clinic, infirmary, R.N. treatment, dental treatment and health education.) The accomplishments of Juvenile Court Health Services have made our program one of the leaders in juvenile health care, and the program is now nationally recognized.

In keeping with the board's mandate regarding university affiliation, all physicians within Juvenile Court Health Services are now faculty members of the University of Southern California (USC) or University of California at Los Angeles (UCLA) schools of medicine. Additionally, in 1987, Juvenile Court Health Services and UCLA's School of Medicine, Department of Pediatrics, and Adolescent Division, entered into an ongoing contractual agreement. The agreement established that the physician(s) would be on faculty at UCLA's Department of Pediatrics, and that their pediatric residents and interns would be rotated through the juvenile hall. In 1988, and each subsequent year,

the board approved a contract between the Department of Health Services, Juvenile Court Health Services Division, and the UCLA School of Medicine, for an adolescent fellowship program at one of the juvenile hall facilities.

In 1991, the board approved a contract between the Department of Health Services, Juvenile Court Health Services Division and the UCLA School of Nursing for a nurse practitioner program/nurse preceptorship program.

There are many advantages to allowing Department of Health Services to provide health care for Los Angeles County incarcerated and shelter care children:

- Juvenile Court Health Services (JCHS) has direct access to county hospitals and public health clinics for consultations, emergencies, supplies, etc., because it is a part of the Department of Health Services.

- The arrangement allows JCHS to participate in the department's quality assurance programs, infection control committee, medical records committee, public health and acute communicable disease control programs, lab sharing, and the dental quality assurance program.

- Juvenile Court Health Services is included in the Los Angeles County Nursing Recruitment and Retention Program.

- The arrangement allows the Health Care Program to be a recipient of block grants from the state to the Department of Health Services (i.e., Tobacco Control Program funds).
- The arrangement allows Juvenile Court Health Services to be included in the state Medi-Cal waiver for all-inclusive billing rates and for reimbursement.
- The arrangement allows Juvenile Court Health Services to coordinate with the department's California Children's Services Program and Medi-Cal office, to shift cost on some of the chronically ill children from net county cost to federal programs.
- The arrangement makes JCHS eligible for the Department Professional Risk Program, to minimize medical malpractice litigation.
- The arrangement gives Juvenile Court Health Services easier access to grant funding sources, many of which are available only to public health agencies, because JCHS is part of the Department of Health Services.
- The arrangement allows JCHS to establish comprehensive health education programs within the juvenile halls and camps. Through the Health Education Program, Juvenile Court Health Services received five separate grants, totaling $745,558, to provide family life education—specific programs focusing

on sexually transmitted disease, pregnancy, smoking cessation, substance abuse, nutrition, family violence, and AIDS prevention.

- The arrangement ensures access to continuity of care for patients with chronic or communicable disease once discharged from probation facilities.

Washington State Model

James Owens, M.D.

Any statewide model of health care for incarcerated adolescents depends on a comprehensive approach based on recognized standards of care. The Washington State model is successful because of the Division of Juvenile Rehabilitation's (DJR—the state juvenile corrections agency) recognition of the necessity of having a medical authority guiding all of its health care activities. The responsibilities of the medical director of DJR include direct patient care, planning and supervising healthcare programs in state facilities, teaching and supervising medical and nursing trainees from the state universities, and dealing with public health concerns of the

various state juvenile facilities. In the state of Washington the medical director is responsible for the division director to ensure the availability of an appropriate level of health care at all of the institutions.

The medical director plays a key role in selecting personnel, such as contract physicians and head nurses for facilities. The medical director recommends equipment and other resources as appropriate, and visits each institution at least three times per year. The state medical authority for juvenile institutions consults by phone with head nurses from other facilities as needed, usually at least two such consultations per week. The medical director makes recommendations regarding the placement of youth with severe medical problems to ensure the availability of needed resources. Usually when more than one facility exists in a state the medical director is instrumental in designating one facility with the greatest resources for placement of youth with severe illnesses, such as HIV infection, congenital defects, unstable diabetes, asthma, hemophilia, and cancer, to name a few. Ideally, the medical authority in the state juvenile system has working relationships with public health agencies and university medical schools.

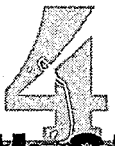
This state model also provides for a yearly teaching session for all health care workers in the state system and other staff from county institutions. The state of Washington has hosted twelve such annual conferences, which have been well received and provided

needed in-service education for institutional health care workers.

In 1987 the five state institutions received two-year accreditation of their health care programs from the National Commission on Correctional Health Care, thus becoming the first state juvenile system in the country to receive such recognition.

This accreditation was again granted for three years in November 1989. The state medical program works cooperatively with county detention facilities and case-workers to ensure continuity of care for youth in transition to state facilities. Coordinated Children's Services, Indian Health Service, Public Health Departments (especially public health nurses), Planned Parenthoods, school-based clinics, private insurance and health-maintenance organizations participate and provide needed care and follow-up for youth before and after they leave the state system. In addition, this state juvenile health program provides standardized health care forms to county detention facilities in order to promote a statewide standardization of health records.

The key components that make this a successful state model include a full-time health authority, statewide recognition of standards of health care, promotion of accreditation at county facilities and key relationships with health and academic institutions.



Health Status

The Overall Health Status of Incarcerated Youth

Robert T. Brown, M.D.

Studies show that incarcerated youth have greater health needs than their nonadjudicated counterparts. These youth bring certain problems with them into incarceration; nevertheless, they often acquire new problems while in residence.

What do we know about these youngsters? First, there are a great number of them. The number of youth in custody in public institutions increased 19 percent between 1985 and 1989. On an average day in 1989, 54,351 juveniles resided in public juvenile facilities. Eighty-eight percent of them were boys, and the majority were of minority groups—42 percent were black and 15 percent were Hispanic—and 80 percent were between 14 and 17 years old. For youth who were incarcerated in state training schools, the age at first arrest was 12.8 years. These youth had spent

about 9 percent of their lives in institutions.

Pre-existing health problems were dominated by drug and alcohol abuse. Sixty-three percent of the youth used substances regularly, and 30–40 percent were under the influence at the time of their latest offense. Incarcerated youth tend to start having sexual intercourse at earlier ages than their "free" counterparts. In a recent study in Florida, about 40 percent of the boys in a detention center reported having had intercourse before the age of 10. Several studies affirm that incarcerated girls have initial intercourse at about 13 years. This early sexual debut greatly increases this group's opportunities to acquire sexually transmitted diseases, including HIV, and also correlates with high pregnancy rates.

This cohort of youth has also experienced much more trauma than a comparable population of non-incarcerated peers. Many have suffered from physical and sexual abuse, and many have had serious injuries. In general, these children are characterized by short stature and delayed pubertal development. Their dental health is poor, and many are under-immunized. Neuropsychiatric problems abound. Many of them have learning disabilities and Attention Deficit Hyperactivity Disorder (ADHD), and many are depressed. Some have personality disorders and some may have psychoses.

The majority of health problems these children contract while incarcerated are trauma-related. Many of

these problems are self-inflicted, or, at least, self-generated. They also suffer physical abuse, and sometimes sexual abuse, at the hands of their staff or of other inmates. Some of this physical abuse comes from the use of restraints, whether they be physical or psychotropic.

Other health problems of incarcerated youth are generated by the often inadequate system of health care provided by these institutions, or through subordination of health concerns to those of security. Add to that the difficulty in obtaining adequate funds for health care for these youth in a period of governmental penury, and the problems of adequate health care for these youth become readily apparent. These youth are among the neediest in our country. Much remains to be done.

The Nutritional Health Status of Incarcerated Youth

Kathleen A. McBurney, Dr.P.H., R.D.

Factors Affecting Nutritional Status: Food Intake

Most of the children in the juvenile justice system are from disadvantaged environments. We know they are unlikely to have had access to varied and nutritious diets or to have received

health services, including nutrition education.[1]

The eating habits of incarcerated children reflect their home and school environments. Many of these children's eating habits also reflect their involvement in the "street culture," with its emphasis on fast foods, including high fat, sodium and sugar content. Some substance abusers, who have been on the street for years, express suspicion of any food they cannot pick up and eat with their hands. This attitude certainly has implications for one designing nutrition services in a correctional facility.

Once incarcerated, children from minority ethnic groups may eat better if familiar foods are offered in the institution. Historically, children and adults with special cultural dietary needs (i.e., vegetarians and Muslims) have difficulty receiving appropriate diets in correctional facilities.

The incarcerated juvenile and adult populations are predominantly male. In the 1985 Census of Public Juvenile Detention, Correctional, and Shelter Facilities, only 14 percent of the population was female.[2] There are some gender differences in the nutritional needs of adolescents. Unfortunately, little attention has been paid to the unique service needs of female children in the juvenile justice system.

Selected factors

An incarcerated child's previous environment affects his nutritional well-being, as does his treatment

during incarceration. The stress of arrest and incarceration can adversely affect a child's food intake. Overcrowding results in a noisy, unpleasant meal environment with shorter mealtimes. Fear, especially for younger nonviolent offenders, may severely decrease or greatly increase food intake.

Institutional policies and practices can enhance or detract from healthy food choices and exercise. In a study of women inmates, I found the correctional institutions in which they were incarcerated had few services devoted to health promotion.[3] Many women gained excessive amounts of weight. Upon release, many alternatives were available to better educated, more socially advantaged women. But younger, more disadvantaged women, without these more appropriate alternatives, stood a greater chance of relying on illicit anorectic drugs, especially cocaine, to lose the weight they had gained during incarceration. Thirty percent of inmates and 71 percent of ex-offenders saw weight loss as a beneficial side effect of using illicit drugs. These women were much more likely to be re-arrested for drug use, or for criminal offenses related to their use.

Nutrient requirements

During adolescence, the rate of growth is faster than at any time other than in infancy.[4] During adolescence there are increases in energy and nutrient requirements, and above the age of 10, requirements differ for boys and girls.[5] The juvenile correctional

facility may need to make caloric adjustments in meals not only for gender differences, but also for residents' restricted activity levels.

Disease, as well as the medicines given to ameliorate disease, may affect nutritional requirements. Other drugs, such as tobacco products, alcohol and cocaine, may affect appetite, and nutrient requirements and utilization.[6,7] Drug use may have affected the nutritional status of the majority of incarcerated youth. The 1987 national survey of youth (i.e., those less than 18 years old) in long-term, state juvenile facilities indicated that 55 percent drank regularly (i.e., one or more times per week in the year before admission) and 60 percent had used some drug (i.e., marijuana, heroin and cocaine) on a regular basis (i.e., once a week or more for at least a month).[8]

Nutrition Intervention

The correctional facility should provide nutritional assessment at admission[9] and be prepared to offer information and counseling for pregnant adolescents[10] and children with nutritional problems. On admission, children may present with problems, such as dental caries, iron-deficiency anemia, and diabetes, while other children may develop problems, such as excessive weight gain and gastrointestinal disorders, during incarceration. Nutritional assessment should cover practices, such as vegetarianism, that affect nutritional requirements, as well as more detrimental choices, like

alcohol or other drug use. Other candidates for assessment include underweight status, lactose intolerance, hypertension, high serum cholesterol, disturbed eating patterns, and HIV infection.

A protocol should be established to assist the physician, physician's assistant or nurse in determining which children should be referred to a nutritionist for further assessment and counseling. The nutritionist should be available to consult with the food service administrator—assuming the administrator is not a registered dietitian—to ensure that meals are not only nutritionally adequate, but also are modified appropriately for children with special dietary needs.

Food and Nutrition Services in Shaping Self-Worth

We send nonverbal messages about how highly we value people by the way in which we select, prepare and serve food to them, whether at home or in institutions, where low self-esteem is thought to be endemic. We need to let children know we care about them, and think they are worthy people. We can demonstrate this by providing them with healthier choices, and letting them know why we are making those choices available to them.

Nutrition Standards for Food Service and Nutrition Education

Nutritionists work with the Recommended Dietary Allowances (RDAs) and the Dietary Guidelines for

Americans to design food and educational services. RDAs are revised periodically by the Food and Nutrition Board of the National Academy of Sciences. They are "the levels of intake of essential nutrients judged to be adequate to meet the known nutrient needs of practically all healthy persons."[5] RDAs have been adopted as minimal standards for food services in the standards developed by the National Commission on Correctional Care[11] and the Commission on Accreditation for Corrections.[12]

The Dietary Guidelines for Americans are general dietary principles adopted by the U.S. Department of Agriculture and the U.S. Department of Health and Human Services.[13] These principles are based on clinical and epidemiological evidence linking diet and chronic disease risk. By following these guidelines, Americans could reduce their risk of developing coronary heart disease, atherosclerosis, stroke, some types of cancer, and diabetes mellitus. Any institutional program must adopt both the RDA and the Dietary Guidelines.[14, 15]

Systems Approach to Nutrition Services

"Health services" and "food services" both play roles in providing nutritional care for incarcerated youth. For those of you who are working to improve services in a facility, I suggest you review the staff's authority and responsibilities related to nutrition, and investigate their lines of communication.

Some facilities staff one or both of these services with their own employees; or a service may be staffed by employees from another government agency, such as a public health agency; or a service may be staffed and administered by an outside, private contractor. I have found lines of communication to be especially poor when each service is administered by a different, outside contractor. If this latter arrangement pertains, someone on the facility's staff should work to ensure there is cooperation between these contractors in meeting standards for services.

Standards may require general menu evaluation by a registered dietitian, on a quarterly or annual basis. Modified menus and instructions should be available to guide food service workers on behalf of children with special dietary needs, such as those with diabetes.

Finally, the dietitians should evaluate not only the written menu, but also the food as it actually is served. Too often, evaluations pertain only to the written menu. When reviewing a facility's policies and procedures, however, a member of the team must verify that the food served is appropriate, and that staff adhere to service policies and procedures.

References

1. Litt, I. F. and Cohen, M. I. (1974). Prisons, adolescents, and the right to quality medical care. *American Journal of Public Health* 64:894–897.

2. Bureau of Justice Statistics. (1986). *Children in custody.* [Bulletin NCJ-102457.] Washington, DC: U.S. Department of Justice.

3. McBurney, K. A. (1990). *Self-reported health problems among women inmates and ex-offenders.* Paper presented at the 118th annual meeting of the American Public Health Association, New York.

4. Pipes, P. L. (1989). *Nutrition in Infancy and Childhood.* St. Louis: Times Mirror/Mosby College Publishing.

5. Food and Nutrition Board. (1989). *Recommended Dietary Allowances.* [10th rev. ed.]. Washington, DC: National Academy Press.

6. Mohs, M. E., Watson, R. R., and Leonard-Green, T. (1990). Nutritional effects of marijuana, heroin, cocaine, and nicotine. *Journal of the American Dietetics Association* 90:1261–1267.

7. Farrow, J. A., Rees, J. M., and Worthington-Roberts, B. S. (1987). Health, development and nutritional status of adolescent alcohol and marijuana abusers. *Pediatrics* 79:218–223.

8. Bureau of Justice Statistics. (1988). *Survey of youth in custody 1987.* [Bulletin NCJ-113365.] Washington, DC: U.S. Department of Justice.

9. Committee on Adolescence, American Academy of Pediatrics. (1989). Health care for children and adolescents in detention centers, jails, lock-ups, and other courtsponsored residential facilities. *Pediatrics* 84:1118–1120.

10. Story, M. (1990). *Nutrition Management of the Pregnant Adolescent.* Washington, DC: March of Dimes, U.S. Department of Agriculture, and U.S. Department of Health and Human Services.

11. National Commission on Correctional Health Care. (1984). *Standards for Health Services in Juvenile Confinement Facilities.* Chicago: National Commission on Correctional Health Care.

12. Commission of Accreditation for Corrections. (1983). *Standards for Juvenile Training Schools* [2nd ed.]. Laurel, MD: American Correctional Association.

13. (1988). *The Surgeon General's Report on Nutrition and Health.* Washington, DC: U.S. Department of Health and Human Services.

14. Dwyer, J. (1980). Diets for children and adolescents that meet the dietary goals. *American Journal of Diseases of Children* 134:1073–1080.

15. Committee on Nutrition, American Academy of Pediatrics. (1986). Prudent lifestyle for children: Dietary fat and cholesterol *Pediatrics* 78:521–525.

The Medical Health Status of Incarcerated Youth

Janet Shalwitz, M.D.

Our information on incarcerated youth comes from two different data sets. One is a study being conducted on the health care profile of high-risk youth in San Francisco by URSA Institute, funded by the U.S. Public Health Service, Region IX (PHS Study). The second is preliminary results from a current study examining sexually transmitted diseases, and their biologic and behavioral correlates, in youth at the San Francisco Youth Guidance Center's detention facility. This study, funded by the National Institute of Child Health and Human Development, National Institutes of Health (NICHD), is

a collaborative effort between the Adolescent Medicine Division, University of California at San Francisco and Special Programs for Youth, San Francisco Department of Public Health (NICHD Study).

Part 1

PHS Study N=214 26% from the detention facility (at the time of this presentation, the data was only available in aggregate form and not specifically for the detention facility). Rounded percentages may not total 100%.

Sex (Percentage of Total)	
Female	60
Male	40

Race/Ethnicity (Percentage of Total)	
White	43
Black	24
Hispanic	22
Asian/Pacific Islander	7
Native American	2

Age

80% between the ages of 15 and 18.

Insurance Coverage (Percentage of Total)	
Medi-Cal (Medicaid)	19.3
Health Maintenance Organization	15.0
None or unknown	51.0

Family Problems	Recent Life Changes
stated by 75%	stated by 71% (42% reported death of a family member or friend in the last year).

History of Abuse (Percentage Reporting:)	
History of Physical Abuse	36.5
History of Sexual Abuse	30.5

Sexual Behavior (Percentage Reporting:)	
Sexually active	90.0
Condom use at last intercourse	37.0

Age of onset of sexual intercourse mean= 13.5 years

Medical Histories (Percentage Positive Findings)	
High Blood Pressure	7.0
Seizures	4.5
Anemia	8.5
Asthma	15.3
Serious Illness/Injury	30.4
STDs	40.4
Headaches	18.9
positive TB skin test	5.5

Physical Exam (Percentage Presenting With Selected Abnormalities)	
Appeared unhealthy to clinician	1
Skin (acne, eczema)	32
Eyes (conjunctivitis, trauma)	9
Ears, nose, throat (otitis, strep)	16
Teeth/Mouth (caries, gingivitis)	14
Chest/Lungs (wheezing)	4
Heart (functional murmurs)	4
Abdomen (tenderness, hepatomegaly)	9
Back, spine, extremities (sprains)	12
Neurology (tremors, ataxia)	2

Gynocologic (Percentage of Females With:)	
Abnormal cervix (cervicitis)	33
Abnormal uterus (enlarged, tender)	10
Abnormal adnexa	11

Laboratory Diagnoses (Percentage With:)	
Abnormal adnexa	11
Chlamydia	13
Trichomoniasis	8
Gonorrhea	4
Venereal warts (by physical exam)	1
Hepatitis B	8

Psychologic Difficulties (Percentage Who:)	
Feel depressed or sad often	44
Have history of counseling/treatment	49
Manifest suicidal ideation/attempts	43

Part 2

NICHD Study Male Subjects = 301 (all detained)

Mean Age

16 years (Range 11–18 years)

Race/Ethnicity (Percentage of Total)	
White	4
Black	65
Hispanic	9
Asian/Pacific Islander	3
Multirace/Ethnicity	15

Living Situation (Percentage of Total)	
Both parents	9
Mother	48
Father	9
Other relative	31
Other adults	4
Friends/partner	7
Group home	26

Percentage Affiliated With Street Gang As:	
Client	42
Friends	60

Percentage Describing Own Health Status As:	
Excellent	33
Good	51
Fair	16

Percentage Describing Last Source of Medical Care As:	
Emergency Room	60
Medical Clinic	31

Sexual Behavior (Percentage Who:)	
Initiated sex voluntarily	98
Have history of sexual abuse	4
Exchanged sex for drugs	19
Exchanged sex for money	13
Engage in intercourse while high	73
Engage in anal intercourse	4
Have gotten someone pregnant	40
Currently have a pregnant partner	14
Have children	10

Onset of sexual activity mean=11.7 years (Range: 4–16)
Mean number of lifetime sexual partners: 25

Sexually Transmitted Diseases History (Percentage Who Have Had:)	
Gonorrhea	22
Chlamydia	10
Trichomonas	11
Crabs	15
Syphilis	2
Warts	4
Hepatitis	9

Current STD Diagnosis (Percentage With:)	
Chlamydia	7
Gonorrhea	4

Drug Use (Percentage Using:)	Ever	Last 3 months	Last month
Marijuana *(32% smoke at least once a day)*	93	74	60
Cocaine	30	12	8
Crack	15	3	2
LSD	19	6	2
Cigarettes	67		
Alcohol *(26% drink at least every other day)*	76		

Part 3

NICHD Study Female Subjects = 55 (all detained)

Mean Age
15 years (Range 12–18 years)

Race/Ethnicity (Percentage of Total)	
White	18
Black	55
Hispanic	4
Multirace/Ethnicity	22
Other	3

Average Number of Times Detained: 4

Age of First Intercourse
70% between 12 and 14 years

Sexual History (Percentage Who:)	
Have history of sexual abuse	42
Have traded sex for money	13
Have traded sex for drugs	8
Have traded sex for place to stay	6
Engage in sex while high	60

Mean lifetime sexual partners: 12 (range 0–50)

Lifetime Drug Use (Percentage Who Have Used:)	
Marijuana	92
Laced joints	28
Cocaine	28
Crack	25
Speed	20
LSD	19

Current Diagnosis of Sexually Transmitted Conditions (Percentage With:)	
Genital warts	21
Gonorrhea	22
Chlamydia	24
Syphilis	8
Hepatitis B	29
Pelvic Inflammatory Disease	10
Pregnancy	11

Summary

The youth studied exhibited the health problems common to all adolescents—i.e., acne, asthma, upper respiratory infections, allergies, anemia, etc. But the data also showed the following:

- Sequelae of years of trauma and abuse; i.e., severe substance abuse, depression, and significant life changes.
- National (urban) and local trends in the incidence of communicable and non-communicable diseases, particularly sexually transmitted diseases. Rates for injury—both violent and unintentional—as well as pregnancy, also exhibited such trends.
- Low prioritization of health care issues in a population with inadequate or no health insurance, and other real and perceived barriers in accessing the health care services.
- The results of confinement in close living quarters.

Conclusions

Only an interdisciplinary, interagency team approach can properly address the many medical and psychosocial problems and concerns identified in these youth. Staff providing health care services to detained youth must be both well trained and motivated to assimilate new knowledge and skills. Staff need a broad repertoire of skills to properly address prevention and health education, as well as to treat chronic and formerly unrecognized/neglected problems and diseases. Staff providing care to young women need considerable expertise in women's health care issues, especially regarding pregnancy and sexually transmitted diseases.

Data sharing and collecting mechanisms must be established and maintained, if we are to evaluate practices, staffing, training and services. Such mechanisms also help staff inform the community of the health status of detained youth.

The juvenile justice health care system and the youth's community (whether at home or in placement) must develop linkages, to assure continuity of primary and specialized care. The issue of violence as a public health problem needs careful integration into the prevention and treatment spectrum of care. The bottom line underlying all these concerns consists of optimism, talent, patience, cultural sensitivity, compassion, flexibility, and commitment. All of these are prerequisites to bringing about the more specific, programmatic objectives.

5 Legal Issues

Liability of Health Care Providers

Michael J. Dale

I: Introduction

Literally hundreds of thousands of youngsters are incarcerated each year in juvenile correctional settings in the United States. The facilities include secure detention centers, group homes, foster care, forestry camps, drug and alcohol abuse treatment centers and state training schools. Children who enter America's juvenile justice system may be detained pretrial, or placed in various facilities after a disposition in juvenile court. Regardless of the setting and the child's legal classification, these youngsters need health care.

The health care community is aware that these children need attention. Just last year the Council on Scientific Affairs of the American Medical Association (AMA) reported that:

> Youths who are detained or incarcerated in correctional facilities represent a medically underserved population that is at high risk for a

> variety of medical and emotional disorders. These youth not only have a substantial number of pre-existing health problems, they also develop acute problems that are associated with their arrest and with the environment of the correctional facility. Although the availability of medical services varies by the size of the institution, established standards are, in general, not being met.[1]

This survey specifically addresses the legal rights of children in the juvenile justice system, and the legal obligations of the health care providers in juvenile institutions. Children held in these facilities are either charged or adjudicated as juvenile delinquents or status offenders. This article does not discuss other classifications of children who come before the juvenile court, such as abused and neglected children, and children in the mental health system.

II. Overview of the Juvenile Justice System

Children who come before the juvenile court charged as status offenders or delinquents, and who are not transferred to the adult court for adjudication as adults, go through a two-stage court process. The typical juvenile court procedure involves an adjudicatory or fact-finding hearing, comparable to a trial in adult court; and a dispositional hearing (if a finding has been made that the child committed the act) which is some-

what akin to a sentencing proceeding in the adult system. During the course of the delinquency proceeding, a child may be detained in out-of-home care.

The system detains children at the pretrial stage to assure their presence in court, and to protect against the commission of crimes during the course of the proceeding. Therefore, neither the operator of juvenile pretrial detention systems, nor the health care providers working in those systems, are obliged to actually rehabilitate the child. The obligation to rehabilitate arises after the child has been adjudicated to have committed a delinquent act, when the court determines an appropriate disposition for the youngster.

It is at this second stage of the proceedings that the traditional juvenile court doctrine of rehabilitation comes into play. However, some jurisdictions have moved away from dispositional rehabilitation, and toward other stated goals—such as protection of the public, protection of the rights of the victims, proportionality and determinacy in sentencing, and punishment, either as an end in itself, or as a factor in rehabilitation.

Much of the substantial criticism levelled against the juvenile justice system over the past two decades has focused on the conditions of confinement of children, both before trial and after disposition. Numerous federal lawsuits challenging the conditions in institutions, the passage and implementation of the Juvenile Justice and Delinquency Prevention Act of 1974, and the policy statements of the major medical associa-

tions, attest to the severity of the problem of poor conditions in juvenile institutions.

Health care is one aspect of the problem posed by poor conditions of confinement. Health care includes medical care, dental care, and mental health services.

One can examine health problems under two interrelated categories: system-wide issues and individualized problems.

The system-wide (or agency-wide) issues generally involve the institutions' administrations and goals. For example, lawsuit plaintiffs have alleged inadequate staffing, inappropriate staffing, failure to hire qualified professionals, failure to train the staff (including professionals), incompetence of staff, lack of supplies and services, and lack of access to specialized care.

Systemic health care problems also arise from the relationship between health care staff and the administration of the institution. The two often work at cross purposes. For example, the administration may dictate the level and kind of health care based on security and efficiency concerns. Institution personnel may place children in isolation, bind them with shackles or other devices, subject them to tranquilizing medication, or change or limit their diets, all based upon administrative and/or security needs. Health care providers may compromise children's health needs based upon perceived administrative and security concerns.

Health care providers are also subject to liability for specific problems that occur in institutions. For exam-

ple, health care providers must treat children with significant and diverse diseases. One issue that arises is the level of care institutions should provide to children with AIDS, and what security arrangements should be made for them.

Children in correctional institutions also suffer a high rate of physical injuries, the result of both participation in athletics and physical assault. Forced sexual acts are common. Dispensation of condoms is an issue. Hygiene problems predominate in these institutions. Children charged and adjudicated as delinquent are in need of hygiene and health care training. The question of whether to handle pregnant young women in the institutions, and if so, how, is a significant issue. Mental health staff must make judgments about the choice of group therapy, as well as individualized care. Finally, dentists may be limited in their ability to provide appropriate care by funding constraints—in some institutions, in fact, the only dental services provided are tooth extractions. Each of these examples can legitimize a possible claim of liability by the children.

III. Legal Theories

Claims by children against health care providers and other officials in juvenile institutions may be based upon violations of state law, federal law, the state constitution, the United States Constitution, and/or general principles of tort law. The child will seek one of two

types of relief—damages and/or an injunction, and a declaratory judgment.

Damages—in the form of remuneration—include, if the claim is successful, payments for compensatory damages, including medical bills, lost income, and other expenses; as well as general or intangible damages for the child's pain and suffering. Punitive damages may also be sought.

A claim for injunctive and declaratory relief seeks to either prohibit the institution from performing certain activities, or mandate that it perform certain responsibilities including changing the kind and quality of health care it offers. The lawsuit may be brought in either state or federal court.

The most common state tort action alleges negligence. It asserts that the health care provider has a duty to provide the youngster with a particular level of care, and breached that duty; that the breach is the proximate cause of the child's injury; and that, as a result of this breach of duty, the child suffered damages. The requirement of breach-of-duty is satisfied if the health care provider acted unreasonably and outside the boundaries of what is considered reasonable health care.

There is one significant overriding defense available to the health care provider against claims of negligence in the provision of health care in juvenile institutions. It is the doctrine of sovereign immunity, which also applies to other public officials sued by the child.

The doctrine immunizes public officials from liability for their actions on behalf of the state or municipality in operating the institution.

Two general limitations apply to the sovereign immunity defense available to health care providers. First, sovereign immunity only applies to discretionary acts (acts involving choices).[2] If the public official's action involves no discretion or judgment, then it is known as a ministerial act, for which there is no sovereign immunity.

Second, some state statutes limit the immunity. For example, some set a cap on damages and foreclose claims against the individual public official in the absence of evidence that the person acted in bad faith, maliciously, wantonly, or with willful disregard of the rights of others.† Under such a statute, and subject to the exception just described, the lawsuit will be brought against the government agency itself and not against the individual.

The most common federal claim is one of a violation of civil rights under 42 U.S. Code § 1983. In essence, that claim asserts that a person acting in the capacity of a state or local official may be held liable for violation of a child's federal statutory or constitutional rights. In the context of health care, the constitutional claim usually involves a claimed violation of the substantive due process clause of the 14th

†Florida is an example of this approach. See Fla. Stat. 768.28 (1990).

Amendment. The assertion is that the child suffered a deprivation of liberty by being placed in an out-of-home placement within the juvenile justice system. According to the United States Supreme Court,

> When the state by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—e.g., food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the 18th Amendment and the due process clause.[3]

The Supreme Court has not expressly decided the degree of culpability necessary to successfully establish a claim of violation of constitutional rights in the context of health care in juvenile institutions. The test involves either of two propositions. Under one standard, the child has a right to minimum adequate care and reasonably safe conditions of confinement including a right to be free from unreasonable bodily restraints.[4] Alternatively, it may be necessary to show a much more elevated level of culpability. The Supreme Court has held that when a prisoner claims that his medical care was inappropriate or inadequate, the test shall be one of "deliberate indifference to serious medical needs of prisoners."[5]

Regardless of which constitutional standard applies to children in institutional care, the common law

sovereign immunity defense, which is available in a tort action, is not available in a civil rights action. On the other hand, a separate and distinct immunity defense is available. Known as the "objective good faith" immunity defense, it provides that if a reasonable public official would not know that his actions violated the child's constitutional rights as defined by the relevant case law existing at the time of the act, then he or she may not be held liable. In the context of health care, while a viable defense, constitutional immunity is much more limited than the all-inclusive sovereign immunity defense available in a tort action.

Finally, and perhaps very significant to the choice of legal theory, is the fact that in a claim brought pursuant to 42 U.S. Code § 1983, if the child is the prevailing party in the litigation, his or her lawyer is entitled to an award of attorneys' fees from the defendant pursuant to 42 U.S. Code § 1988.

IV. Conclusion

There are two conceptual sources of liability for health care providers working in juvenile justice settings—violations of state law and violations of constitutional law. Each theory contains some limited protection to the public official. However, neither setting provides an absolute ironclad defense to the health care provider. Therefore, prudence, commitment, and professional skill and training are the best protections against a possible claim against a health care provider

by a child held in out-of-home placement in the juvenile justice system.

References

1. Krisberg, B. and Herrera, N. (1991). *National Juvenile Detention Statistical Trends.* San Francisco, California: National Council on Crime and Delinquency.
2. Council on Scientific Affairs, American Medical Association. (1990). Health Status of Detained and Incarcerated Youths. *Journal of the American Medical Association* 263(7): 987–91.
3. See Restatement Second of Torts, 895D, Public officers 1974. Alabama, for example, applies the discretionary act test. See Barnes v. Dale, 530 So. 2d 770 (1988); Horn v. Dunn Brothers, Inc. 79 So. 2d 11 (1955).
4. 489 U.S. 189 (1989).
5. Youngberg v. Romeo, 457 U.S. 307 (1982).
6. Estelle v. Gamble, 429 U.S. 97 (1976).

6 Standards

Standards for Health Services in Juvenile Confinement Facilities

B. Jaye Anno, Ph.D.

The National Commission on Correctional Health Care, which I represent, is a not-for-profit 501(c)(3) organization that grew out of a program developed at the American Medical Association in the early 1970s. The National Commission's Board of Directors represents 31 different professional associations. These include not only the American Medical Association but also other health professional associations: the American Nurses Association, the American Psychiatric Association, the American Psychological Association, the American Medical Record Association, the American Pharmaceutical Association, the American Dietetic Association, and others. Organizations of most of the health professions with workers in correctional institutions have representatives on our board.

We also have representation from health professional associations emphasizing adolescence or youth. These include the American Academy of Pediatrics, the American Society for Adolescent Psychiatry, the Society for Adolescent Medicine, and the American Academy of Child Psychiatry. We have representation from public health as well: the American Public Health Association and the American Association of Public Health Physicians. Each of the individuals on our board has an interest in improving health care of incarcerated adults and youth.

The commission's primary goal is to help institutions improve their health services. We accomplish that through a series of activities. We have developed standards establishing the minimum components of an adequate health delivery system. In addition, we have developed a voluntary accreditation program to measure facilities against those standards. Third, we provide external quality assurance reviews where we are invited to do so. Fourth, we operate a program of certifying correctional health professionals. Individuals working in the field can take a self-assessment examination, and, if they pass, become certified as correctional health professionals. After three years, they can apply for advanced status, where they take a proctored exam in a specialty area.

The program is new, but the exams are already offered twice a year. We conduct conferences. We hold the largest annual conference on correctional health

care. Approximately 700 individuals attend each one. Most are health professionals working in jails, prisons and juvenile facilities. We have, at times, held a separate juvenile track to encourage more juvenile justice workers to participate.

We also develop and disseminate a number of publications on correctional health care, in addition to the standards we have developed at different points through the course of this program. We sponsor the *Journal of Prison and Jail Health,* as well as *CorrecCare,* a quarterly newspaper. That publication is sent free of charge to approximately 15,000 individuals with an interest in correctional health care.

Beyond that, we procure grants and contracts to perform specific activities. One of our primary activities at the present time is a cooperative agreement with the Centers for Disease Control, to "train the trainers." It started out with an emphasis on AIDS prevention, but has expanded to include other areas of health education for juveniles.

The focus today, however, is on standards.

I mentioned to you that the commission's activities grew out of an American Medical Association program. At its outset in the early 1970s, that program concentrated on jails, because there were at the time more jails than any other type of institution, corresponding to the needs of the era. At least at the state level, some semblance of health care was provided to state prisoners and to juveniles within state institutions; the coun-

ties, however, tended to be resource-poor, with no health coverage whatsoever and no system of care in place. Their usual way of providing care was to take an individual who complained to the local emergency department and pay whatever charge resulted—that is, when they took them.

The first standards for juveniles were published only in 1979. Those standards went largely unused for a long period of time. There was no accreditation program attached to the publication of the juvenile standards, so they served only as a reference. The juvenile standards were revised in 1984 with assistance from the Thrasher Research Fund, a private foundation emphasizing juvenile health. As part of that project, juvenile confinement institutions in the United States were accredited for the first time by the National Commission on Correctional Health Care with respect to their health care delivery systems. The first two systems accredited were the Los Angeles County juvenile detention system, and the Jefferson County, Kentucky, youth facility.

The National Commission on Correctional Health Care's standards are separated into two types: essential standards, which means that they are mandatory for accreditation, and important standards. A facility has to meet all of the essential standards and 85 percent of the important standards to be accredited. The standards cover a variety of topics, including administrative matters, such as policies and procedures, meetings,

statistics, disaster plan and drill; personnel matters dealing with licensure and job descriptions, training, and prohibition against using of juveniles in the health care areas as workers; and care and treatment issues; intake procedures, detoxification, initial health appraisals/screening, provisions for emergency care, hospitalization, regular sick call, dental care, and mental health care. Some ancillary services are discussed, including management of pharmaceuticals and medical records. The standards also touch upon medical legal issues, including informed consent and prohibitions against biomedical research within the institution.

Those standards were meant to address what had been a persistent problem in the delivery systems within juvenile facilities: some facilities tended to use juveniles in some capacity, perhaps to file records, to set up appointments, or to do some other types of health care activities. This staffing practice was not, however, so rampant in the juvenile area as in the adult area, where inmates were even used to provide care and treatment.

In addition to the National Commission on Correctional Health Care standards, there are three other sets with possible application in corrections.

These include the standards of the American Correctional Association (ACA), essentially an association of corrections professionals. ACA does have a set of standards specific to juvenile institutions. They are not detailed, and do not address a number of impor-

tant health issues, including the potential for ethical conflicts in these settings.

The Joint Commission on Accreditation of Hospital Organizations (JCAHO) has a set of community care standards. They strongly emphasize quality assurance, which is important. But JCAHO standards are not specific to corrections; they certainly are not specific to juveniles; and they do not address many of the topic areas that would be of interest in juvenile confinement facilities.

The American Public Health Association (APHA) has an excellent set of standards geared primarily towards jails and prisons. Again, they are not specific to juveniles. The other problem with APHA standards is that there is no accreditation program attached to them, so there is no way to measure compliance.

The fourth set, then, is the one that I discussed, the National Commission on Correctional Health Care's. Our strengths, I think, are that our standards were developed by health professional groups, and are specific to juveniles. Our weakness is that we do not deal with issues such as environmental health as well as APHA, nor with quality assurance as well as JCAHO. The current version, published in 1984, is ready to be revised.

A task force is working on that revision now. The new areas of emphasis are likely to include environmental health, preventive health, and quality assurance. Some of the other standards might be tightened,

and new issues that have arisen since 1984, such as AIDS prevention and management, will be addressed.

Seven years after we started the initial accreditation program for juvenile institutions, however, we still have only accredited about thirty across the United States. There are none accredited by JCAHO, by the way, and the number of juvenile institutions accredited by ACA is small. Over 1,000 public juvenile facilities operate in the United States, and approximately the same number of private institutions. At the last count, in 1989, the government survey *Children in Custody* reported that the juvenile population had reached an all-time high. On any day in the United States, there are over 56,000 juveniles being held in our institutions. In 1989, 619,000 children passed through public juvenile facilities.

Compare these statistics with the small number of health-accredited juvenile confinement facilities—or even those with a program in place—and the difficulties become self-evident. We need to do everything possible to protect the health and welfare of our most valuable resource, our children. I am hopeful that as a result of meetings such as this one, with representatives of the public health sector and the juvenile justice sector, we can together begin to make that happen.

7 Academic Involvement

Using University Trainees to Ensure Better Care

Robert Deisher, M.D.

During much of my medical career I have been fortunate to have been both associated with a university, and also to have had the opportunity to work closely with state institutions for incarcerated youth. This arrangement has been advantageous to both the university and the institution. The university gets a setting in which medical trainees can work with incarcerated youth and their problems, and the institutions get a high level of medical care that might not otherwise be possible.

Physicians involved in the health care of incarcerated youth need both a genuine interest in the adolescents they treat, and specific training in the field of adolescent medicine. Simply hiring an available physician, without looking at his or her interests and training, is not enough.

In the 20 years that I have been involved in the care of institutionalized youth, we have come a long way. Much of the progress in our state has been due to Dr. James Owens, who has led us at both state and national levels. His work for the health care standards now applied to incarcerated youth has resulted in many health care improvements for that population. I can remember when our largest institutions employed only part-time, retired, or elderly physicians, whose primary role was to sign their names when necessary, not to practice medical care. Institutions conducted no interviews or physical exams. The standards we now have mandate that we maintain a higher level of health care.

Working with a university or medical school in the vicinity is one effective way to ensure better care. Not only does this provide us access to well-trained physicians, but it also allows trainees such as interns and residents to participate in institutional programs under supervision, and to learn more about the problems of this particular population. Frequently students other than doctors or doctors-in-training have an opportunity to participate; students from nursing and social work can also be involved. We have found that the presence of students in an institution is stimulating to the staff. I realize that many of you are from states with no medical school or university close enough for such cooperative arrangements. Other potential areas for trainees should be considered, such as community colleges, hospitals and other training schools.

Most institutionalized youth have been outside the health care system all their lives. The early health care that we like to see children have has often not been possible for them. They have not had routine visits to their pediatricians or physicians, and suffer from conditions which would have been treated in the case of more fortunate youth. I remember one 17-year-old youth with only one testis present. He told me that he had seen a doctor when he was four, and been told that if this did not descend in a year, he should return to the physician—but that he had not seen a physician since that time, *a period of 13 years.*

It is necessary not only to do a thorough physical on these youth, but also to interview them regarding their past health and the health of their families. One should look for depression, use the exam as an opportunity for health education, and, above all, take time enough to answer questions and show that you care.

Using student trainees raises the subject of cost. It may seem cheaper on the surface just to contract for a few hours of medical care in the community from anyone who is available than to become involved with a university and student training. When one looks at the amount of time available from advanced-level trainees as compared to time from the physicians, one usually comes out ahead on both cost and quality of care.

Finally, those same students involved in such care learn about incarcerated youth and their problems—knowledge which may be important later on in their

practices, and also when they are in positions of leadership in the community.

The Role of Academic Institutions in New Strategies for Health Care

Jean R. Setzer, Ph.D.

This meeting constitutes an acknowledgment that we have reached the limits of our individual, perhaps fragmented, efforts to address the problems of the detained and incarcerated youth. Our endeavors to reduce rates of juvenile delinquency, adolescent pregnancy, and school dropouts are not working. Our purpose here is to formulate new strategies, and my topic is the role of academic institutions in this process.

Conventional wisdom assumes that research should inform policy—that is, decisions about what programs and services should be offered, in what settings, by whom, to whom. Research isolated from community practice, however, leads to unworkable, infeasible, and unsustainable interventions. In other words, as researchers we must take the bench into the trenches. My intent today is to present a conceptual framework adapted from the Institute of Medicine's *Report on the*

Future of Public Health, to illustrate—and to facilitate discussion about—the role of the university in assuring access to quality services for incarcerated youth, at an affordable and sustainable cost to the community. Finally, I will present a case example of our Integrated Program for Detained Youth at the Bexar County Juvenile Probation Department in San Antonio, Texas, to demonstrate the collaborative relationships among government, the university, and the juvenile justice system.

Domain of Health Action

In 1987, the Institute of Medicine, an arm of the National Academy of Sciences, undertook a study of the future of public health in this nation, and formulated recommendations concerning policy, programming, and work force, precisely to address the perceived limits of our science in improving community health.

The National Academy of Sciences provides us with the basics of the role definition for universities and the community agencies in this process of disease prevention and health promotion:

> Throughout the history of public health, two major factors have determined what problems were solved: the level of scientific and technical knowledge, and the content of public values and public opinion. Over time, public health measures have changed with important advances in understanding the causes and control of disease. In addition, practice was affected

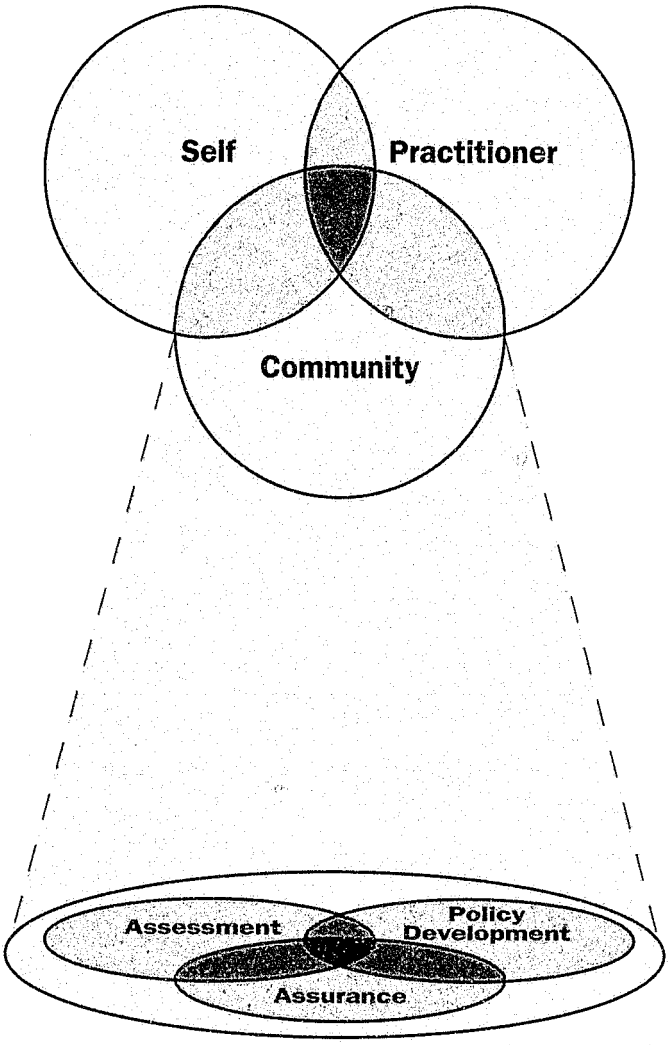
> by popular beliefs and by public views on appropriate government action. As poverty and disease came to be seen as societal as well as personal problems, and as governmental involvement in societal concerns increased, collective action against disease was gradually accepted. Health became a social as well as individual responsibility.[1]

What is health, and whose responsibility is it? The World Health Organization defines health as the optimal state of well-being for all by the year 2000. Figure 1 illustrates the intersection of domains of actions: those taken by ourselves to promote and improve our health; those taken by practitioners who act on our behalf, i.e., health educators, physicians, social workers, psychologists, judges, educators, probation officers; and those taken by the community—groups of individuals who function in organized systems to reduce the threats to our health. The community's role includes regulating the environment (i.e., judicial process); protecting our health (i.e., probation authorities); and preventing disease (i.e., health professionals, through access to essential services).

Roles and Responsibilities and Territories of Community Health

The university's primary mission is to generate science and technical knowledge research, and to teach. In the scheme presented by the National Academy of

Figure 1
Domain of Health Actions



Sciences, the university's mission is to train practitioners and equip them with the skills and knowledge to further community health. In contrast, community-based organizations, such as the local mental health/mental retardation agency, the juvenile probation department, or school district, provide services.

The domain of health actions features at least interconnecting activities: assessment, policy development, and assurance. Assessment is the process of gathering and organizing information about the needs of youth (individuals and groups); aggregating data and analyzing it to ascertain community needs; and matching individual/group needs with program interventions. The individual and collective needs assessment process gathers and orders many kinds of information—environmental, demographic, behavioral, and epidemiological.

Universities, in contrast with government or community-based agencies, traditionally excel at assessment. Assessment results inform policy development prior to program implementation, by helping to determine what programs are needed, by whom, and at what level of intensity.

Assessment data form an information foundation from which one can identify and define problems, match problems with likely program solutions, and establish problem and program priorities. The same assessment knowledge and skills applied during and after program implementation, address the "so what" questions: those asking what difference the program

made in furthering the community towards its public health objectives. Answers to these difficult questions form the basis on which policymakers evaluate alternative approaches, and hold program staffs accountable.

Demographic changes affect policy and intervention decisions. For example, as we face great growth in the 12- to 17-year-old population, we simultaneously confront a political environment that is reluctant to invest in secondary interventions for youth—be they ordinary education programs, or special intervention programs for detained and incarcerated youth. In 1974, there was a century-high 25 million adolescents, born during the baby boom years of the 1950s and 1960s. In the past 15 years, the number of adolescents has declined to below 20 million in 1988; the 1990 population is expected to be 19.2 million.[2]

As we experience the echo effect of the baby boom, however, the number of 12- to 17-year-olds is projected to reach 22.1 million in 1999, and continue to grow. According to the Office of Juvenile Justice and Delinquency Prevention, the number of admissions to juvenile facilities during 1988 reached 619,181, the highest intake since 1970, and an increase of approximately 18 percent over the past four years.[3] If the 1989 custody rate of 221 per 100,000 for youth ages 10 to 17 (the statutorily defined maximum age of original juvenile court jurisdiction in each state) is applied to the 1999 projected youth population, the estimated number of admissions will increase to

625,590, or roughly 3 percent of the 1999 youth cohort.

Facilities and programs seem crowded now. But without policy initiatives to prevent delinquency or promote community-based alternatives to institutionalization, today's numbers will represent the lowest average daily census of the decade.

Policy development refers to decisions taken by political bodies regarding program priorities and resource allocations for achieving democratically defined societal objectives. Both objectives (or policy ends) and program means (allocation decisions and program content) reflect our values, beliefs, and information about program alternatives. Although government is chiefly responsible for policy development, universities—through research, needs assessment activities and program evaluation—shape this process to a great extent.

The regions of interdisciplinary problem solving or opportunities for research relating to incarcerated youth are:

1. *Prevention.* Disease and injury can often be prevented through health care and health education. Examples relating to high-risk youth include health curricula and approaches to prevent HIV/AIDS and other sexually transmitted diseases; adolescent pregnancy; and substance abuse among detained and incarcerated youth.

2. *Protection.* Develop and test the following strategies: Cognitive approaches and those stressing decision-making and skill-building that enhance an adolescent's ability to recognize and resist negative peer pressure; community-based strategies to encourage school continuation; and cost-effective ways to engage adolescents and their families with the mental health service delivery systems. Examples relating to high-risk youth include individual and group interventions effective in changing youths' attitudes and behaviors regarding decisions around their sexuality; substance abuse; school continuation; and use of condoms to prevent HIV infection and for family planning methods.

3. *Restoration.* Mental health, educational and medical intervention can rehabilitate and restore—or even prevent the deterioration of—cognitive, emotional and physiological functioning. Examples pertaining to high-risk youth include: reduction in depression leading to suicide; interventions to decrease substance use leading to addiction; detection of learning disabilities; and deficits or behavioral problems leading to school discontinuation.

A news headline in the March 27, 1991, *Washington Post* caught my eye: "New Drive to Aid Children Often Cuts Adult Programs." The article chronicled the shift in domestic spending, dubbed "a new line in the sandbox," away from traditional

income assistance programs, like Aid to Families with Dependent Children, and towards prevention and early intervention programs, such as Head Start, childhood immunizations, and prenatal care.

The article went on to say that this shift was precipitated by the public realization that millions of children are living in deep poverty, and that we cannot lose them and still have a competitive work force.[4] Income assistance grew to a record 4.26 million families in January 1991, the 18th consecutive monthly increase.[5] The Children's Defense Fund spokesperson articulated the stark policy choices: Pay $1 now for childhood immunizations, or $10 later for medical costs; $1 now for preschool or $4.75 later for special education, crime and welfare costs.

In a conversation with our deputy chief of probation, I came up with my own tradeoff: It costs $87.10 a day to detain a youth in the Bexar County Juvenile Detention Center, or if the president of Harvard University is correct, about the cost of maintaining a student at Harvard. Reading between the lines of this newspaper article, the trend in policy is to cut from interventions targeting adolescents, especially multi-problem ones, and give to programs focusing on younger, more salvageable infants and children. Some conservatives argue that current enthusiasm for early childhood programs is but the latest example of the "nothing works" syndrome. I fear that the logical extension of this syndrome, in the face of stringent

state and federal budget cuts, is a policy of warehousing troubled youth.

Perhaps the greatest contribution that universities can make in this implicit policy dilemma is to demonstrate the cost effectiveness of a workable, sustainable, affordable set of program interventions for multi-problem youth. These research and development and diffusion functions are extensions of traditional university roles within our society. The university's role in conducting and supporting biomedical research is well established. This same research and development role in relation to community health practice fulfills the Institute of Medicine's vision for Schools of Public Health, and programs in community medicine. This role of demonstrating innovative service models, and informing policy directly, relates to the third domain—that of assurance.

Assurance activities are those undertaken to inform policymakers and program implementors about:

1. The accessibility of services. The activities answer the question "Are all those who need services receiving them?", and

2. The quality of services, or "Are services provided of an acceptable quality, and what is the cost and cost effectiveness of these services?" Policymakers want to know whether these innovations are both affordable and sustainable for the community. Community-based agencies, governments, and

boards share the dominant roles and responsibilities in the assurance area, as they are directly accountable to voters, taxpayers and users of their services.

The university, in many cases, is a community partner in the assurance function in two ways: (1) in standards development/quality assurance; and (2) in service program evaluation addressing issues of access, cost and quality. The university's operational roles and responsibilities in communities are blurred, however: Medical school departments, for example, are primary service providers for the medically indigent, as well as recipients of research and demonstration funds. As educational and biomedical research dollars become scarcer in the 1980s, universities have begun to look to service dollars as a source of funds. Community-based agencies, in many cases, resent and resist university-based service provision efforts. I submit to you that the tension between town and gown, in the area of incarcerated youth and community health domains, is inherently a constructive, albeit uncomfortable, one. At least this has been our experience at the Department of Pediatrics of the University of Texas Health Science Center (UTHSC) at San Antonio.

The University of Texas Health Science Center's Integrated Program for Detained Youth

Let us turn from theory to a real-world example.

In 1988, the Department of Pediatrics at the University of Texas Health Science Center at San

Antonio was awarded a Pediatric AIDS Demonstration Grant from the Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA), Public Health Service (PHS), U.S. Department of Health and Human Services (DHHS). As part of our community-based efforts to educate high-risk groups about HIV/AIDS, we began providing six hours of AIDS prevention/education classes weekly to detained youth, ages 10 to 16, at the Bexar County (San Antonio) Juvenile Detention Center. This was a natural extension for us, as the Department of Pediatrics faculty had been providing medical care (i.e., medical physicals and sick call) to all detained youth since 1986 under contract with Bexar County Medical/Psychiatric Services Department—the county agency responsible for providing medical and mental health services for detained youth and incarcerated adults in the county.

In fall 1989, the Community Pediatrics and Adolescent Medicine Program of the Department of Pediatrics was awarded a three-year grant to demonstrate the effectiveness of integrating primary care, substance abuse treatment and HIV/AIDS prevention services to detained adolescents. This program is one of 21 projects funded jointly by the Alcohol, Drug, and Mental Health Administration and HRSA to demonstrate the feasibility of linking primary care and substance abuse treatment, to improve the effectiveness of drug abuse treatment, and to slow the transmission of HIV.

Our program is only one of two targeting high-risk youth; it is also one of two targeting incarcerated populations. These projects are administered under the Bureau of Health Care Delivery and Assistance, HRSA, PHS, DHHS.

Although varied in models and target groups, the 21 linkage programs share one exciting feature: They bring together systems of care, the medical and substance-abuse treatment systems, that have traditionally been separate and distinct. For me, as a public health professional, this is the most innovative program guidance under which I have had the opportunity to work.

In collaboration with the Bexar County Juvenile Probation Department and the Bexar County Medical/Psychiatric Department, our multi-disciplinary team of physicians, nurses, psychologists and social workers conduct comprehensive assessments of each of the 700 youth detained longer than 96 hours, and develop a detailed care plan. The goals of the program, which has been operational since April 1990, are as follows:

1. To determine the medical, social, psychological and drug-treatment/rehabilitation needs of detained adolescents;

2. To provide primary medical care, substance-abuse education and treatment, and HIV/AIDS-prevention services at the Juvenile Detention Center, and aftercare for up to a year after detention, using a case-management model of service delivery;

3. To provide individual and group counseling, enhancing an adolescent's ability to cope with feelings of anger, stress and negative peer pressure in order to develop behavioral alternatives to chemical dependency; and
4. To evaluate program effectiveness and communicate outcomes.

Over the past year we have served 650 youth, a majority (81 percent) of whom are Hispanic or black. In the process of assessing the medical, psychosocial and substance-abuse treatment needs of these youth, who represent about 12 percent of all youth referred to the probation department, we determined that about one-third of these youth were in need of substance-abuse treatment, and that about one-fourth had serious emotional problems, including suicidal ideation and previous suicide attempts. As part of our HIV/AIDS risk-assessment activities, we have ascertained that 7 percent of the males and 15 percent of the females have used intravenous drugs within the past year.

The program offers confidential HIV testing and pretest and posttest counseling. All adolescents learn about the risk factors for HIV/AIDS in mandatory, weekly AIDS prevention classes. Mandatory HIV/AIDS prevention education fills an important gap: Forty-four percent of these youth are either not enrolled or not attending school, and therefore receive no school-based HIV/AIDS education.

In the past year, 290 youth have voluntarily requested HIV/AIDS testing. For us, accessing confidential testing while at the Juvenile Detention Center is an essential program element, because most of these youth do not have a regular source of medical care, and have had little or no experience with a medical system of care. While in the safe environment of the center, they can practice making health-related decisions and accessing services. As part of the HIV/AIDS classes, youth learn where and how to access community-based HIV/AIDS testing, counseling and medical care, and the importance of repeated testing if they continue to engage in risky behaviors.

One of the significant outcomes from the program's first year of operation was documentation of the adolescents' unmet needs, particularly in the areas of mental health and substance-abuse treatment. These assessment activities have led us to seek out and develop close working relationships with community mental health and substance-treatment providers. Certified substance-abuse counselors, employed by the mental health/mental retardation agency, now attend our weekly case conferences and participate in our care-planning process. These counselors receive referrals for substance-abuse treatment directly from our case managers, and begin outpatient treatment while the youth is still in detention, and then continue counseling with the youth and family after release from detention.

Moreover, our social workers now hold weekly individual and group social skills counseling to program participants in three schools attended by a large number of our youth. Our psychologists conduct group counseling for the 8 to 10 females at the detention center twice weekly. Most of these females are pregnant or parenting. Again, our assessment activities have led us to develop other ties with the local housing authority, as 25 percent of our youth reside in public housing. We have developed ties with minority-based providers of youth recreation, and with substance-abuse prevention and intervention services; and we are in contact with two community health centers, as about 27 percent of all detained youth have medical problems requiring follow-up.

Our department chair and project director, Dr. John Mangos, has testified before federal, congressional, state and local committees, advocating for needed services. In other words, our program assessments have fueled our advocacy efforts.

As we have identified and documented need, and fostered working relationships with other community-based agencies, we have begun to look for additional funding to address the enormous scope of the problem at hand. One of the most valuable roles our university-based program plays is that of grant-writer and program-evaluator. Over the past year, we have collaborated with six other community-based agencies in applying for federal and state grant monies in the areas of

suicide prevention, substance abuse intervention, parenting education, and prevention/intervention services in public housing. In only three of the grants was the Community Pediatrics Program the primary grantee.

The next challenge in our research and demonstration role is to address the assurance questions through our evaluation efforts. What proportion of youth who need medical, mental health and substance-abuse treatment, actually receive services? What are the outcomes of care? Are these services of an acceptable quality, given the pervasive national and community standards of care? And, perhaps most importantly, is this program cost-effective, and can it be sustained after this service demonstration is over? The answers to these questions in combination with other program evaluations will help shape the policy choices for the next decade.

Thus, the university's role in health care, founded in research and development concerns, moves outward toward community-based collaborations—which can work to everyone's advantage. Every partner in such joint efforts—universities, community-based agencies and the government—have vital roles and responsibilities to play in being part of the solutions to the problems of our clients, detained and incarcerated youth.

References

1. Institute of Medicine. (1988). *The Future of Public Health.* Washington, DC: National Academy Press, p. 3.
2. National Center for Health Statistics. (1988). *Health United States.* [DHHS Publication 89-1232 1989.] Hyattsville, MD: U.S. Department of Health and Human Services, Public Health Service.
3. Office of Juvenile Justice and Delinquency Prevention. (1991). *Juvenile Justice Bulletin,* January, p. 3.
4. Personal communication, Cheryl Hayes, National Commission on Children.
5. (1991, March 27). New drive to aid children often cuts adult programs. *Washington Post.*

8 Mental Health

Mental Health Issues in Incarcerated Adolescent Populations

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

Adequate health and mental health care for criminally involved youth has become a critical issue for health providers working in the corrections setting. Incarcerated youth are admitted with acute health and mental health needs, requiring immediate, specific care and treatment. Increasingly, youth involved in the criminal justice system have serious and chronic health and mental health needs, as well as histories reflecting multi-system involvement. For example, many youth now incarcerated have histories of rejection from mental health systems and community-based health and social programs, because the programs can neither meet their severe needs nor contain their seriously disturbed behaviors.

Addressing the needs of this population of youth not only challenges the practical resources of the insti-

tution, but also represents a moral and ethical mandate for the nation. As interest in this population rises (due in part to the high costs of detecting, monitoring, and housing criminally involved youth), programs will be required to become more specific in their aims and goals, and will be required to target specific populations with specified health and mental health needs.

For the institution, adequate care will depend not so much on newly designed programs, as on improving the overall sensitivity of facility staff—not only to the particular needs of the incarcerated youth population, but also to the abilities and the limits of treatment within their institution. The autonomy that health care professionals create to enhance treatment can become a detriment. Health care professionals working in corrections settings may not be attuned to the multifaceted effects of institutional stress on staff and youth, which places limits on treatment options. Motivated and caring corrections staff may not be prepared to manage large numbers of acutely disturbed youth. Few institutions have formal guidelines for training staff to assess and manage youth with health and mental health impairments, or to train health care professionals to be sensitive to facility and staffing limits, crowding, environmental and legal stresses and security issues. Administrators of institutions can no longer afford to assume that these variables are nominal, or simple aspects of "on-the-job training." Instead, institutions must begin to prepare their staff in appropriately

responding to these critical situations. Dealing with a high-volume, high-turnover population will also require more attention to adequacy of screening and evaluation techniques, and to the ability of the corrections system to coordinate treatment responses.

Studies available on juvenile offenders clearly show that the incarcerated population is at considerable psychological risk. From available data, juvenile corrections populations clinically differ from inpatient psychiatric populations only in their significantly lower socioeconomic status, and their criminal involvement, be it major or minor. Criminal justice programs will be required to evaluate, treat, and plan for these youth in a more sophisticated manner, given the population's propensity for psychiatric disorders.

Overall, research on criminally involved youth spans many disciplines, each offering its own spectrum of perspectives on and analyses of behavior, motivations, pathology, risks, costs and causes. Issues reflected in these studies include (1) the nature, etiology, prognosis, and appropriate management of the severe and complex problems evidenced in incarcerated adolescent offender groups; and (2) what role mental illness (such as depression, schizophrenia) or other psychiatric conditions (attention deficit disorder, fetal alcohol syndrome) has in the onset, and how high-risk, hard-to-manage behaviors manifest themselves in the corrections setting (including suicidal or assaultive behaviors). These research deficits pose problems for

institutional staff, who are struggling to manage this difficult population without clear direction from research. Clear information and a consensus on the problem are vital to providing solutions.

Abundant evidence shows that juveniles in corrections facilities suffer serious health and psychological impairments. Whether a youth goes into the health/mental health system or the criminal justice system is not a simple function of need for treatment. It is more likely that youth in the criminal justice system have multiple additional factors affecting their pathology, but at this moment this is speculative. Specific and adequate care will come about only if further research can provide more specific information about the needs of this population at risk.

Challenging Perceptions of Youth: "Bad" or Disturbed?

Janice Hutchinson, M.D.

I was recently asked to describe the target population for a proposed residential treatment for a group of grant reviewers from a major foundation. The list of severely emotionally dis-

turbed youth included adolescents from the area youth detention centers. Objections were immediately raised by the grant reviewers. In their views, incarcerated youth were "conduct disordered," and therefore not an appropriate part of the target population. There is a lingering perception among both mental health and non-mental health persons that incarcerated youth are simply bad, not emotionally disturbed. This paper hopes to challenge that belief.

The American Medical Association recently released *Health Status of Detained and Incarcerated Youth,* a review of youth in detention or correctional institutions throughout the United States that revealed the following facts. In 1984, there were 1.3 million delinquent and status offense cases processed by the juvenile court system. In 1987, more than 200 juveniles per 100,000 juvenile population were in custody;* 25–35 percent of adolescents have "broken the law" by 19. More than 85 percent of those charged are boys, and more than 55 percent are of racial or ethnic minority. Most (82 percent) are ages 14–17. The average age at first arrest is 12.8 years. Forty percent are repeat offenders.

Of those detained, 95 percent have committed a legal offense, 44 percent have committed property offenses, 25 percent have committed offenses against persons, 8 percent have committed offenses related to

---

** This number underestimates the actual number of delinquent offenses, since 50 percent of those charged are released to their families or other agencies.*

alcohol/drugs, 8 percent have committed probation violations, and 10 percent have committed "other" offenses. Status offenses include runaways, abused and/or neglected and voluntarily admitted youth.

The most commonly diagnosed mental health problem in this population is conduct disorder. This is really just a euphemism for bad. Conduct disorder is a useless diagnosis. It reveals nothing about the characteristics of the person committing the act. It is a diagnosis that is superficial and narrow, and ignores underlying pathology.

For the past two years I have been a consulting psychiatrist to a youth detention center. A random review of 50 psychiatric assessments revealed that 10 youth had been hospitalized in mental health institutions and/or had been treated with psychotropic medication. Psychiatric examinations revealed a wide range of signs and symptoms of mental health disorders. About one in five boys gave histories that were compatible with attention deficit disorder. Hyperactivity, inattention, and impulsivity were common findings. Occasionally, a young man had been treated with ritalin or placed in a special program to address these signs. This was the exception rather than the rule. Most were undiagnosed and untreated.

Another common finding was hallucinations, both auditory and visual. Several residents described tactile hallucinations. The boys usually experienced hallucinations during the first week of detention and/or when

confined to their rooms with the doors closed and locked. They occurred most frequently during the night. Very few boys had histories of drug abuse. Diagnoses included bipolar disorder, organic brain syndrome, schizo-affective disorder, and psychotic depression. When the hallucinations were related to lock-up, they usually resolved within a week or two of detention without medication.

Self-mutilation was a common finding. Boys carved their initials or other designs into their skin with erasers. They marked themselves with the sharp edge of any object, e.g., the edge of a paper clip or a pen or pencil. Self-mutilation is associated with schizophrenia, borderline personality disorder.

Extreme anger and unusual levels of aggression were common. This is a know manifestation of depression. Identification is necessary, however, for treatment to begin. High levels of anger and aggression have also been found in complex partial seizures (formerly know as temporal lobe seizures), episodic dysfunctional syndrome, and post-traumatic stress disorder (PTSD).

The most common finding, however, is depression. Feelings of sadness may be related to the lock-up, to loss of freedom, and/or to the trauma of life in the streets. Many of the incarcerated youth have been exposed to and/or are victims of violence early in life. PTSD is a frequently undiagnosed problem. Family problems are also a major source of depressed feel-

ings. Some of these boys have experienced severe episodes of abuse and/or neglect, especially in their early lives. This is a difficult part of the history to obtain. Dorothy Lewis et al. has suggested that the boys are embarrassed to relate the abuse and wish to protect their parents. While this may be true, it is also likely that many of these young men do not understand that the behavior they receive is abusive and/or neglectful. Depression seems also related to a notable absence of parents in the lives of these young people. A young man who had recently attempted suicide drew a telling picture that seemed to express his emotional state better than words. Neither parent had called or visited since his detention.

These incarcerated young men show varying degrees and types of pathology; however, they share a common denominator. The two most telling aspects of their lives relative to their behaviors are a lack of a father presence and drug trafficking.

Of the 50 adolescents reviewed for this article, 6 had fathers who had died. Eight boys had some type of consistent fatherly support. The majority of the boys—36 to be exact—had little or no contact with their dad. Interviews with these boys reveal deep-seated feelings of anger and abandonment. Their comments included the following:

"My father has never done anything for me."

"I hate my father . . . he doesn't help me out, he doesn't buy me clothes, shoes, or anything."

"I have no respect for my father."

"If I ever see him again, I'll kill him."

"Frankly, I don't know where he is and I don't care . . . as far as I'm concerned, my mother is my father."

"Perhaps if my dad were more of a dad, my brother and I wouldn't be in so much trouble."

The antisocial behavior that characterizes their lifestyle almost always occurs in the presence of other young men. These boys are each other's father. They seek to impress and prove their maleness, their self-worth. Accounts of the Central Park jogger attack state that about 50 boys entered Central Park together. They eventually pared down into smaller groups. In numbers there was mutual support and approval for the night's activities.

Almost all of the boys detained in detention centers have a current or previous charge of drug trafficking. Again, questioning that examines their attitudes and feelings about their drug activities is revealing.

"Drugs give a better appearance."

"Money, money, money . . . gets you anything you want—women, cars, jewelry."

"It's competitive . . . you want to make the most, be the biggest . . . then you get to hang out with the main dealer . . . it's important to be seen with him."

Many of these drug traffickers carry guns. Shootings are commonplace. "They make you seem manly" and "it impresses the other guys" several boys have said.

These young men have empty lives. They are addicted to excitement and fun at almost any cost. There is a startling absence of empathy. Their behav-

iors are narcissistic; their relationships often unstable.

Father absence plus a commitment to the drug culture are directly related to low self-esteem. Kohut teaches that the presence of loving, warm caretakers in the early life of a child is critical to the development of a positive sense of self.[1] When caretakers are not present, children turn to others to help validate themselves and their lives. The absence of a primary parent, in most cases a father, sends the child a message of rejection and suggests to them they are not good enough to have the love, attention, and energy of a father. These young men turn to each other for that type of same sex affirmations. They then turn to the drug culture for material affirmations as well as the opportunity to excel at something, even if it is illegal and dangerous to themselves and others. These common factors, combined with the abuse and neglect of their lives, often converge to create serious emotional problems. Although girls tend to handle these issues in a more passive, personal way, i.e., a pregnancy, the recent rise in rates of adolescent female incarceration may reflect a changing pattern.

The solution to the problem of incarcerated youth lies in the creation of a totally therapeutic facility, staff, and program. The goal must be treatment and not punishment. Centers to redirect growth and development should be established. The program should focus its energy on making these young men accountable and responsible for their lives. The problems of black male youth, in particular, are often more generic than

stated. Black males are often raised without demands for accountable, responsible behaviors and attitudes. Conversely, girls are expected to do everything and suffer consequences for not meeting expectations.

All staff members should have backgrounds related to child/adolescent care. Staff have to be willing to examine their own fears and prejudices regarding incarcerated youth. A program should consist of a fully scheduled treatment day that will include school; family, group, and individual therapy, drama, art, and music therapies. All activities should be created and implemented to increase self-esteem. Parents and/or guardians and family members must be an integral part of the therapy process. Visitation should be frequent, and therapeutic support should be offered to parents. These young men must also be offered school and vocational options. Many have no knowledge or awareness of their own possibilities and of opportunities to develop and express their talents and skills.

According to Dorothy Lewis's study of 95 New York delinquents, all except six became adult offenders.[2] For the child, the solution can not wait; the problem is now.

References

1. Kohut, Heinz. (1971). *The analysis of the self.* New York: International University Press.

2. Lewis, D., Lovely, R., Yaeger, C., and Femina, D. (1989). *Toward a theory of the genisis of violence: A follow-up study of delinquents.* Washington, DC: American Academy of Child and Adolescent Psychiatry.

9 Financing

Five Creative Financing Principles for Health Care of Incarcerated Youth

Michael W. Brady, M.D., M.P.H.

Our exploration into creative financing of health care for incarcerated youth can be framed in cultural, macro-economic, and micro-economic terms.

As a culture, we have historically allowed harsh treatment of social deviants and minority groups. Two hundred years ago we burned witches at the stake. Not one hundred years ago our government condoned giving disease-contaminated blankets to incarcerated Native Americans. Not fifty years ago we interned many of our Japanese American citizens, though they had been convicted of no crime. Until recently, we put juvenile offenders, status offenders and pre-adjudicated detainees alike into jails with convicted adult felons. In some cases inmates controlled access to health care in jails, could get medical records and extort favors for

treatment, and even had control of dispensing medicines. Jails and prisons employed few qualified and licensed practitioners, and many cases of abuse and neglect of juvenile detainees went unnoticed. For the past fifteen years or so, members of an active movement for health care standards have been trying to improve the way our culture treats incarcerated youth.

Principle #1:

Support national standards for care and legislative initiatives to codify standards

Most of us in this room owe our jobs and budgets to this national movement to set standards for health care for juvenile detainees. The standards of care set for juvenile detainees are meant to approach the community standards; in some cases funding for health care for incarcerated youth equals or even exceeds minimal standards mandated for all U.S. children. The courts have ruled that, though legally deprived of their freedom, juvenile detainees are entitled to health and access to health care; depriving such care constitutes cruel and unusual punishment. The individuals and associations that have helped bring about these standards are the greatest community resource for improving standards of care available to incarcerated youth, and thereby for improving funding at the local, state and national level, as laws begin to incorporate and enforce these standards.

It is no longer acceptable in this country to give contaminated blankets to inmates, or to expose youth to tuberculosis in adult jails, without diagnosis or treatment. It is no longer acceptable to put minority Americans in jail because of their ethnicity alone, as was done with the Japanese—often without adequate health care. Care for incarcerated youth must meet comparable community standards of care. As health professionals we can positively affect the creation and implementation of these standards, insuring funding and adequate health services for incarcerated youth on the state and county levels. Indeed, we may be able to set inmate/health care provider ratios much as inmate/probation ratios were set two decades ago.

Principle #2:

Make optimal use of existing funding services

To adequately fund health services for incarcerated youth, programs must access all available categorical funds from the local, state and national programs for which they are eligible. Title V, Title XIX, and Supplemental Security Income funds are important to local juvenile screening and treatment programs. In Washington State, all pre-adjudicated minors are eligible as wards of the court for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). In California, all post-adjudicated minors awaiting "suitable placement" are EPSDT-eligible, as are many medical recipients whose medical condition allows for early release from

detention. Public funds, private insurance and special children's services from Crippled Children Services, Shriners Hospital, drug/tobacco/alcohol prevention, and other categorical funds, can greatly reduce health care costs—as can early release programs that place the payment burden outside the juvenile justice system.

Principle #3:

Use training programs for low-cost, high-quality care

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, and are expert in dealing with their health problems.

Principle #4:

Manage care for cost savings

Given the necessity of quality care by licensed providers for incarcerated youth, the creativity comes into play. Costs for travel, payment rates, training of providers, and supplies, are not constants. Workers in San Bernardino County found that residents and fellows often provide onsite services otherwise available only at the hospital. Using mobile x-ray and lab units is often more cost-effective than transferring the minor to the hospital or maintaining onsite facilities. Some counties initially save costs by hiring contract firms, rather than using county employees to provide care (though

these savings may be short-lived). Free care can be arranged in return for preceptorships for trainees, or through religious and community action groups concerned with ongoing child welfare issues.

Principle #5:
Implement networking strategies for cost sharing and savings

Incarcerated youth health care programs often cut costs by working within coalitions. Such coalitions can access federal and local grants to decrease adolescent pregnancy; to reduce risk of infection with HIV and other sexually transmitted diseases; to provide drug, alcohol and tobacco education; and to provide mandated special education programs to disadvantaged youth. Many adolescent fellowship and residency programs add a number of sites in the community together to fund a trainee's stipend, e.g., juvenile health, school, clinics, college health services, and job corps. Sexually transmitted disease clinics and hospital-based programs might also combine resources to give trainees a well-rounded experience in adolescent health. In addition, combining resources can improve quality of care and continuity of service for high-risk youth after incarceration ends. Eliminating duplication of services and waste of limited resources is crucial to establishing high-quality, affordable care.

These are just a few general principles for creatively financing health care for incarcerated youth. The

next step, of course, is to address specific questions, and share the creative solutions already in place throughout our region. To succeed, we must plan strategies to form grant-writing and fund-seeking coalitions, to improve health care services for these high-risk youth, and to continue to provide some services for youth who have left the juvenile justice system.

Navigating Benefits Systems to Ensure Incarcerated Youth's Health Care

Gary Shostack, M.P.H.

Generally, children in state and county youth facilities receive health care funded through the operating budgets of the county, a state agency, or the individual facility. Although the vast majority of youth in the juvenile justice system are from low-income, Medicaid-eligible families, the youth often lose state Medicaid coverage once they enter the juvenile correction system.

Why? State-level administrators often misread federal regulations as prohibiting incarcerated youth from participating in a Medicaid program. In fact, federal regulations do prevent the state Medicaid program

from obtaining federal financial participation (FFP) to pay for health care for youngsters placed in state or county institutions. This is a limitation, however, rather than a total prohibition and both state and federal Medicaid funds may be available for certain youth in the juvenile justice system.

The "Medicaid problem" is often discussed by health providers and other professionals involved in caring for this population. These discussions generally focus on obtaining congressional support for changing the federal regulations prohibiting FFP. While I support these efforts, this presentation will outline a fairly simple strategy we have used in Massachusetts to gain access to Medicaid funding under certain circumstances, which may also be of benefit to other states.

The first part of the paper outlines the limited circumstances under which youth involved in the juvenile system may be eligible for medical services supported by FFP. The second part outlines an argument for inclusion of these youth as eligible participants in a state-supported Medicaid program even under circumstances which completely preclude any federal financing.

In addition to these strategies, I will discuss the importance of strong alliances with state public health, maternal and child health, and welfare agencies. These agencies are absolutely necessary for successfully advocating for inclusion of incarcerated youth in state-funded Medicaid programs.

Deinstitutionalization in Massachusetts in the mid to late 1970s led to several major changes which, among other things, set the stage for participation in the Medicaid program. Large state- and county-operated facilities were closed and replaced by a system of small, privately operated secure facilities serving approximately 5 percent of a total population of 1,750 incarcerated youth. In addition, about another 5 percent remained placed in state-run secure facilities. This meant that 95 percent of the juvenile population was not residing in a government-operated secure detention facility.

Approximately half of the 1,750 youth are placed at home, and the remaining 40 percent reside in group care, foster care, or in specialized programs for substance-abuse treatment, psychiatric treatment or sex-offender treatment.

In the late 1970s, discussions with the Department of Public Welfare—the agency in Massachusetts which operates the Medicaid program—led to an interagency agreement which designated youth in private placements as potentially eligible for Medicaid and FFP; youth placed at home and in state facilities were deemed ineligible for FFP. In addition, youth in private placement faced monthly eligibility reviews. As a result of this first step, we realized some savings—but it was less than $20,000 per year.

In early 1982, we negotiated a new agreement with the Department of Public Welfare, allowing Medicaid

cards to be issued for all adjudicated youth, irrespective of their placement or financial eligibility. However, we continued to collect FFP eligibility information, which we submitted to the Department of Public Welfare. The Department of Public Welfare paid medical and dental expenses, and FFP was claimed only for eligible youth. The Department of Youth Services repaid the Department of Public Welfare at the end of the year for expenses incurred for youth who were ineligible for FFP.

Therefore, the savings to the Department of Youth Services included the entire cost of care for all youth eligible for FFP. Although we repaid the Department of Public Welfare for the costs for ineligible youth, we still saved the difference between what medical providers would charge the Department of Youth Services and what Medicaid would pay. By repaying Medicaid, rather than paying directly, we benefited by paying according to the Department of Public Welfare rate structure.

In 1986 a new agreement with the Department of Public Welfare went into effect. At that time Medicaid agreed to include all Department of Youth Services youth in the Medicaid program, to continue to track eligibility for FFP, and to absorb all costs for any youth whose placement in a state-operated facility, or income level (if living at home), excluded them from FFP eligibility.

How did we persuade another state agency (welfare) to assume financial responsibility for Department of Youth Services youth?

We decided to take the idea to a level of the government which was higher than both the Department of Youth Services and the Department of Public Welfare. We hoped that a good case could be made that the commonwealth would benefit by including Department of Youth Services youth in the Medicaid program, increasing our chance for success. The following argument was put to the cabinet secretary overseeing both agencies:

1. The Department of Public Welfare pays all costs for youth placed in the Department of Social Services; why should Department of Youth Services youth be treated differently? They are just as disadvantaged, and the state has similar responsibilities for both populations.
2. By using Medicaid to pay for the Department of Youth Services youth who were eligible for FFP, the state cut the cost of caring for youth by 50 percent.
3. Using state Medicaid dollars to buy health care for FFP-ineligible Department of Youth Services youth costs the state much less, because Medicaid pays much lower prices than what hospitals, labs, dentists, mental health workers, etc., would charge the Department of Youth Services. So even though the cost to the Department of Public Welfare would increase, the net cost to the state would decrease.

At these discussions, we received strong support from the Department of Public Health and from within

the Department of Public Welfare by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program staff. Their advocacy for the unqualified inclusion of Department of Youth Services youth in the Medicaid program was substantial political support for the Department of Youth Services case. Their support was based on the view that these were mostly low-income youth, who were risk takers, who suffered from high sexually transmitted disease and pregnancy rates, among other problems. They were generally at higher risk for health problems than non-delinquent adolescents. EPSDT staff stressed that it made sense, both from the economic and public policy perspectives, to provide this population with comprehensive primary health care. This support from other agencies within the same secretariat added credibility to our case, and was an important factor in gaining a favorable decision.

The Department of Youth Services agreed to the following:

1. Aggressively seek private insurance information from parents (always first payer).
2. Complete Medicaid applications for every youth, and repeat quarterly, to monitor for FFP eligibility.
3. Provide Social Security numbers at initial application, or apply for one if the youth does not have one.
4. Continue to employ and pay for health care staff working on-site in secure locations, for both state-run and private facilities.

5. Cooperate with the Department of Public Welfare policy of placing Medicaid recipients in managed care plans, unless placed out of the area.
6. Allow Department of Public Welfare staff to randomly audit selected cases monthly, to assure FFP eligibility. This generally involved 5–6 cases a month.
7. Allow federal Health Care Financing Administration staff access to Department of Youth Services case files on the same basis, generally 4–8 cases a year.

Medicaid pays for all care for youth in private community placement, and for youth placed at home, unless the family has private insurance. Department of Youth Services youth are eligible for all Medicaid benefits which (at this time) includes inpatient and outpatient hospital care; laboratory and radiology tests; physician fees; dental work; psychiatric hospitalization; and prescription fulfillment. The average monthly payments to various medical and dental vendors is approximately $100,000.

The Department of Youth Services does not get a report on how much is federally reimbursed and how much is totally state paid. However, the Department of Public Welfare tracks FFP eligibility carefully to assure maximum federal reimbursement.

Since many states have, or are considering, community-based treatment and private treatment for adjudicated youth, this health funding approach may prove

beneficial. Even for those states which cannot obtain federal reimbursement, one might make a case for using all state Medicaid funds to purchase health care for delinquent youth, since the state agency which operates the Medicaid program can generally purchase health care at a much lower cost than can the juvenile corrections agency. But this argument can only succeed if presented to a government entity overseeing both the Medicaid program and juvenile corrections. In some cases this may be a secretary, or perhaps even the governor.

10 Interagency Programming

Filling the Gaps, Avoiding Duplication

Janice Piepergardes, R.N., M.A.

In Arizona, the departments of Juvenile Corrections, Health Services, Economic Security, Public Safety, and Education all draw state funds, and all provide services for youth. Although the expressed goal of each agency differs, they frequently overlap when providing services. With 15 counties supporting their own agencies as well, one might surmise that youth receive all the services they need.

Unfortunately, this is not the case. Efforts are duplicated in some instances, and gaps remain in others. Therefore, interagency programming is essential for three basic reasons: cost containment, continuity of care, and common sense.

Children who commit crimes are too often considered in the same light as adults who commit crimes. One still hears callous statements like, "Why should we spend money on *them*?" "*They're* a lost cause, just lock them up and throw away the key."

The Maternal and Child Health Bureau sponsored an enlightening conference in 1988, entitled "The Forgotten Child in Health Care: Children in the Juvenile Justice System." It was rewarding to find that the Maternal and Child Health Bureau has long advocated interagency collaboration in addressing the needs of high-risk children and youth.[1] Incarcerated youth—because of the lifestyle many of them choose to live, or are subjected to—fall into the group at risk for physical and mental health problems.

A quick comparison of four chronic conditions present in the Arizona Department of Juvenile Corrections' (ADJC) youth during the last quarters of 1989 and 1990 points to an increase in chronic conditions, although the overall population has decreased.

Figure 10.1: Four Chronic Conditions Present in the Arizona Department of Juvenile Correction' Youth

	1989	1990
Population	772	672
Allergies	48	117
Asthmatics	15	44
Seizure Disorder	6	7
PPD* Convertors	10	18

**Purified Protein Derivative*

Sexually transmitted disease figures for the same period of time remained essentially the same.

However, Adobe Mountain Juvenile Institution—the male diagnostic center—reported an increase in the number of syphilis cases.

In 1990, psychiatric hospitalizations for ADJC youth resulted in 573 hospital days, compared to 526 in 1989.

Arizona's juvenile health services treats 900–1,000 children within the Department of Corrections, whose primary focus is on the needs of its nearly 12,000 adult inmates, and the litigation they continually promulgate. Requests for juvenile health needs, perhaps understandably, fall to the bottom of the "priority pile."

Arizona's Department of Corrections juvenile health services has long been cognizant of the need for *intra-agency cooperation.* Since the Department of Health Services works for a different assistant director, and under a different budget from the institutions, cooperation is essential for a smooth operation. No service organization, for instance, can function in a secure facility, without the cooperation of facility security staff.

On July 1, 1990, the Arizona Department of Juvenile Corrections became a separate entity. In addition to already-established agencies, ADJC now requires its own budget. Funding, therefore, continues to be a problem, and education of state legislators, regarding juvenile health care needs, has become a priority.

The legislature has charged ADJC with the responsibility for providing legally defensible health care to

their youthful population. However, *cost containment* appears to top the legislature's agenda. Budget cuts are predicted. Unfortunately, cost containment without thoughtful care and planning jeopardizes quality health care.

Because the Department of Health Services is dedicated to providing quality health care for Arizona's incarcerated youth, outside resources are imperative. *Continuity of care* requires community resources as well. Bridging the gap from facility to community becomes even more important, given ADJC's emphasis on returning youth to the community as quickly as possible.

Today, the average youth incarcerated in an Arizona correctional institution stays for six months. Such problems as long-standing mental health needs, or chronic medical conditions, should not be treated and dropped. It is not unusual for a youth to be discharged from a facility with a healing surgical incision, casted (fractured) extremity, or some other incomplete treatment in progress. Continuity of follow-up care is basic to a satisfactory outcome.

Dr. James Owens, in his article, "The Importance of Standards in Providing Health Care for Incarcerated Youth," notes that accreditation assures *continuity of care.*[2] Along with accreditation, Dr. Owens suggests interagency programming, involving local pediatricians with programs for children who are in trouble in their communities. The medical community is a marvelous,

often untapped, resource for education and support of youth in correctional facilities.

Family involvement, of course, is the most potentially valuable means of support. However, with so many dysfunctional families in the United States today, community resources often have to supply an appropriate significant other.

The list of volunteer programs utilized by ADJC grows daily. These volunteers provide substance-abuse counseling, special visits, entertainment, teacher's aides, tutoring, and prenatal and parenting classes, among other services. Networking with other community agencies has allowed ADJC to institute an immunization program at *no cost*, which ensures that every youth admitted is currently immunized against mumps/measles/rubella, tetanus, diphtheria, and polio. This same network has also resulted in free Purified Protein Derivative and cocci vaccine. The National Commission on Correctional Health Care joined ADJC's list of network benefactors in January 1991, when they sponsored a three-day workshop on AIDS for ADJC personnel and other health care professionals from community corrections. As a direct result of that workshop, Black Canyon Juvenile Institution has gleaned another volunteer who teaches AIDS classes to the female detainees.

Interagency cooperation will also be essential for securing funding for AZT or an alternative drug, prior to encouraging mandatory HIV testing of all incarcerated youth.

Health care costs continue to rise; therefore, *common sense* dictates that we utilize every possible means to cut these costs. The Arizona Revised Statutes do no actually mandate that health care be provided by ADJC. Again, common sense tells us that we need a good health system for incarcerated youth. An impossible task? Not if we maintain a good network of interagency programming.

References

1. Thompson, L. S. (Ed). (1991). *The Forgotten Child in Health Care: Children in the Juvenile Justice System.* Washington, DC: National Center for Education in Maternal and Child Health, p. vii.

2. Owens, J. (1991). The Importance of Standards in Providing Health Care for Incarcerated Youth. L. S. Thompson (Ed.), *The Forgotten Child in Health Care.* Washington, DC: National Center for Education in Maternal and Child Health, pp. 49–53.

11 Coalition Building

A Ten-Minute Primer on Coalition Building

W. David Braughton, M.S.S.A.

Begin with an identifiable problem

Problems are not objective conditions, but are inferred from perceptions of and value judgments on those conditions. Unless there is agreement that a problem exists, there is little that can be done to correct it. Whether one can form a coalition or enter into some type of cooperative or collaborative strategy depends upon the level of consensus, difference and the value/interest saliency surrounding an issue.

Survey the interorganizational field

The interorganizational field consists of an organization's constituency, sphere of influence, programs, and relationships. One must identify those organizations with which the organization in question shares enough interests to justify forming a coalition.

Organize around mutual self-interest

Potential for coalition building rises when a high degree of value/issue consensus among the groups being organized converges with a high degree of mutual organizational self-interest. Generally, interests converge around resource issues; i.e., improving one's own access to resources, and limiting others' access to these same resources.

Do not let self-interest be the only tie that binds

In the absence of a "guiding vision" and a healthy concern for organizational maintenance, mutual self-interest can easily become "competing" or "crippling" self-interest.

Select a realistic strategy or intervention depending upon the issue in question

The issue of collaborative service delivery calls for a different strategy from the issue of greater state funding for health care services to juveniles; changes in existing statutes limiting juveniles' access to essential heath care services calls for yet another approach. Although a campaign strategy may be appropriate in the first instance, a contest or sum/zero strategy may better suit the issues of increasing resources or improving access.

Make certain you have what it takes

Whichever strategy is adopted, successful implementation requires leadership; legitimacy; a well-

defined product or program; resources (including staff and money); and a suitable organizational structure.

Agree to disagree

Along the way, self-interest and other considerations will create serious differences. How these are handled will not only determine the success of the particular venture, but also may well determine the long-term viability of the coalition itself. By acknowledging, at the outset, that differences will arise, conflict can be managed in a healthy rather than destructive manner.

Mutual accountability is key

The coalition must have a strong sense of mutual accountability and account-ability to the larger systems of which it is a part and from which it is seeking legitimacy, as well as power and access to resources, to succeed and effectively address the issues.

Nothing succeeds like success

The success of past undertakings affects the success of any future endeavor. Start modestly, know your strengths and weaknesses, learn from your failures, and build upon your successes. Also remember that every exchange involves some cost. One should carefully measure costs against benefits before moving ahead.

Adapt to change

The very existence of a successful coalition will change the interorganizational field and the nature of

the issues which must be addressed. The coalition must be flexible enough to accommodate the new reality which it itself is helping to create.

Coalition Building for Systems Change

Nancy Grasmick, Ph.D.

As society's systems do not change easily, and government bureaucracies are especially resistant to change. Those comfortable with the "old order" will not profit by change, and even those who know that change is needed are unclear as to what specific changes are necessary, and how they will work together.

One way to promote positive change—whether focused on foster care, health care for incarcerated youth, or other issues—is to promote a coalition-building model. That is, to bring together all the major stakeholders in any major systems change effort. In using this approach, careful consideration must be given to involving those with a stake in the outcome in the process.

This model has worked in Maryland, in planning for the restructuring of children's services. Our process involved all branches of government (executive, judicial, legislative), as well as the private organizations and advocacy groups. It was a formally structured process with committees and task forces; however, we also relied on informal networking and coalition-building.

In building such a coalition for health care, physicians, professional organizations (such as the American Academy of Pediatrics), hospital professionals, and health care workers must be involved. The family—both parents and their children—are critical to any systems change. Any coalition model must involve families, as they are the best predictors and indicators of what is needed.

As the coalition develops, attention must be given to group analysis of the problem, to goals and objectives of change, to group consensus on the new model, and to an honest analysis of both the positive and negative impact of the change. Parties within the coalition can negotiate issues on which they disagree.

Such coalitions can help foster systems change, as change is easier to implement if existing groups support it. While building such coalitions may initially take more time, in the end, their support makes such an effort essential.

Building Coalitions at the Local Level

Shelly D. Yanoff

As a child advocate, I believe strongly in coalitions; as an activist from the largest city in a decidedly anti-urban state, I believe even more strongly in coalitions and coalition building. But here, as elsewhere, we must be careful about our definitions—words must mean things, as Byron said. The phrase *coalition building*—like *networking, coordinating, empowering* and *case managing*—is pushed into service to solve many problems these days. But the phrases themselves are not enough. They are strategies or tactics, dependent on a value structure and on appropriate goals, if they are to be meaningful or realizable.

Sometimes, they may hinder rather than help in reaching a goal. In Pennsylvania, for example, there have been more programs dedicated to blind people, historically, than to people with other disabilities. Many organizations for the blind have chosen not to join in state level coalitions, calculating that, in a time of scarce resources, they would be more likely to secure resources by *not* joining. They believed that, for their limited goal, enhancing their numbers would diminish their effectiveness.

The example underscores the importance of the series of questions which must be asked of every coalition. The answers may be different, but the questions remain the same:

- What are the goals of the coalition?
- Who needs to join to make them happen?
- What are the strategies for action?
- Who or what is the public face of the coalition?
- How long should the coalition exist?

Obviously these questions are all interrelated, and mutually dependent. Many of the answers carry both strategic and definitional nuances.

One goal of a coalition may be to create the environment in which interagency coordination and consultation may occur. This might be considered an insiders' coalition—requiring certain strategies, for a specific period of time, within different government agencies.

In one Philadelphia program, a psychological team from a children's psychiatric hospital, under contract with the city's Department of Health, works with a youngster and his or her family while the youth is in the detention facility. This program, which seeks to intervene preventively in the family dynamic, is a good example of an insiders' coalition.

If the program aimed to increase the number of families served, or to enlarge the scope of the services

provided, the coalition itself might need to expand. Philadelphia Citizens for Children and Youth (PCCY) or the Juvenile Law Center, for example, might be consulted regarding public budget and programmatic coalition building and advocacy. This would be a move toward an inside/outside coalition.

The inside/outside coalition can serve many purposes and take many shapes. PCCY works actively with a variety of coalitions dedicated to improving health care centers service, to developing more programs for early prevention and treatment for low-income children, to improving birth outcomes, and to increasing immunization funding. In many of these coalitions, we work with representatives of government; in others we do not.

An interesting example of the inside/outside coalition is our recent work in expanding the demand for, and the supply of, community-based alternative settings for adjudicated juvenile delinquents. We began by noting the inadequate number of community-based programs, and the city's increasing reliance on institutionalization of youths.

We aimed to develop a consensus among those invested in the current system, to move toward a more community-based continuum of dispositional alternatives for juveniles. We surveyed juvenile probation officers, asking them to describe the youngsters for whom they had the most difficulty in providing adequate programs. In addition, we asked what kinds of

programs they felt were needed or lacking. We then asked the judges the same questions.

Based on their responses, we conducted research, compiled data on information, utilization and costs, and invited some program representatives from other states and counties to a series of four lunch conferences.

At these conferences, key members of family court, judges, probation officers, providers of support services, public officials, leading citizens and members of the bar discussed the issues. Participants helped develop the kind of programs which are needed and which, if developed, would be used. This inside/outside coalition (particularly necessary in the juvenile justice field) is on the way to realizing the goal—the development and utilization of an appropriate community-based services continuum for juveniles.

Another inside/outside model would involve working with other states, counties, and communities to allow Medicaid reimbursement for institutionalized youth. Assuming that the released funds would then be used to meet other needs, groups and citizens could be enlisted in the effort.

The last coalition model I wish to speak about is the hardest, the longest-lasting, and the one for which we need to compromise and persevere. This model is not just about public awareness. It is not just about one or two programs. It is about prevention. It is about budgets. It needs many hands and many voices. It

needs some victories and some persistent and insistent hope.

This nation's cities are in deep financial need, leaving many of their citizens feeling desperate. Many state budgets are swimming or sinking in red ink, and the Federal Government does not appear able or willing to ease the pain in other levels of government. Into this setting steps a large, expensive growth industry; prisons, or facilities for adult criminals or adjudicated youngsters.

No level of government appears to be keeping pace with this country's "imprisonment binge." According to the state operating budget, Pennsylvania will spend $42 million next year on youth detention centers and youth forestry camps. The average cost for institutionalizing one child for one day is $142.

In Philadelphia, we will spend $43.7 million in operating costs for basic programming for juvenile delinquents. This money is not a luxury; we provide for these youth poorly at present. We have got to find better ways to help adjudicated youth.

The city and the state are having difficulty paying their workers, their vendors, and their rent. We have got to build the coalition to invest in people, not prisons—to protect and nurture, not to punish.

If we were to show that a child who had a quality preschool program like Head Start was less likely to be in trouble with the law, to drop out of school, to be unemployed—and we can—then we who are con-

cerned with the health care of incarcerated juveniles must join the coalition for preschool programs.

If we were to show that a child who had been abused was more likely to abuse, to assault, to commit crimes, to fail in school—and we can—then those of us concerned with the care of incarcerated youth need to join coalitions working on preventing or limiting child abuse.

If we were to show that lead poisoning is a primary cause of the kind of neurological deficit, developmental delay, short attention span, and problem behaviors found among large numbers of delinquent youths—and we can—then advocates for the improvement of health care for juveniles must join coalitions working to eradicate lead poisoning problems among this nation's children.

If we were to show that drug abuse or the lure of drug money contributes significantly to the number of juveniles who are committing crimes today—and we can—then we must join with coalitions who are fighting to give children and families in poor neighborhoods programs and possibilities, something to say yes to.

We must wholly embrace the task of coalition building. Our children are our future, and the battle to save them will neither be won cheaply, easily, nor quickly. We need a long-term, broad-based coalition. In the short run—and here, as everywhere, there are short- and long-range strategies—here are some things we can do.

- Join with groups working to improve health access and utilization for youths capable of living in the community, with their health care provided the same way it is provided for others.
- Join with family preservation activists/coalitions to develop programs working to improve the youngster and family's dynamic, and to provide the support necessary to help the family cope.
- Join with those who advocate for increased health insurance for youth; in particular, we should advocate for the "bridge" card, a health insurance card good for a year after a youth's release from state care.
- Join with those advocating school-based clinics and other empowering outreach models that encourage young people themselves to seek and secure health care.
- Join coalitions to create non-stigmatizing programs where youth can more freely seek help reentering their community.
- Join efforts to apply drug and alcohol expenditures to increasing the number of treatment programs.
- Join to insist that juvenile programs be administered by people willing to take risks on behalf of youngsters served.

Every coalition working to increase services to children and their families needs a broad-based, focused strategy. Coalition spokespersons must be sympathetic to the listeners' perspectives, and must tell stories of success and possibilities. Compassion works best if it appears to be fiscally sound.

So we must remind the community that:

- It costs six thousand dollars to remove the lead from a house, versus $100,000 for a year in an institutional bed.
- One dollar for immunization saves $10 in curative costs.
- One dollar for Head Start saves $4.75 in special education.
- Library and recreation programs, health clinics, education tutorials, mentor programs, family counseling, and adolescent counseling are a lot less expensive than providing care after the fact.

What we must do for young people who are already in state care, and for their younger brothers and sisters, is to insist that our rhetoric match our reality, and that we make our children and young people our priority.

12 Future Challenges

Creativity in the Business of Improving the World for Children

Ellen Schall, J.D.

Human beings seem to cluster in narrow professional groups; the security of being with people who were trained as we were, who assume value where we assume value, who speak the same language, and who know the world by the same abbreviations or acronyms we do, is powerfully comforting. The world designed this way must serve our interests; it clearly does not serve our clients'.

What can we do to serve our clients, these children many in our society are willing to forget, to overlook, to write off? How can we serve them usefully and creatively?

A constructive way of thinking about our work is that we are in the business of trying to improve the world for children. In this business, health turns out to be both a powerful leverage, and a critical indicator.

Let me tell you about my work on the criminal justice and juvenile justice side, so we can think together about how much more powerful our interventions could have been, if joined creatively with efforts spawned in the maternal and child health (MCH) world.

As deputy commissioner of corrections in New York from 1979 to 1982, I oversaw a health care program for 15,000 prisoners, including 3,000 adolescents. As commissioner of New York City's Department of Juvenile Justice (DJJ), from 1983 to 1990, I developed with my executive staff an innovative health care program for adolescents in detention. For the last year, as president of National Center for Health Education (NCHE), a national nonprofit organization devoted to using education to improve health, I have been able to reflect on the health care issues for incarcerated and other at-risk youth from a broader perspective. From a service perspective, incarcerated youth are basically the same population as other high-risk youth in the community: runaways, school dropouts, substance abusers, and so on. Their incarceration, along with its many negative consequences, can provide the opportunity for intensive health assessment and treatment services, as well as for other assessment and service, but only for a relatively short time. What happens to their health care and health status when they return to the community is the paramount issue for us today, an issue very difficult for juvenile corrections agencies to

address alone. But, working together on this issue, we can make considerably more progress.

The health care program at the Department of Corrections was an adult corrections model. That is, it was neither preventive nor developmentally focused. It only addressed the acute health care needs and the chronic medical and mental health problems of adult inmates. Even in the period before AIDS was a major issue, New York City spent $13 million on prisoners' health, and had a nationally recognized program. There were, however, no "extra" resources available to meet the special preventive and health education needs of the 3,000 adolescents in the adult system—or the special needs of adults, for that matter. In New York State, adolescents 16 to 18 years old are handled as adults, and are incarcerated in adult prisons.

When I become New York City's commissioner of juvenile justice in 1983, I was determined to develop a program of health services appropriate to a juvenile justice population. DJJ's mission, as we defined it, was to provide custody and care to children awaiting adjudication of their cases. These youngsters range in age from 10 to 15 years with an average age of 14. They are overwhelmingly minority (65 percent black and 30 percent Hispanic); 94 percent are male. The department is responsible for approximately 5,000 children each year whom it detains in a number of group-home nonsecure detention facilities, and at Spofford Juvenile Center, the city's only secure juvenile detention facility.

On an average day, there are 200 to 300 youngsters in detention, three-quarters of whom are at Spofford.

One of the first things I learned about this population was that it seemed healthier than the adult prison population for whom I had been responsible at the Department of Corrections. The chronic diseases that now afflict adult prisoners—infection with HIV, diabetes, hypertension, liver disease secondary to alcohol abuse, the consequences of poor nutrition, the effects of drug dependency—are only rarely found among young adolescents. For example, while I was at DJJ, we never encountered a youth with HIV symptomatology even though it is clear that had we been required to test, a number of them would have tested positive. This fact almost certainly explains the relative lack of attention to youngsters in correctional health care: Their medical needs are less urgent than those of an adult prison population.

Nevertheless, these children do have significant health care needs, needs that, if met when they are 14 or 15 years old, could significantly improve their health status. These needs reflect a serious lack of primary pediatric care, care that is in short supply in most inner-city neighborhoods from which the juvenile justice population is drawn. Health problems include high rates of sexually transmitted diseases, injuries and other trauma, poor vision and hearing, and chronic problems such as asthma and seizure disorders. Dental disease is also a major problem and reflects these children's lack of dental care.

Youth admitted to detention are the same youngsters who are hard to reach in the community. The opportunity to meet their health care needs when they are a "captive audience" can be an extremely positive consequence of juvenile detention. Yet detention is a difficult setting in which to address these problems.

Children stay for variable and unpredictable lengths of time in detention, ranging from a few hours to more than a year. Their lengths of stay are determined by the court, and not the detention system. Children are typically released directly from court, and it is impossible to predict the length of stay of any particular youngster.

These are barriers to service but not impenetrable ones. We developed a care management system involving needs assessment, service planning, and service delivery for each child. We provided the best possible care to the child in detention, and then followed up with an aftercare program of our own invention. Aftercare is rare in detention—and we had no legal authority over these children—but we knew that if we did not find ways to keep working with the children once they went home, the work we started in detention would be of very limited use. So, while we could make sure that every child had a comprehensive health assessment on admission, treating the problems that were identified was a challenge. The child identified as having a vision problem, for example, was likely to be released before his or her glasses could be made.

Nevertheless, establishing a high-quality health care program was one of our first priorities. We knew we wanted to contract for health services, rather than hire staff to provide them directly. Health care professionals affiliated with major teaching hospitals would be freer to act as medical advocates for the children than department employees for whom issues of security and population control might become preeminent. Outside staff were also likely to be better qualified. Finally, they could provide coordination and continuity of care between onsite services and hospital subspecialty and inpatient care.

We knew conflict would inevitably arise between DJJ staff and contract staff. Issues ranged from who had the authority to make what decision about a particular child, to more general differences of opinion on policies and procedures. But over time we developed an effective working relationship, and the advantages of contracting for health services seemed more than worth the difficulties.

During my tenure, the Montefiore Medical Center provided most of the adult prison health services in New York City, and was well known for its concern with social as well as health care issues. Montefiore ran a 24-hour onsite clinic and infirmary at Spofford to which children in nonsecure detention were also bought. The infirmary was directed by a full-time pediatrician and was staffed by full-time psychologists, a part-time psychiatrist, a full-time dentist, and appropriate support personnel.

The basic caregiver was a nurse practitioner or physician assistant; two were on duty, around the clock, 365 days a year. Each child received a complete medical assessment on admission, including a physical examination, a medical history and systems review, a laboratory screening, a mental health assessment, and a dental screening. Problems identified were managed in the infirmary, or were referred to Montefiore. Children with acute illnesses were kept in the infirmary, so that hospitalization—with its difficult security and management problems—was avoided whenever possible.

The program was expensive. During its six years of operation, annual contracts averaged about $1.5 million. Its services significantly exceeded New York State standards, which mandate only one nurse for every 25 juveniles, and explicitly prohibit preventive care. Each time the contract came up for renewal, we had to convince both city and state budget officials to continue to support a program of this scale.

Nevertheless, the program became a national model. In its time, it was one of only four accredited juvenile health care programs. As I look back on the program from a broader perspective, it had a number of features beyond the provision of primary pediatric care that are more widely applicable.

Mental health services are a key need for these youth. Anxiety about what will happen in court compounds the stress of detention itself. Many detainees—both adult and

adolescent—are maintained on psychotropic or sedative medications. Detainees' "best interests" are used to justify this policy, as are population management and control concerns. Montefiore's policy was to keep the use of these drugs to a minimum.

In practice, this meant that only children who had been appropriately maintained on such medications before admission to detention received further medication. Most youngsters who could not sleep and "acted out," or were depressed, were counseled and reassured about their understandable fears and anxieties. This approach required not only high-quality mental health staff, but also child care workers committed to this notion. The percentage of youngsters on psychotropic drugs decreased from 15 percent before contracting with Montefiore to less than 1 percent after.

But we never satisfactorily addressed the development of a group-centered adolescent mental health program. We oriented our medical model around the individual, and so ignored the group approach. A group systems perspective model for incarcerated youth needs to be developed.

We did know we wanted health professionals to work with our institutional staff to institutionalize "healthy living" policies beyond simple medical services provision. Smoking, for example, was a major issue. It had been used at Spofford as a behavior management incentive in much the same way as in adult prisons: Children who behaved well could smoke at particular

times. Adopting a no smoking policy was, therefore, as much a staff concern as a child issue. Smoking was successfully phased out by our fourth year at DJJ.

Food is another example. Over time, we were able to introduce more fruit and vegetables into the Spofford diet, in lieu of fat and starch. After some initial resistance, the salad bar became a popular feature for both staff and youth who had subsisted mostly on fast food for years.

Hygiene and personal appearance were another focus. Many of the youth in our facility had little parental supervision, and so needed basic training and encouragement. Many of those detained had never even owned a toothbrush before they were admitted to detention.

Finally, we developed health education programs focusing particularly on substance abuse prevention education (SAPE) and HIV. These programs were initially too didactic, but as we learned more about how to work with this population, we began to try different techniques. Group discussion and counseling replaced classroom sessions. A federally-funded grant for SAPE provided substance abuse education geared to different subgroups. Children whose drug involvement was limited received less intensive services than those with substance abuse problems. Mark Wade, our medical director, became a nationally known AIDS educator based on the direct and powerful approach he developed at Spofford.

It is very important that high-risk adolescents take responsibility for their own health. Each time a child came to the infirmary, he or she got the necessary care, but also an explanation—for why a given symptom required the prescribed intervention. We provided all discharged youth with a health card summarizing the treatment they had received in detention, including immunization status. It could be shown to community-based providers to promote continuity of care.

Most youth in the juvenile justice system return home relatively soon. In New York State, for example, so-called long-term placements with Department of Family and Youth now average six months, and only one-third of the juvenile detention population ever reaches placement. Most youth are released within 10 days of admission. This means their futures are determined much more by what happens when they return to their communities than by what we do while they are incarcerated.

We developed the country's first detention-based aftercare program to address this issue. Aftercare's mission is to link youth with community-based services; this task is especially difficult in health and health-related areas. In many inner-city neighborhoods, the only available providers are hospital emergency rooms, the least effective and most expensive source of primary and preventive care. Dental care is virtually nonexistent. Substance abuse treatment for adolescents is in extremely short supply.

We tried to operate aftercare on the individual child and system levels simultaneously. Our goal for each child was to deliver the services he or she needed—with an emphasis on returning youth to school—but we also used our experience with individual children to identify system gaps and create new programs when needed.

For example, the lack of effective educational services for this population led us to work with the Board of Education to design an alternative education program for court-related youth. Similarly, we developed an intensive home-based services program, Family Ties, to provide crisis-intervention and support to prevent long-term placement. It is interesting that we did not do this in health care; for some reason, on the system level we stopped short at the institutions' door. We did not design community programs to meet the special health and health education needs of the juvenile justice population. In part, this shortsightedness reflects the relative health of these children compared to adult prisoners; as a group, their educational needs simply seemed more acute. We also interpreted health services too narrowly. We failed to aggressively advocate for the health needs of this population in the community after discharge. Finally, we failed to identify Maternal and Child Health programs as a potential source of collaboration and support.

When I look back on our work at DJJ, I know we got as far as we did for many related reasons: We pushed hard for our youth, we knew a good idea

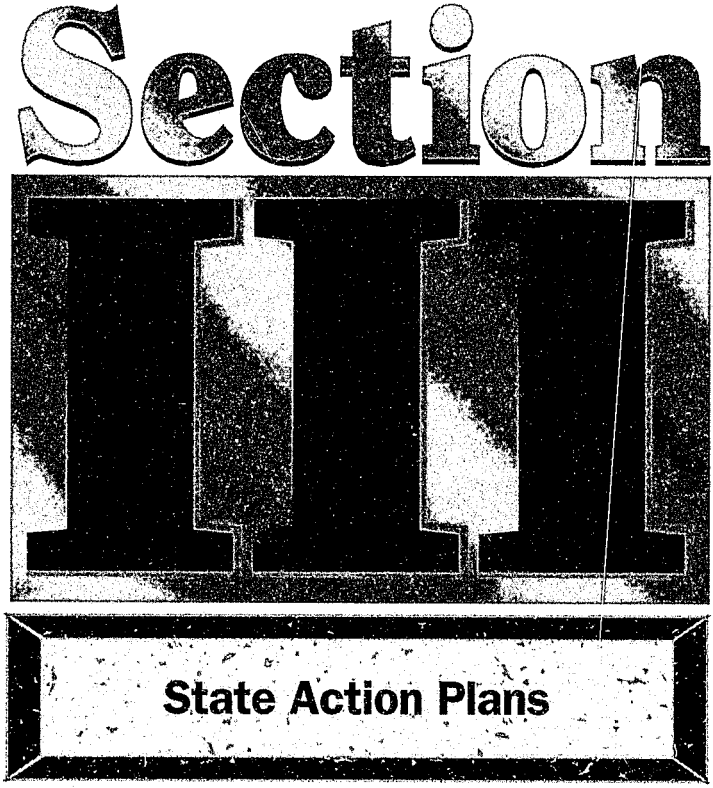
when we saw it, we borrowed liberally, and we were good at identifying funding sources that could serve our incarcerated (and discharged) population.

We looked at the Board of Education and saw they had good alternative high schools for children with difficulty in regular school settings, but our youth were not getting to high school. We asked why the Board of Education could not maintain alternative junior high schools for children returning to schools, and developed that model with the Board of Education. We saw that the state had developed a system to provide preventive services to families with children at risk of being placed in foster care, and asked whether our youths' families were eligible for such services, and if not, why. With New York City's Child Welfare Agency, we developed the first preventive service program specifically targeted to families with a child in detention.

There are a parallel set of questions to be asked about adult health care. What are the adolescent health services available in your community, and how can they be designed to include juvenile justice children? If AIDS is such a major health threat to our country and all the behavior that puts one at risk of AIDS is established during adolescence, why is AIDS money not spent on this population? And what is the best model?

My hope is that these three days of working together have generated a long list of questions that demand

to be asked, and the determination that together we can answer them and in so doing create new models of serving children.


Section
III
State Action Plans

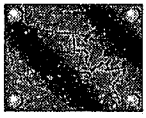
How to Use This Section

The state action plans that comprise this section are organized by standard federal administrative regions, which are numbered from I–X. To find your state or jurisdiction's action plan, locate its region on the map below. The regions in this section appear in order by roman numeral.

The pages of each plan are organized to note the state or jurisdiction's goals and objectives, as well as the program-, local-, and state-level actions that representatives developed to meet those objectives and goals. If no actions were developed at a given level, that category does not appear on the page.

States and jurisdictions that did not submit action plans do not appear in this section.

Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont



Region I

Improve the health care of incarcerated youth and of youth that attend after-care in local community placement.

Goals

Build collaborative relationships between public health and corrections and juvenile justice systems (Department of Children and Youth Services).

Objectives

1. Plans in this area depend upon the outcome of actions at the state level.

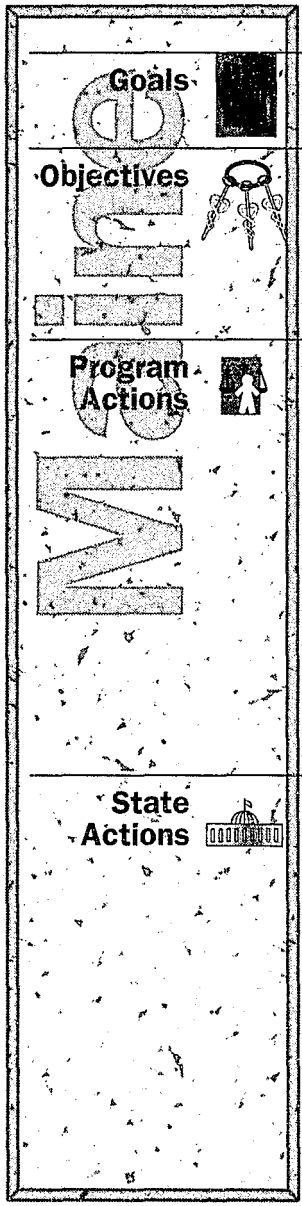
Program Actions

1. Plans in this area depend upon the outcome of actions at the state level.

Community Actions

1. Set up meetings with Department of Health Services, Maternal and Child Health, and Department of Children and Youth Services to discuss the health care system in community placement facilities.
2. Explore areas where Department of Health Services could offer assistance (i.e., training, consultation, etc.).
3. Clarify with new commissioner at Department of Health Services ways to achieve more active involvement in the State Advisory Committee on Juvenile Justice and Corrections.
4. Encourage State Advisory Committee on Juvenile Justice to include health on their agenda.

State Actions



Goals

Improve the health of youth that are incarcerated.

Objectives

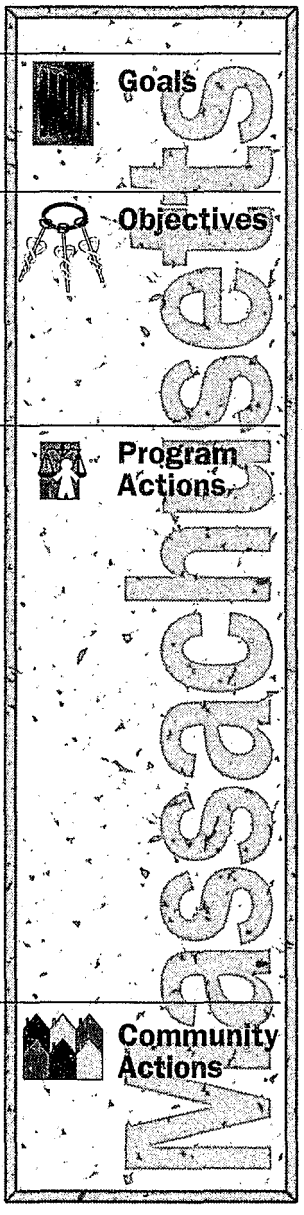
1. Identify the unmet health care needs of this population.
2. Establish a coalition of state and private groups to address health care needs of incarcerated youth.

Program Actions

1. Identify how health care services are currently being provided in Maine including assessment, treatment and preventive activities.
   - A. Contact personnel at Maine Youth Center and identify how health care is being provided.
   - B. Identify standards and protocols used.
   - C. Identify state qualifications and continuing education needs.
2. Develop plan to address identified needs.

State Actions

1. Contact the following groups to encourage coalition building:
   - A. Juvenile Justice Advisory Committee;
   - B. Maine Chapter of American Academy of Pediatrics;
   - C. Department of Mental Health and Mental Retardation;
   - D. Substance Abuse;
   - E. Bureaus of Health including Maternal and Child Health, AIDS, STD, Dental, Disease Control; and
   - F. Medicaid.

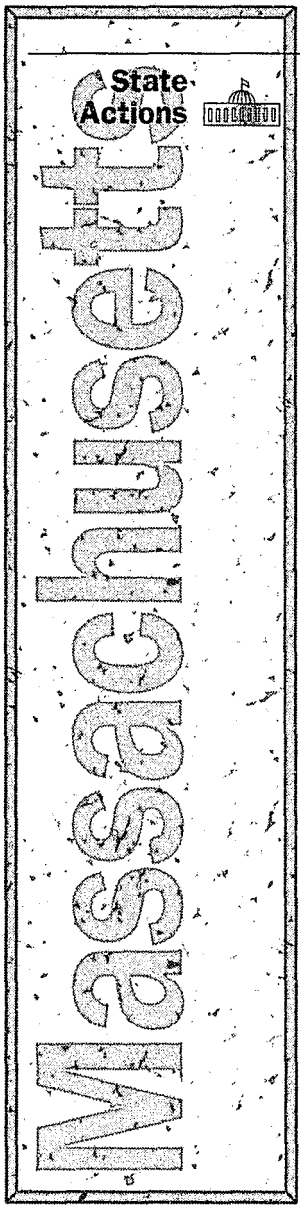


Improve the quality of health and mental health care for youngsters placed in the custody of the Department of Youth Services.

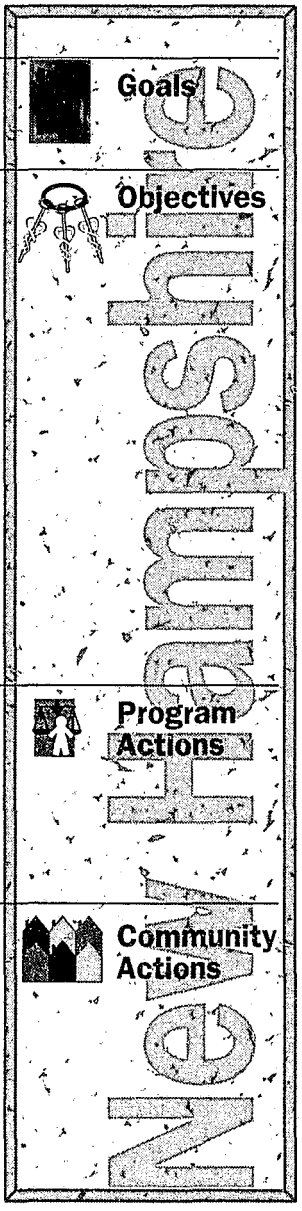
1. Strengthen Department of Youth Services collaboration with Department of Public Health, Maternal and Child Health staff, staff of the Children's Division of the Massachusetts Department of Mental Health and private providers.

1. Include health maintenance goals in Department of Youth Services plans for juveniles returning home.
2. Improve follow up of juveniles released from detention by referring to Maternal and Child Health funded programs or other health programs.
3. Improve mental health consultation to Department of Youth Service on staff/juvenile interactions.
4. Improve value of mental health treatment recommendations through better training for mental health professionals regarding the actual methods of operation and capacity of various programs.

1. Raise the issue of care for juveniles in the Department of Youth Services system to various coalitions that advocate or deliver health services to adolescents.



1. Identify already existing interagency groups dealing with children's issues and get Department of Youth Services on agenda. This may be the Adolescent Health Council. Add Department of Youth Services providers to the group.
2. Explore accreditation.
3. Explore the possibility of Medicaid funding beyond health services to include actual reimbursement for cost of program.
4. Facilitate provision of a list of of all Department of Public Health funded adolescent services from Department of Public Health to Department of Youth Services.
5. Facilitate provision of a list of of all Department of Youth Services funded adolescent services from Youth Services to Department of Public Health.

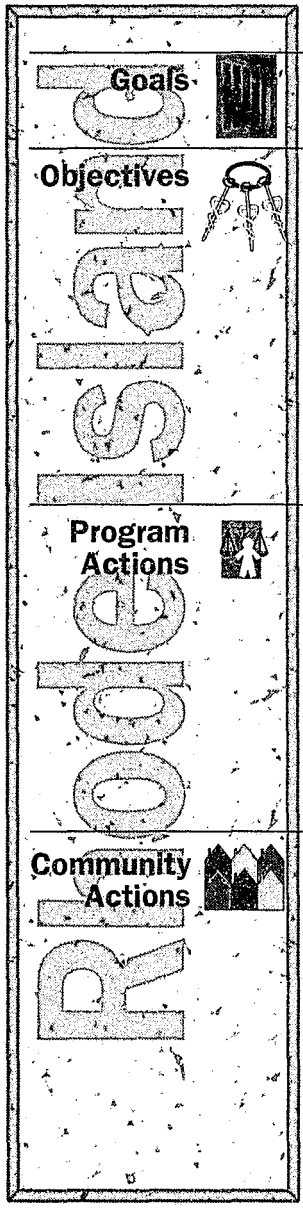


Improve the availability of comprehensive medical/dental care for Division for Children and Youth Services.

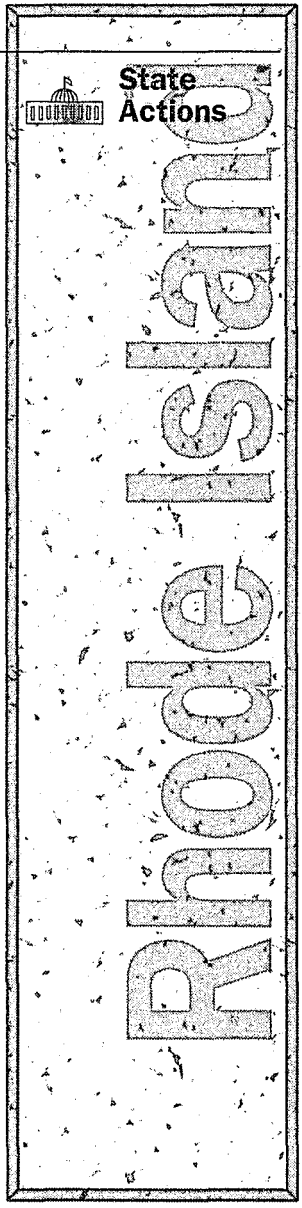
1. Provide National Commission on Correctional Health Care standards to Ann Norris, Youth Development Center, and Scott McLain, Youth Service Center.
2. Meet with National Commission on Correctional Health Care to develop sensitivity on medical issues and need for advocacy.
3. Explore with Department of Health Services the possibility of collaborative efforts to change Medicaid eligibility.
4. Include medical issues in the training process for new employees.

1. Develop a relationship with VT and monitor reporting staff.
2. Encourage Juvenile Justice Advisory Committee to increase community sensitivity to medical issues and develop practical arguments.

1. Find the contact persons in Maternal and Child Health for the state.
2. Apply for additional funding for medical care.
3. Seek authority and funding for screening, diagnosis and immunization.

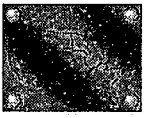


Goals	*Improve health care for all incarcerated youth.*
Objectives	1. Inform, educate and improve communication between juvenile corrections and courts. 2. Improve mental health with emphasis on substance abuse and drug dealing. 3. Improve education for staff and residents requiring medical staff accreditation by National Commission on Correctional Health Care.
Program Actions	1. Set up meeting between courts and juvenile corrections staff. 2. Continue program monitoring by Medical Advisory Committee. 3. Set up subcommittee of Medical Advisory Committee to concentrate on health and substance abuse. 4. Improve dental care by increasing access to dentists.
Community Actions	1. Enhance public relation in the community. 2. Study home environment of children. 3. Continue medical care after release for detailed facility. 4. Get parents involved in policy decisions and programing.



1. Offer education about mental health and child advocates.
2. Hold informational meetings.
3. Enhance public relations.
4. Address the staffing needs in medical nursing.

New York, New Jersey,
Puerto Rico, Virgin Islands



Region II

Goals

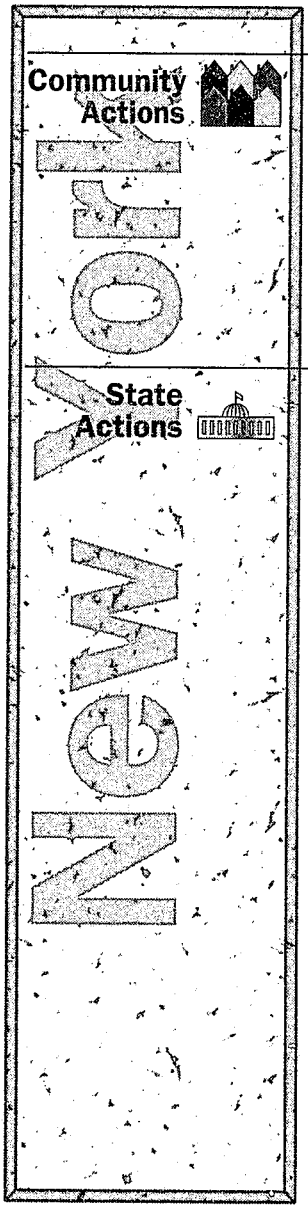
Improve the quality and access of health, education and social services for incarcerated youth.

Objectives

1. Develop a network of state agencies to work collaboratively on a statewide plan for adolescent health services.
2. Identify funding resources.
3. Establish a statewide network for monitoring services on an ongoing basis.

Program Actions

1. Establish a statewide network to review local, state and national regulations and to make recommendations for change. Include representatives from health, social services and education in the network.
2. Develop a referral and follow-up mechanism for youth once discharged from the criminal or juvenile justice systems.
3. Develop a curriculum that specifically addresses the health care needs of youth in the criminal justice system.
4. Provide training, education and technical assistance to staff working in juvenile facilities.
5. Develop an evaluation mechanism for monitoring program effectiveness.
6. Recruit and increase qualified health personnel.

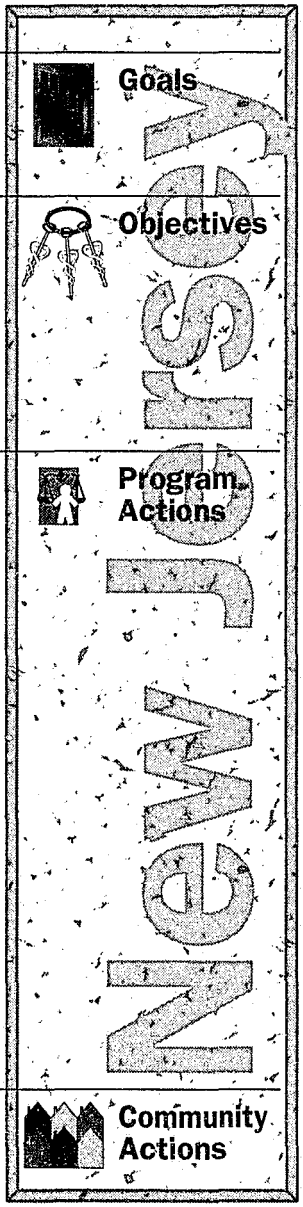


Community Actions

1. Establish a community advisory committee.
2. Form coalition advocacy groups to seek alternate resources and lobby for new legislation.
3. Increase community awareness and linkages with other community-based health and human service organizations.

State Actions

1. Request additional funding to ensure the provision of quality health care services.
2. Identify a state liaison to work with the various correctional systems.
3. Assess the adequacy of state allocated funds for the incarcerated youth health services verses other youth services throughout the state.

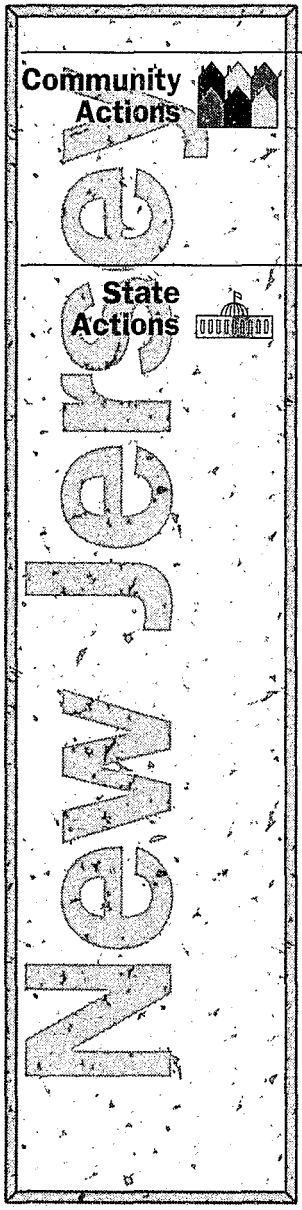


Improve quality of health care for all youngsters served by the Division of Juvenile Services, Department of Corrections.

1. Obtain memorandum of understanding between Department of Health and Department of Corrections, Juvenile Division.
2. Develop expertise in finding funding for care. Identify staff who will be sources of information.

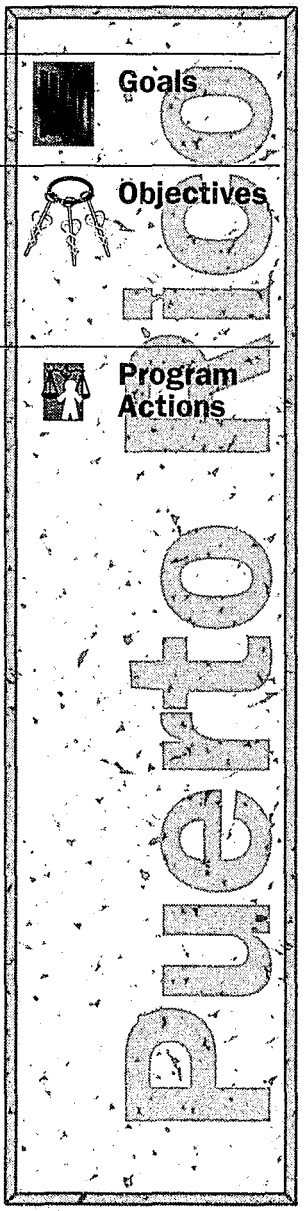
1. Get information regarding health care standards for Division of Juvenile Services population with special emphasis on standards used in Massachusetts.
2. Set up meetings between Juvenile Division and state Department of Health representatives to explore cooperative ventures.
3. Work to get eligible youth on medical reimbursement and identify related administrative costs. State Department of Health and Division of Juvenile Services should explore resources within state colleges and universities, including University of Medicine and Dentistry of New Jersey.
4. Identify existing resources (including federal, state, regional and local).

1. Form coalitions for interested parties and advocate for improved health care for Division of Juvenile Services.



2. Link Division of Juvenile Services clients with school based youth services in the community.
3. Develop substance abuse awareness sources to prevent alcohol and drug problems.

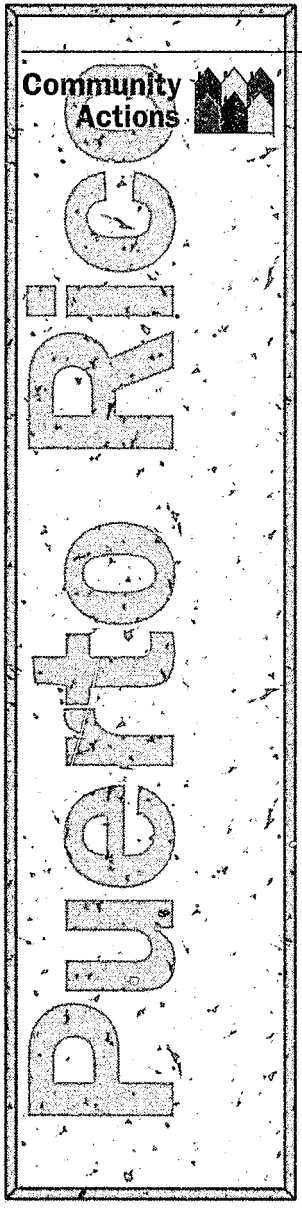
1. Involve State Interagency Coordinators Committees in an attempt to use resources of agencies outside Division of Juvenile Services to improve standards of Division of Juvenile Services.
2. Develop expertise in finding funding for care. Identify staff who will be sources of information.
3. Work to get eligible youth on medical reimbursement and identify related administrative costs. State Department of Health and Division of Juvenile Services should explore resources with state colleges and universities, including University of Medicine and Dentistry of N.J.
4. Identify existing resources (including federal, state, regional and local).
5. Bring to attention of state legislators and governor's office the need for changes in Medicaid reimbursement practices and regulations, including changes in federal and state regulations.
6. Develop a working relationship between Division of Juvenile Services and the agency administering Title XIX Medicaid with an objective to increase eligibility and access for Division of Juvenile Services clients.



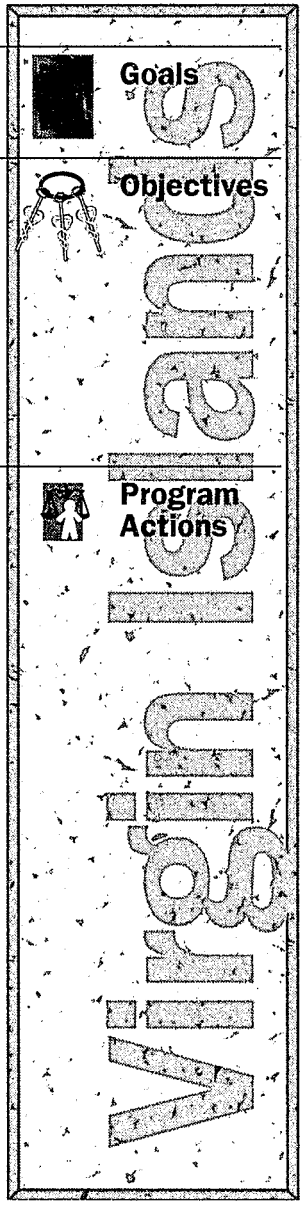
Improve the quality and access of health, education and social services of incarcerated youth.

1. Actualize service evaluations by health experts.
2. Establish a coordination system which facilitates information and service exchange.

1. Petition the health department to evaluate health services at residential facilities.
2. Prepare a corrective action plan based on the recommendations.
3. Allocate sources to implement the corrective action plan.



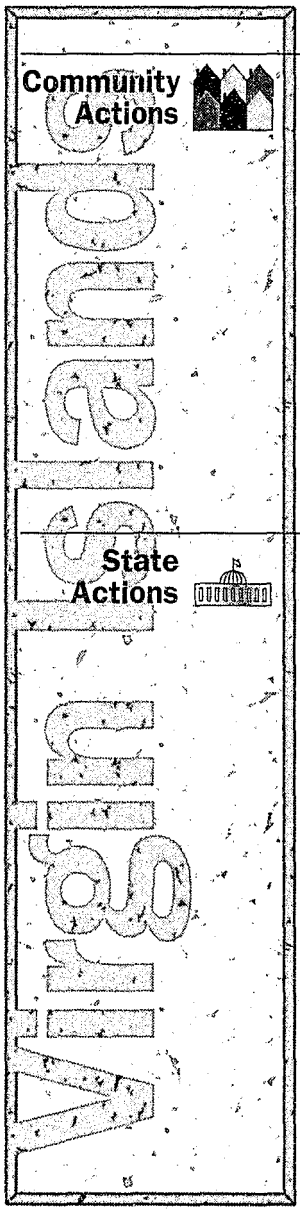
1. Ask the Health and Welfare Council at the governor's office to appoint a task force to discuss the special health needs and possible service alternatives of incarcerated youth. All related agencies and programs should be represented.
2. Promote decision making and discussion on the following:
   a. Who should provide the services;
   b. who and how should they be funded; and
   c. what should they include.
3. Contact funding experts to explore funding possibilities for special projects.
4. Contact the Heath Commissions of the Senate and the House of Representatives to share information on the subject.



Develop an information network to assure that incarcerated youth receive proper health care services.

1. Create a task force including representation from juvenile justice, health care, government, private enterprise, community organizations and advocacy groups, education and media.
2. Increase public awareness through dissemination of information, especially through media (i.e., radio, television, newspaper).

1. Ensure understanding of a common mission for all involved in task force.
2. Create linkage by identifying contacts within regions.
3. Gather information about standards and accreditation program.
4. Gather information about possible funding sources.
5. Devise strategies for improving working conditions and training programs for health care and juvenile justice personnel.



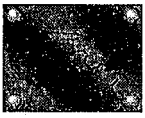
Community Actions

1. Utilize media to impress upon community the magnitude of the problem including:
   a. Lack of good health care;
   b. minority overrepresentation in the juvenile justice system;
   c. inadequate juvenile justice facilities;
   d. isolation and reduced access to other services; and
   e. understanding of the world of the troubled child.

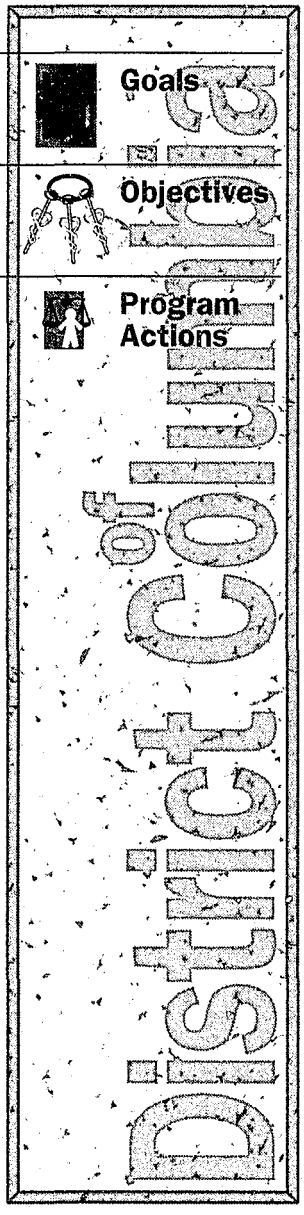
State Actions

1. Educate governor's office, legislators and other government officials about the task force, its functions and recommendations.
2. Gain access to possible state funding sources.
3. Establish ongoing linkages through national and regional meetings, to gather and share new information and to discover programs that have worked in other areas.

Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia



Region III



Goals

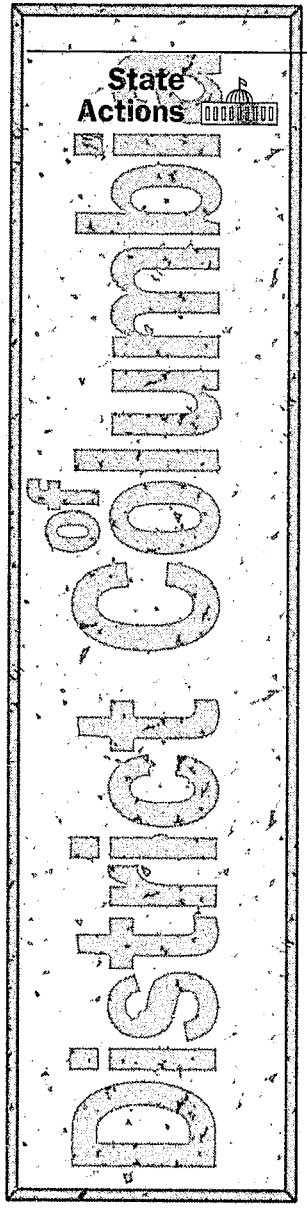
Improve the health care of incarcerated youth.

Objectives

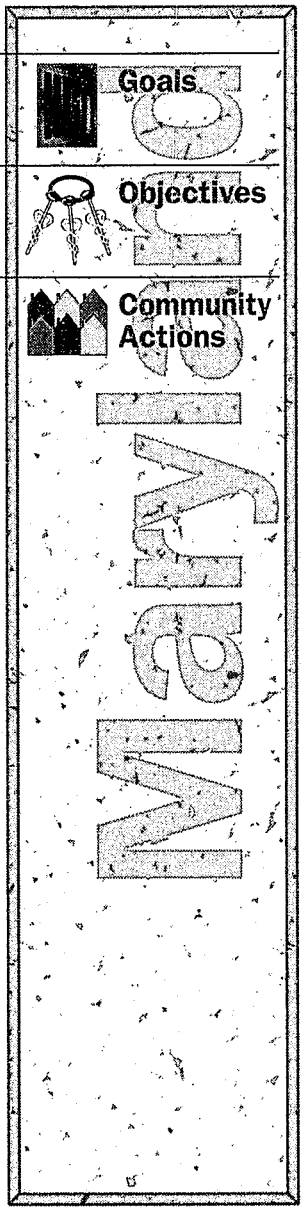
No objectives were recorded for the District of Columbia.

Program Actions

1. Commitment of Maternal and Child Health program staff to further identify and meet with appropriate juvenile justice authorities in the District to identify joint mental health/juvenile justice collaboration. A working group will be formed if feasible.
2. In negotiating a health/medicaid interagency agreement (currently underway) the issue of including medicaid coverage for youth in juvenile justice system will be explored. They will use the experience of Massachusetts and others in pursuing this.
3. Preliminary efforts by Maternal and Child Health regarding ensuring adequate care to all pregnant women and pregnant adolescents in the correctional system in D.C. will be pursued.
4. Maternal and Child Health staff will collaborate with Maryland staff on the possible piloting of the Hopkins Intake Assessment and staff training module developed by Dr. Linda Thompson.



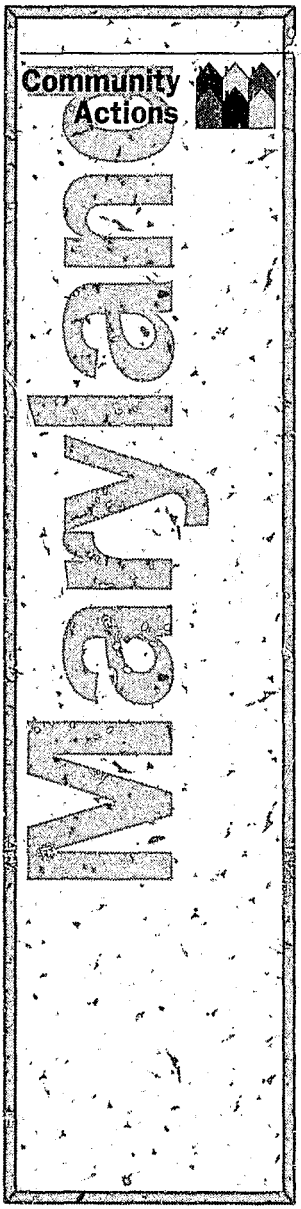
1. Pursue the formation of a mayoral level task force on children, youth and families.



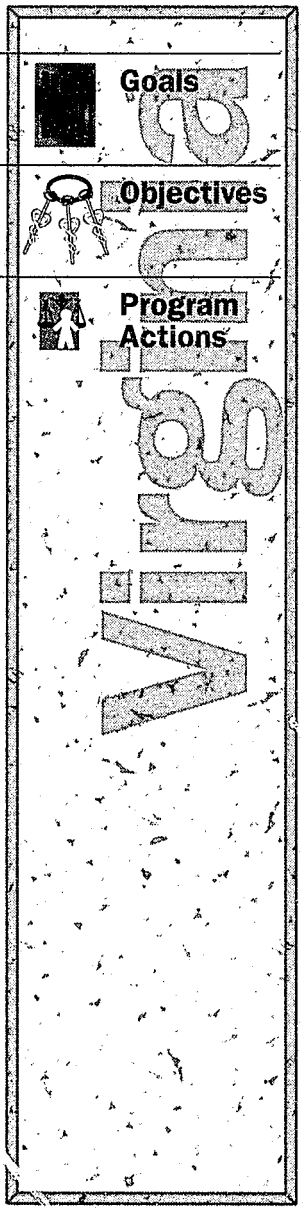
Improve the health care of incarcerated youth.

No objectives were recorded for Maryland.

1. Present to the new secretary for Children, Youth and Family the assessment instrument (adolescent focused) and training module for youth workers, as developed by an earlier MCHB grant. Pilot assessment tool in at least one state juvenile justice facility to bring the issue of systems change into the limelight.
2. Explore with District of Columbia staff the possibility of piloting the assessment tool in one of the District's facilities. Share the project materials with D.C. Public Health staff.
3. Revisit the Medicaid coverage issue especially as Maryland moves ahead with its commitment to "privatization" and to "in-state" community-based juvenile justice residential treatment services.
4. Consider Maryland's preliminary efforts at implementing the OBRA '89 EPSDT expanded service provision as a way to maximize federal dollars to support needed specialized services for the population of youth in the juvenile justice system.



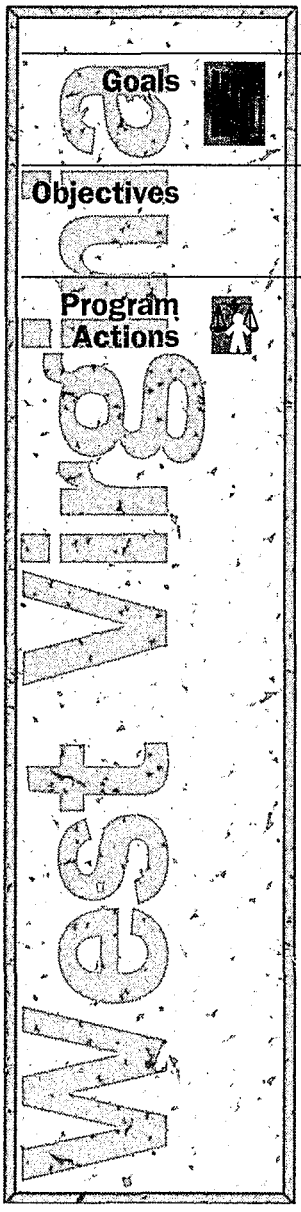
5. Encourage use of the Hopkins Assessment Instrument in an effort to facilitate continuity of information for this population as it moves from residential to community based to aftercare status.



Improve the health care of incarcerated youth.

No objectives were recorded for Virginia.

1. Make attempt to get a youth services representative on recently formed Governor's Task Force on Children's Health.
2. Build on and make more systematic the use of local health department staff to provide relevant health education programs and materials to clients in juvenile justice facilities. Attempt to move this activity up to a formal state level activity.
3. Re-examine the Medicaid coverage issue for this population especially as the state moves to more community-based treatment programs. This will be timely in that a re-negotiation of the interagency agreement between mental health, youth and family service, education and other agencies is currently underway.
4. Use "interagency consortium" approach to identify a flexible pool of resources.
5. Continue use of the relevant portions of the Hopkins Training Manual for health assessments by juvenile justice health programs.



Goals

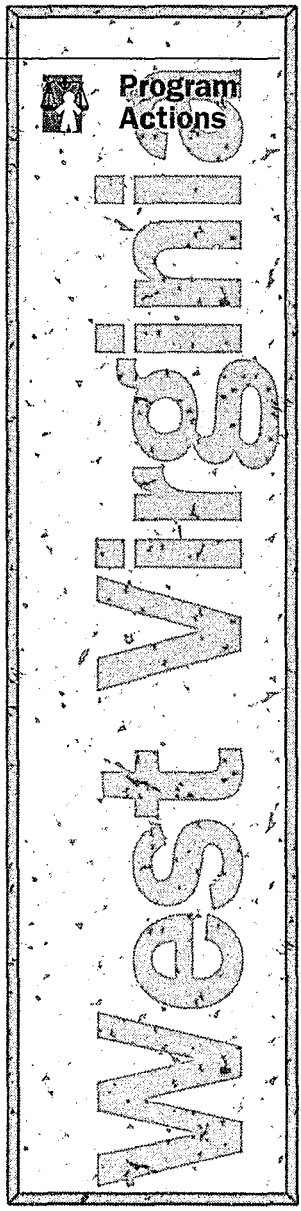
Improve the health care of incarcerated youth.

Objectives

No objectives were recorded for West Virginia.

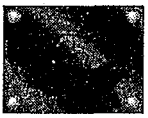
Program Actions

1. Continue staff level meetings between child health and juvenile justice staff that began at tri-regional workshop.
2. Contact recently formed Governor's Task Force on Children, Youth and Families to suggest that they include the special health care needs of youth in the West Virginia Juvenile Justice Facilities in the plan to have a flexible funding pool for children's early intervention services in the state.
3. Encourage juvenile justice state level authorities to pursue the adoption of model health standards for incarcerated youth as developed by National Commission on Correctional Health Care. The health department will advocate for this and provide technical assistance as appropriate.



4. Staff of juvenile justice and health will explore possible collaboration to develop staff training and orientation for newly hired juvenile justice facility nursing personnel, addressing specific needs of the staff, staff burnout, and lack of skills of staff members to effectively deal with this population.
5. Assistance from the health department to improve the admission and health history process for juveniles committed to juvenile justice facilities.

Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee



Region IV

Goals

Improve health of adolescents involved with the juvenile justice system.

Objectives

1. Develop communication and teamwork among state and local agencies.
2. Develop communication and teamwork with private sector.

Program Actions

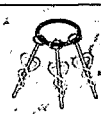
1. Develop Individual Health Care Plan (IHCP) and create a mechanism for monitoring and tracking.
2. Obtain an organizational chart which documents options for juvenile once in the system.
3. Identify present providers of health care to training schools.
4. Contact president of state probation office and arrange a meeting.

Community Actions

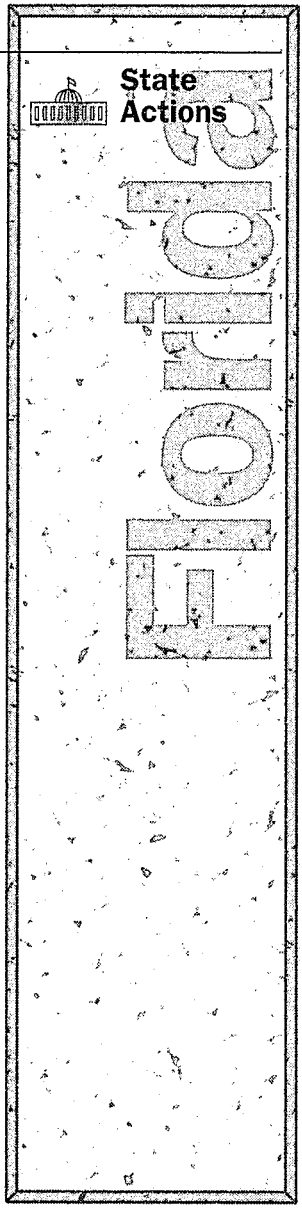
1. Develop access to community mental health clinics.
2. Develop access to public health clinics.

State Actions

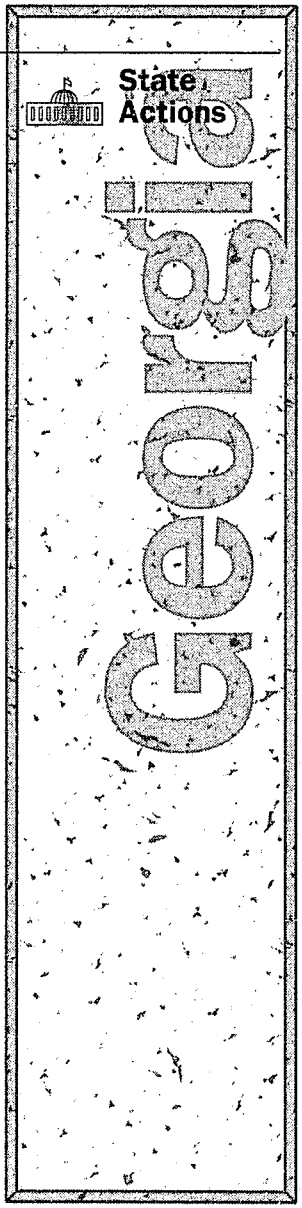
1. Develop lines of communication between state agencies including Department of Youth Services, Children's Rehabilitation Services, Public Health and Department of Human Resources.
2. Develop health care needs assessment.
3. Make concerted effort to have all facilities accredited.
4. Medical representative on State Advisory Committee.

Goals 	*Study the issue of adolescents (under the age of 19) in the adult forensic mental health system as incompetent to proceed or not guilty by reason of insanity.*
Objectives 	Identify: 1. Numbers; 2. how they got there; 3. criminal charges; 4. counties; 5. placement to and within facilities; 6. receipt of special treatment; 7. where they go when they leave; and 8. loss.
Program Actions 	1. Review data on adolescents from community forensic programs. 2. Contact programs that serve this population for further information.
Community Actions 	1. Review issues with district forensic coordinators.
State Actions 	1. Review forensic data base, current residents and admission trends. 2. Contact each of the forensic hospital administrators regarding their perception of problems, special treatment needs (medical, mental health and dental) and policies for this population.

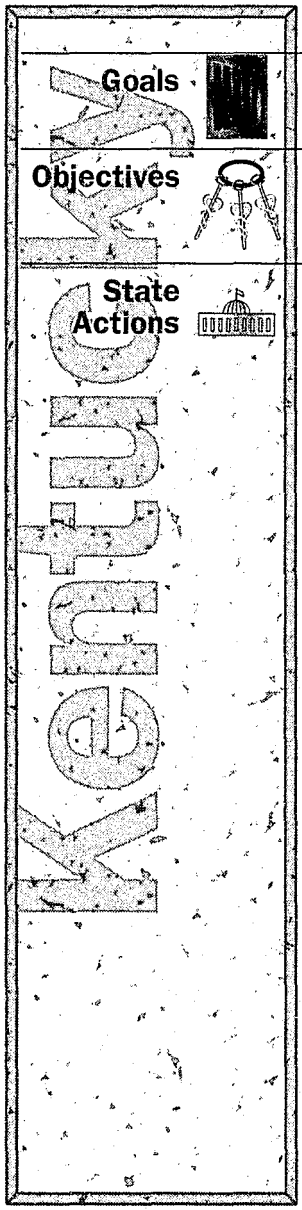
3. Contact chief jail inspector for information regarding Florida's laws and handling of adolescents in adult jails.
4. Examine documented data regarding age and demographics of juveniles in jail.
5. Contact Michael Dale regarding the work he referenced on juveniles being certified into adult prosecution.
6. Review forensic statutes and decide whether the department should pursue revisions to Chapter 916, F.S. similar to guidelines used by civil hospitals.



Goals 	*Improve medical services available to adjudicated youth in Georgia.*
Objectives 	1. Advocate for attention to medical care issues as Georgia begins to reorganize its children and youth services delivery system.
Program Actions 	1. Focus on the Atlanta Youth Detention Center as a starting point: a. Re-examine medical expenditures in order to re-allocate resources and improve benefits. b. Maintain accreditation according to standards from the Commission on Correctional Health Care and update procedures as revised standards are published. c. Explore potential linkages with colleges/universities. Report recommendations from conference to Department Youth Services management.
Community Actions 	1. Disseminate conference findings and other relevant data about the health needs of adjudicated and/or incarcerated youth to local commissions on children and youths. 2. Offer to report to Department Youth Services District Directors on conference findings in order to enhance local level medical care (detention and community programs).



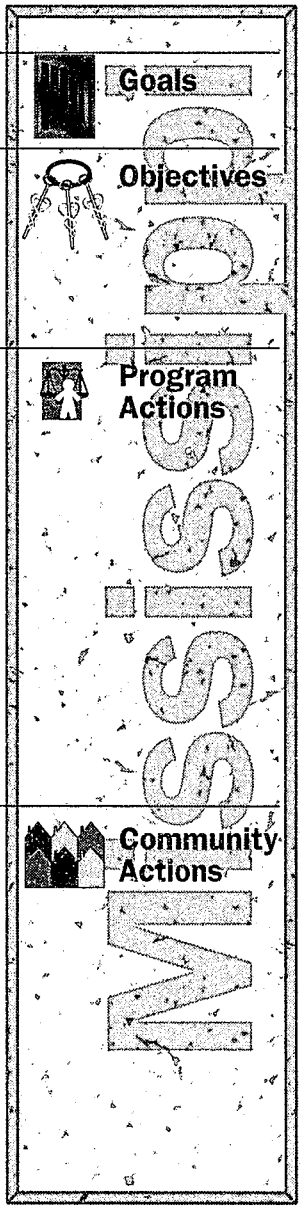
1. Summarize results of conference and provide relevant background information to Council of Juvenile Court Judges, Children and Youth Coordinating Council, governor's office, DHR Division Directors (mental health, mental retardation, substance abuse, public health) and Department of Family Children's Services.
2. Explore untapped resources available through colleges and universities statewide.



Provide quality health care to securely detained juveniles in Kentucky.

1. Assess current health care provided in juvenile detention centers and juvenile holding facilities.

1. Questionnaires will be sent to directors of 2 juvenile detention centers and 11 juvenile holding facilities to ascertain services provided, service providers, available financing, and standards followed.
2. Data will be compiled and a report of the information given to Interagency Committee on Juvenile Detention.

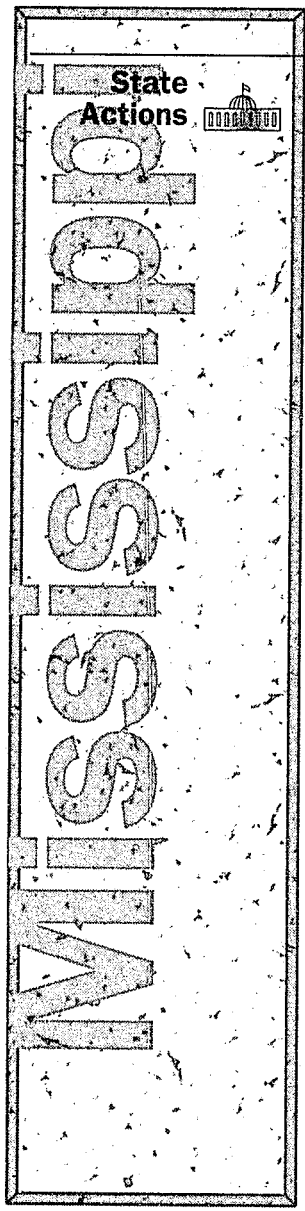


Improve the quality of health care for youth who are incarcerated.

1. Develop networking opportunities for health care professionals, public officials, legislators, administrators and community leaders to collaborate regarding the importance of health care for youth who are incarcerated.

1. Get information about state standards, and state regulations.
2. Get information on national standards and disseminate to appropriate persons.
3. Inform health officials and others on accreditation.
4. Work to insure that primary health care is provided to youth who are incarcerated.
5. Report and disseminate information from this conference to Department of Human Services Director.

1. Get youth advocates involved in health care for youth who are incarcerated.
2. Inform community leaders/church groups/non profit organizations about the health care issues of incarcerated youth.



1. Get the state advisory group involved in health care for incarcerated youth.
2. Inform administration heads of standards.
3. Inform Attorney General of liability for not providing minimal health care for youth who are incarcerated.
4. Include training at statewide conference of youth court personnel.

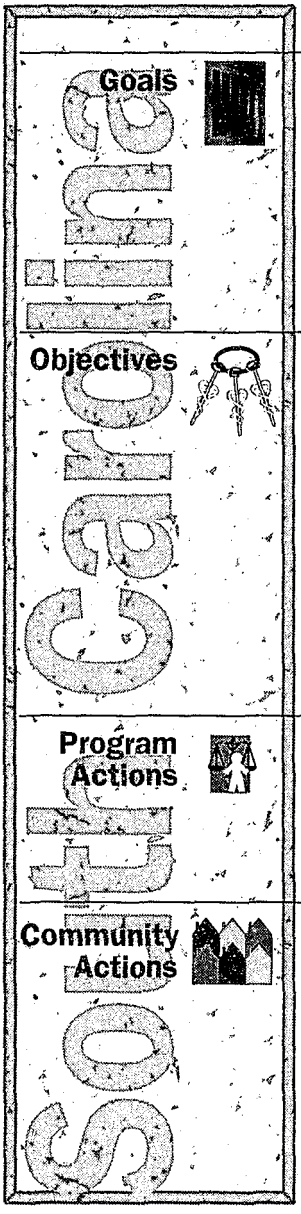
Increase medical and mental health services available to incarcerated youth.

1. Publicize the health needs of juveniles at the time that they have been detained.
2. Strengthen linkages between juvenile-serving agencies, mental health agencies and primary care providers.

1. Identify gaps in the comprehensive health care program.
2. Identify desirable holistic health profile for each child.
3. Provide feedback mechanism to update the community and the state regarding missing resources.

1. Assess linkages which may already exist at the community level.
2. Amend community-based alternatives, juvenile justice indicators to include health statistics regarding juveniles.

1. Compile health statistics regarding detained and incarcerated youth. Set up a system for routine data collection.
2. Market health needs of the target group to the health community (pediatrics, medical schools, etc.).
3. Develop health care plan with policy statements.



Goals

1. *Impact the probable consent negotiations that are currently taking place between plaintiff attorney and the Department of Youth Services.*
2. *Develop and implement health care standards for the new regional detention centers which will be required by state law after January 1, 1991.*

Objectives

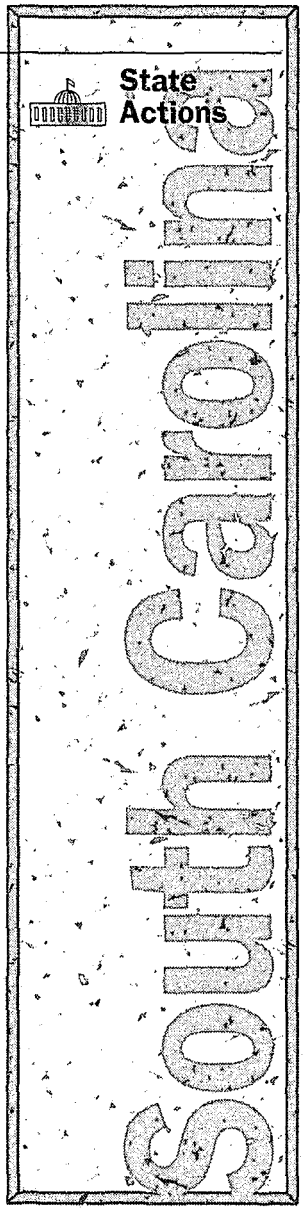
1. Seek to involve health service agencies in a coordinated effort to provide assistance and counsel to Department of Youth Services and the Attorney General's office.
2. Formulate an overall state plan, county by county plan, and provide direct consultant services to clusters of counties to address the mandated removal of jails and lockups by January 1, 1992.

Program Actions

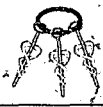
1. Provide data from this conference to appropriate representation at Department of Youth Services and offer assistance in the revision of health care standards.

Community Actions

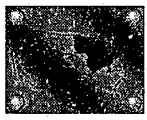
1. Engage the services of consultants by May 15, 1991, and adopt state plan within three months.
2. Provide local plans for county government approval within six months.



1. Monitor progress of Department of Youth Services consent agreement and coordinate state agencies to assist local jurisdiction in establishing health care clinics for regional detention centers.

Goals 	*Develop a methodology for continuing all health care delivery while youth are in custody at both local and state levels.*
Objectives 	Share medical, psychological and behavioral records.
Program Actions 	1. Share an example of medical clearance and screening forms and medical protocols between state and local facilities. 2. Select three local courts and one state facility which will serve as models for one year and will expand to other courts at the end of this period. 3. Develop forms and protocols where gaps appear at the front end. 4. Target Williamson, Davidson and Giles counties.
Community Actions 	1. Review and redesign forms and protocols to be consistent with awareness of mutual need for documentation with assistance from health department and for the benefit of the child. 2. Expand utilization of local, public, and private health care providers for decreased cost per child.
State Actions 	1. Expand to other 2 grand regions of the state to include all 29 local detention centers and 4 state training schools at the end of the trial program. 2. Continue Youth Advisory Board including 15 state agencies.

Illinois, Indiana, Michigan,
Minnesota, Ohio, Wisconsin



Region V

Goals

Improve collaborative efforts with legislature, state agencies, and advisory groups to maximize funding options in order to maintain and improve health care services for incarcerated youth and youth on parole.

Objectives

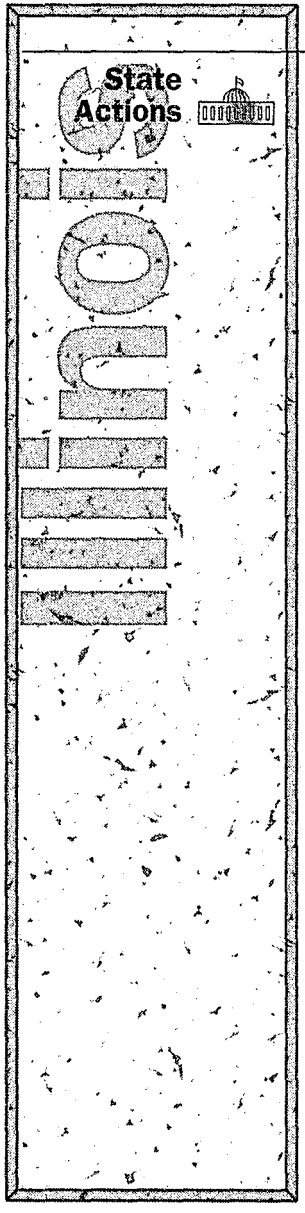
1. Get superintendents more involved in serving on statewide coordinating groups including Department of Correction, Department of Mental Health, Department of Children and Family Services, State Board of Education, and Department of Alcohol and Substance Abuse.

Program Actions

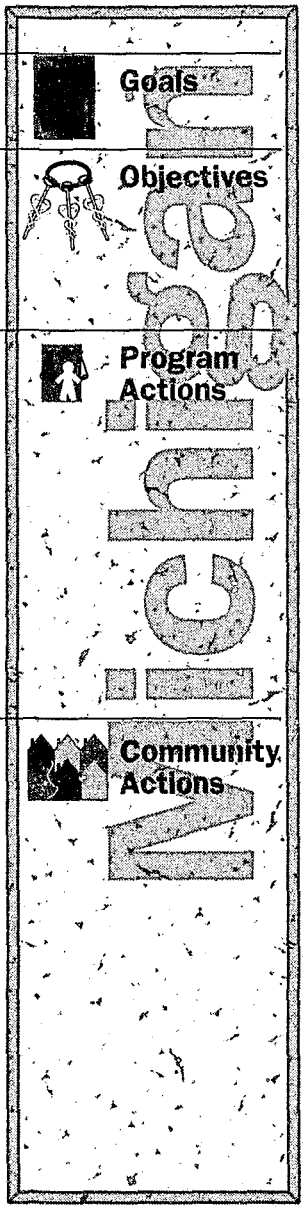
1. Look at different state systems or case management services.
2. Work with individual superintendents to develop their own coalition (i.e., more meetings to address specific issues).
3. Deal with overcrowding in institutions and make sure health care services obtain fair share of scarce resources.

Community Actions

1. Form coalitions to apply for funds.
2. Maintain accreditation status and high health care standards.



1. Convene problem solving/planning work group with sister agencies.
2. Develop a coordinated case management system.
3. Look at long-range planning and become proactive regarding needs.
4. Maintain quality of health care services and improve staff training.

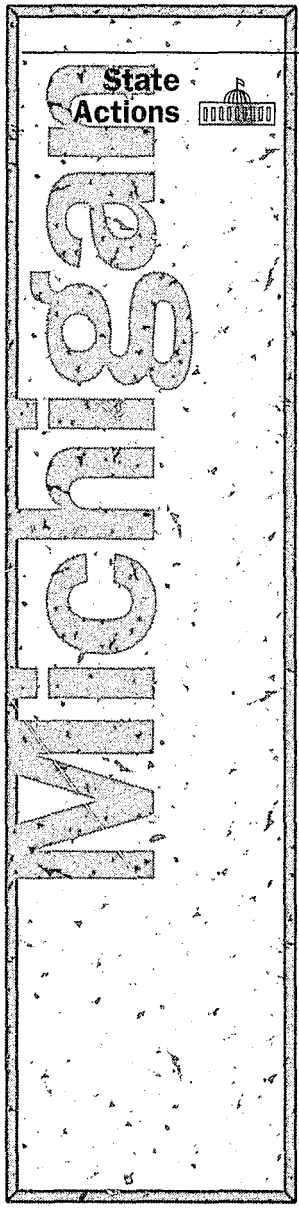


Improve communication on the health issues of incarcerated youth.

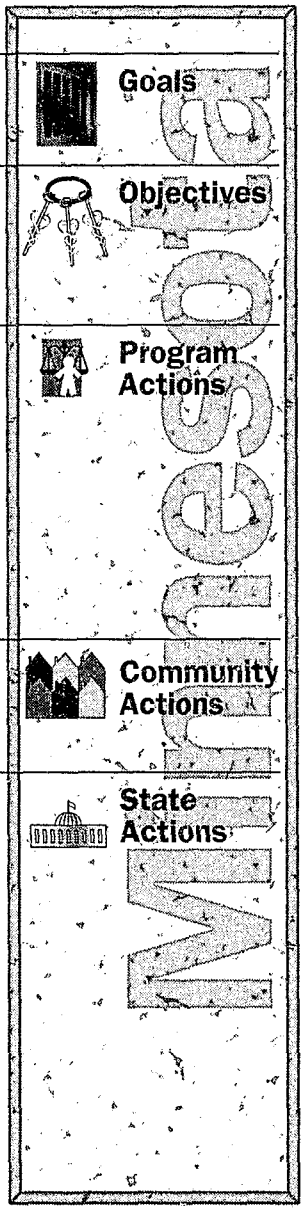
1. Identify key resource persons at state level for juvenile justice and comprehensive health.
2. Develop a mechanism for discussion of issues across state agencies.

1. Analyze current resources for health with standards for incarcerated youth.
2. Provide materials on number of youth incarcerated, characteristics of the incarcerated population, and distribution of that population by location.
3. Recommend health needs currently unmet and costs to provide optimum care.
4. Advocate for services needed at the local level within their state agency.

1. Provide reports to state level on health issues and resources and make suggestions for resolving and coordinating services locally.
2. Communicate local alliances to the state which are successful in meeting needs.



1. Schedule health issues of incarcerated youth as a topic for discussion by state Interagency Adolescent Health Steering Committee, and Michigan Department of Public Health to increase awareness of status and issues over the next year.
2. Include on committee a representative from a state agency whose primary responsibility is for juvenile justice by November 1, 1991.
3. Explore incorporation of the health needs of youth in the juvenile justice system with plans for health care delivery for children in state.



Interstate collaboration for specialized services between corrections department and mental health.

Goals

1. Develop culturally competent drug and alcohol treatment programs for Native Americans who comprise 15 percent of our juvenile population.

Objectives

1. Provide programing which is culturally specific to the Native American population of Minnesota, Wisconsin, North Dakota, South Dakota, and Indiana at one site.
2. Recruit and train Native American counselors to provide care and treatment and to serve as role models within the community.

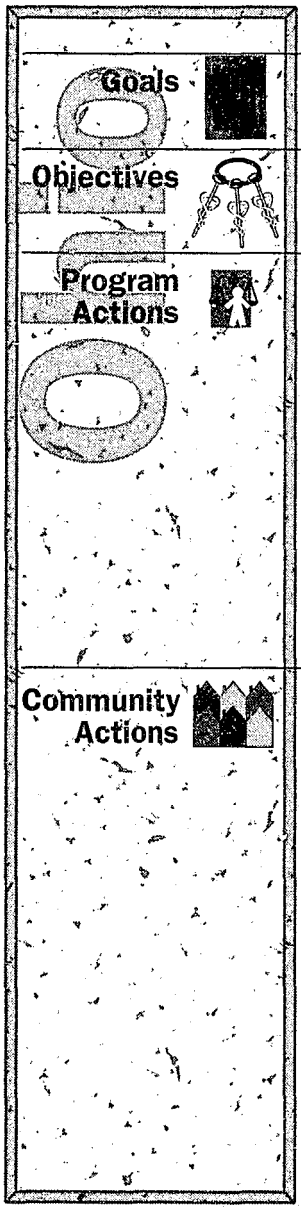
Program Actions

1. Provide resources (buildings and other capital equipment) within the Native American community.

Community Actions

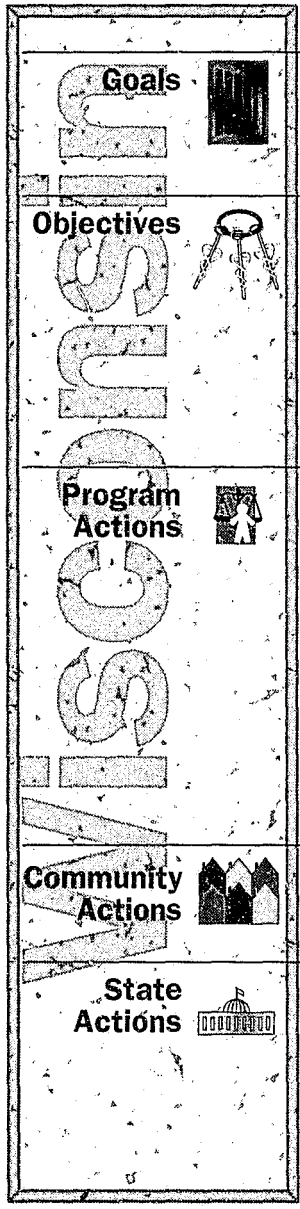
1. Provide funding sources through the Office of Drug Policy, Bureau of Indian Affairs, and Department of Corrections.
2. Encourage participation of other states through the development of interstate compact agreements.

State Actions



Goals	*Establish comprehensive health care services for all incarcerated youth.*
Objectives	1. Identify specific issues.
Program Actions	1. Follow results of state level actions. a. Secure funding; b. look for qualified staff to implement actions; c. develop quality assurance/monitoring; d. develop a managed care system; and e. provide ongoing education/awareness activities around the state for different disciplines.
Community Actions	1. Follow results of state-level actions. 2. Participate in conference task force.

1. Hold a problem-solving conference hosted by the governor's office to raise issues and deal with problems. Invite key administrators and policymakers from Department of Youth Services, Ohio Juvenile Justice Department, State Association Leadership, Department of Youth Services Superintendents (correction facilities), Child Advocates State Association, Ohio Legal Rights/Attorney General office, legislators, Ohio Department of Education, Division of Special Education, Department of Health, County Health Care Association, state Academy of Pediatrics and Family Practice, Department of Alcohol and Drug Addiction Services, Department of Mental Health and Department of Human Services.
2. Secure funding for a conference (i.e., grants, host agencies, Robert Wood Johnson, foundations, state agencies, state auditor, Ohio Juvenile Justice Department, Maternal and Child Health).
3. Document reasons for meeting in attractive terms.
4. After initial conference development, convene a problem solving/planning task force to continue to work on specific issues and insure ongoing coordination.
5. Develop policy for local application.
6. Hold regional meetings for education, awareness, and information sharing on state and local levels.
7. Develop procedures for access to better care.
8. Coordinate provision of specialized care.



Explore and develop a plan to improve total health service, including medical and mental health, to youth in correctional institutions.

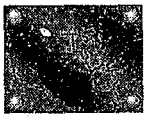
1. Implement state department (corrections, social services and health) collaboration on medical and mental health services to develop action plan for improved services.
2. Combine mental health and health records into one record.

1. Get information on standards for combining records (mental and health).
2. Convene meeting of identified staff in each department at division and bureau levels to discuss fragmentation of health system funding and service delivery in institutions. Develop action plan.
3. Meet with secretaries of department for endorsement of plan.

1. Involve aftercare private agencies to advocate for improved institutional services.

1. Involve key legislators to initiate appropriate legislation.

Arkansas, Louisiana,
New Mexico, Oklahoma, Texas



Region VI

Goals

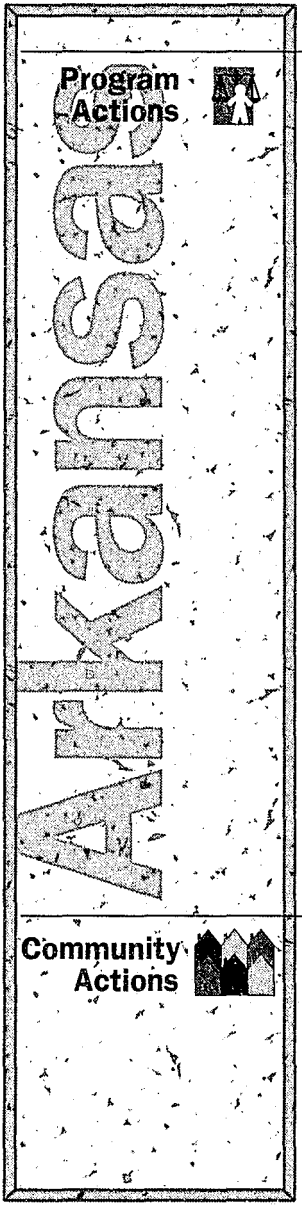
1. *Improve the quality and continuation of care to incarcerated youth while in juvenile youth services. Obtain resources for follow up.*
2. *Coordinate services for problem youth that are common to the juvenile justice, child welfare, and mental health systems. Services shall include education, health and drug and alcohol services.*
3. *Improve the quality of services and the continuity of care for incarcerated youth.*

Objectives

1. Find/develop statewide network of health care with coordination of services.
2. Investigate and develop expertise in finding available funding and avenues for funding.
3. Urge coordination between three existing state task forces charged with designing new community-based alternatives.
4. Continue the exploration and development of the work initiated by the Juvenile Justice Task Force.

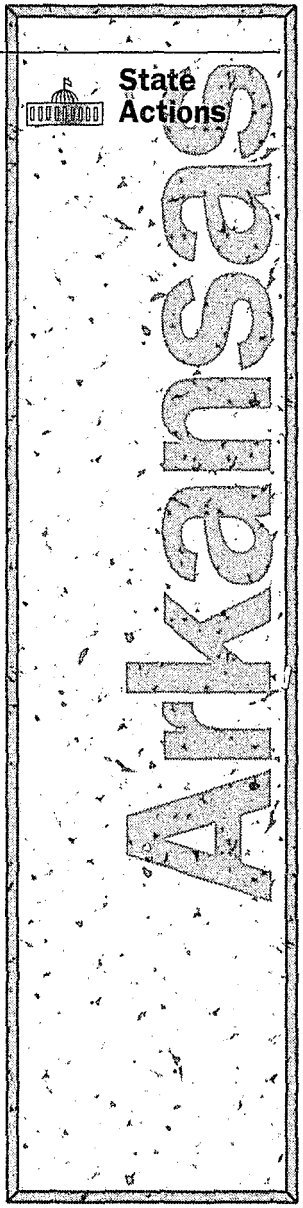
Program Actions

1. Increase interest and information among the various agencies in an effort to get a designated representative from each.
2. Seek accreditation from a correctional medical commission and give this information to various agencies.

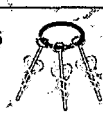


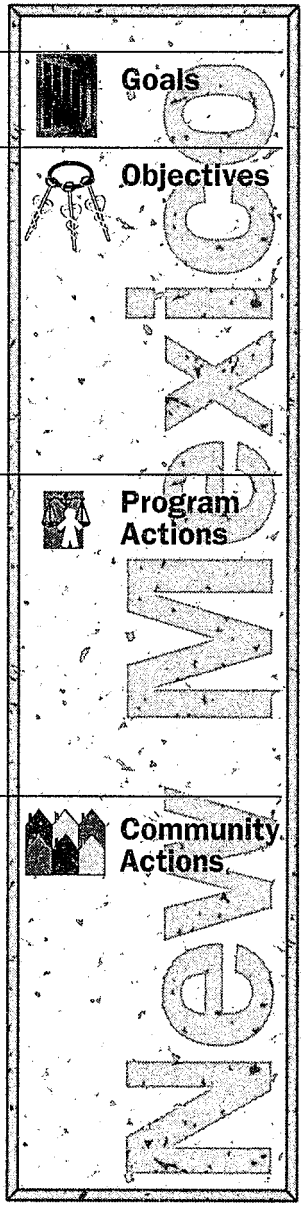
3. Improve recruitment for nurses and doctors who will work to improve the quality of care.
4. Work for medical reimbursement.
5. Talk to the governor about merging results from the three task forces into a comprehensive continuum of care for problem youth.
6. Work with the three task force chairs to merge their plans and funds to develop comprehensive services.
7. Explore other funding avenues for service development (i.e., private, state and federal).
8. Reconvene Juvenile Justice Task Force for design and implementation of new services for delinquent youth which include consolidation of youth service facilities, expansion of community alternatives and regionalization of services for serious offenders.
9. Expand membership of Juvenile Justice Task Force to include representatives from education, health and drug and alcohol.

1. Work for reimbursement at county level and free services from various agencies.
2. Seek involvement from political representation with respect to positive information and feedback in order to form coalitions for applying for grants and avenues of funding.



1. Seek input from various heads of departments of state agencies for support and invite their expertise.
2. Contact the Department of Health for support of health services and their expertise for free training resources and free supplies.
3. Contact University of Arkansas Medical Science Center for support and training.

Goals 	*Improve the quality of care for incarcerated youth.*
Objectives 	1. Develop statewide coordination and consistency of adolescent care. 2. Develop a network of health care providers for the provision of services. 3. Re-evaluate ability to compete with private sector for the hiring of nurses.
Program Actions 	1. Improve recruitment of health care workers to increase quality of care. 2. Obtain information about accreditation. 3. Obtain information about standards and state regulations.
Community Actions 	1. Develop a reciprocal working relationship between local universities and institutions to provide/expand services. 2. Develop a network with other state and local agencies and private providers to complement present services and provide a comprehensive system of care.
State Actions 	1. Complete a comprehensive self study to determine needs for prevention, intervention and follow-up of adjudicated youth. Look at where we are and where we need to go. 2. Complete a review of literature to determine standards of care that meet identified needs. 3. Explore and pursue alternate funding sources.

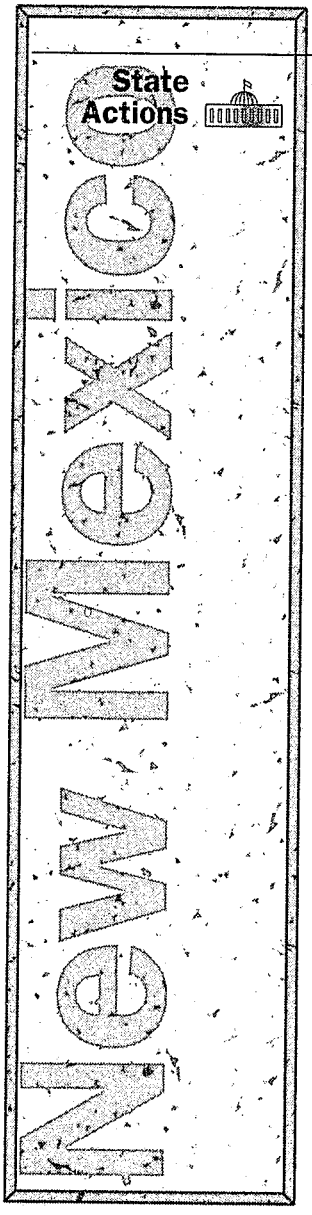


Improve the quality of health care for incarcerated youth.

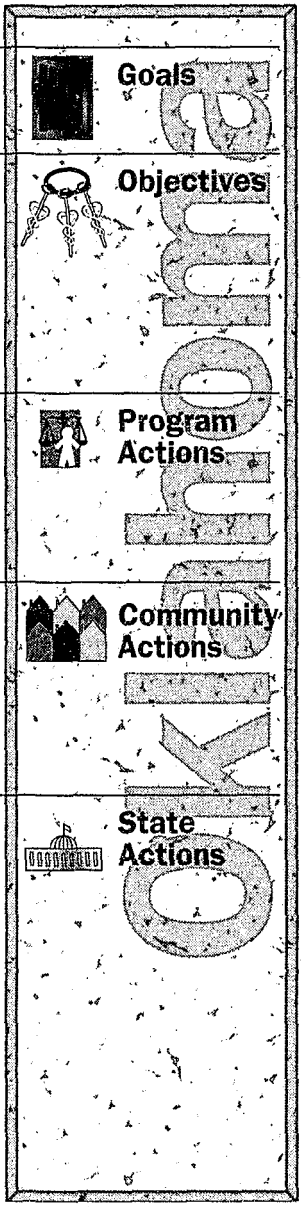
1. Develop collaborative working relationship with persons working on child health care.
2. Develop better coordinated health care delivery systems for incarcerated youth.
3. Increase awareness of the need for quality health care for incarcerated youth.

1. Educate juvenile justice health care professionals and legislators regarding the health care needs of incarcerated youth.
2. Identify state, local and university persons who are or should be involved in health care for incarcerated youth and meet to begin process of collaboration.

1. Obtain participation of counties in the development and implementation of detention standards and work with association of counties.
2. Obtain participation of counties in statewide detention study including study of health care services and needs in local detention facilities.



1. Develop working relationship between health department (maternal and child health staff), youth authority and university medical school regarding health care for incarcerated youth.
2. Obtain input from health care professionals into state advisory committees and youth authority.
3. Meet with medical school to discuss access to grant funds.
4. Develop statewide detention standards which include health care.
5. Conduct study of juvenile detention including health care needs.
6. Develop collaborative efforts between state agencies, university, Indian Health Service, Bureau of Indian Affairs and Native American jurisdictions regarding health care for incarcerated Native American youth.



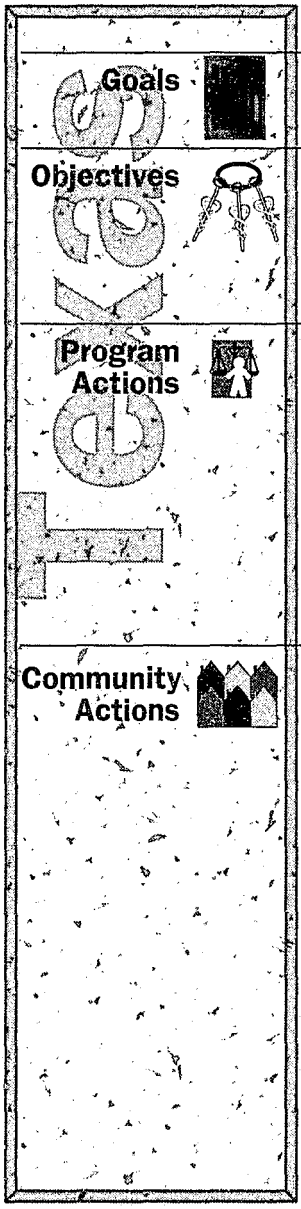
Develop a system of health care for children and adolescents in the juvenile justice system.

1. Identify how health needs are being met in the juvenile justice system by June 1992.
2. Develop and implement a comprehensive system of health care for those in the juvenile justice system by June 1993.

1. Identify appropriate tools to assess problems.
2. Identify key people to participate in meeting listed below.
3. Explore funding sources.

1. Continue development of subcommittee on child and adolescent health issues.
2. Involve Planning and Coordinating Council (1729) to instruct district and regional planners to amend institute.

1. Convene a group of people to analyze existing systems by September 1991. Groups should include chief child abuse examiner, chairman of Permanancy Planning Task Force, Department of Mental Health, child services, Department of Health personnel, Oklahoma State Department of Health, juvenile bureaus, Council for Juvenile Justice, Planning and Coordinating Council (1729).
2. Develop a plan of action according to recommendations of the committee.

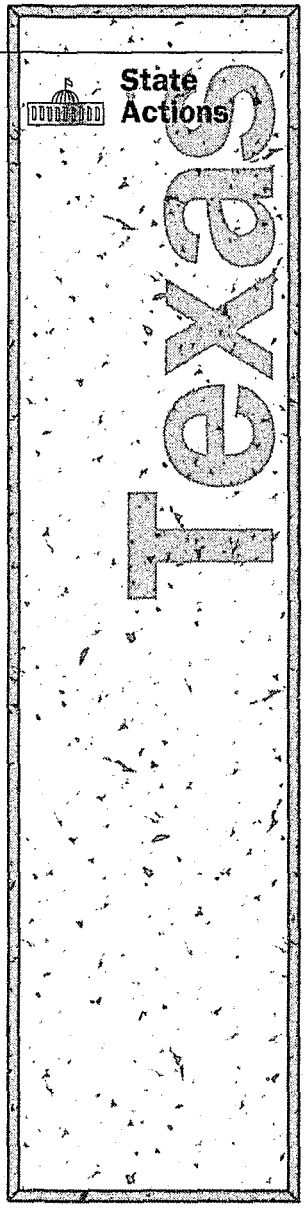


Improve the quality of health care services to detained and incarcerated youth.

1. Improve access to mental health services, substance abuse treatment and educational and vocational training to detained and incarcerated youth.

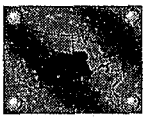
1. Determine the extent that University of Texas Health Science Center at San Antonio program meets the standards set forth by the National Commission on Correctional Health Care.
2. Continue to provide adequate health care to detained and incarcerated youth.

1. Encourage similar agencies to maintain contact with each other by meeting quarterly and developing a newsletter.
2. Encourage concerned agencies to participate in the community consortium sponsored by the Texas Juvenile Justice Coalition.



1. Leadership of Texas Juvenile Justice Coalition by advisory agency for juvenile matters.
2. Identify statewide efforts which are directed toward juvenile justice matters and compile a list of resource agencies.
3. Re-assert existing relationships with state legislators in order to keep on the forefront of current issues and maintain high visibility.
4. Utilize the Texas Juvenile Justice Coalition as a clearinghouse for information concerning the juvenile justice system.

Iowa, Kansas,
Missouri, Nebraska



Region VII

Goals

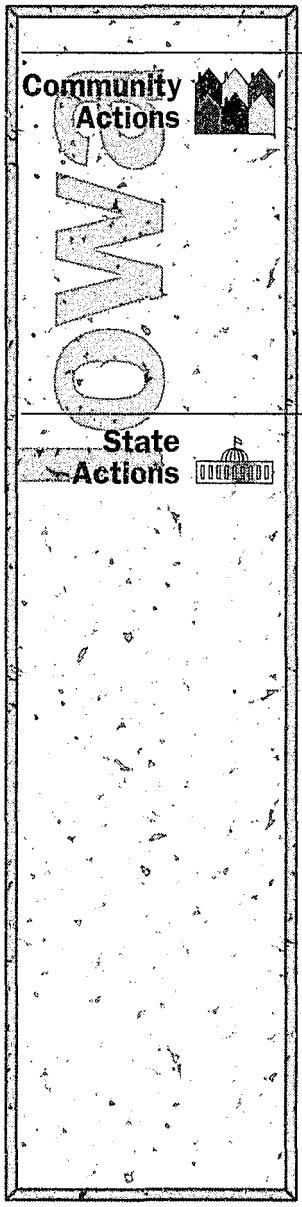
1. *Create information exchange between institutions, maternal and child health and state incarcerated youth centers.*
2. *Determine juvenile justice funding status by May 1991.*
3. *Share information by fall 1991.*

Objectives

1. Include a non-threatening status report article in *Maternal and Child Health* newsletter by fall 1991.
2. Amend or expand juvenile justice target money for incarcerated youth health issues by December 1991.
3. Write SAP# into Maternal and Child Health Grant application to be developed for 1992.
4. Continue to develop lines of communication within and between states.

Program Actions

1. Find out about state standards, American Correctional Association standards and interest in National Commission on Correctional Health Care standards by March 1991.
2. Make contacts for information by March 1991.
3. Collaborate agreement by February 1, 1992.
4. Distribute findings by fall 1991.

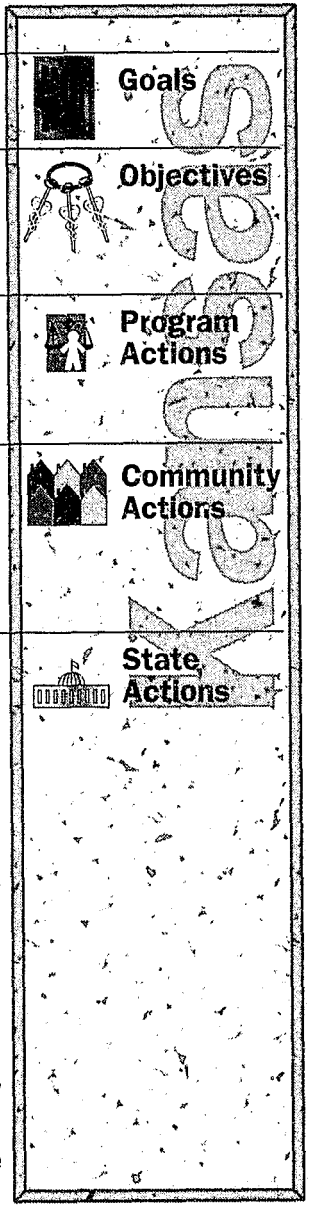


Community Actions

1. Find out about state standards, American Correctional Association standards and interest in National Commission on Correctional Health Care standards by March 1991.
2. Make contacts for information by March 1991.
3. Collaborate agreement by February 1, 1992.
4. Distribute finding by fall 1991.

State Actions

1. Invite health and incarcerated youth staff to participate by January 1, 1992. Groups to be involved include:
   a. Iowa Coalition for Comprehensive School Health Education;
   b. Iowa Public Health Association;
   c. Iowa Association of Physical Education, Recreation and Dance;
   d. Smoke Free 2000;
   e. Governors Council on Physical Fitness and Sports; and
   f. Iowa Peer Helper Association.
2. Include article on issue in state Maternal and Child Health newsletter by fall 1991.
3. Justify, design and write agreement based on possible pilot or initial program by spring 1992.
4. Submit agreement to information clearinghouse by spring 1992.



Improve health care services delivered to incarcerated youth in the state of Kansas.

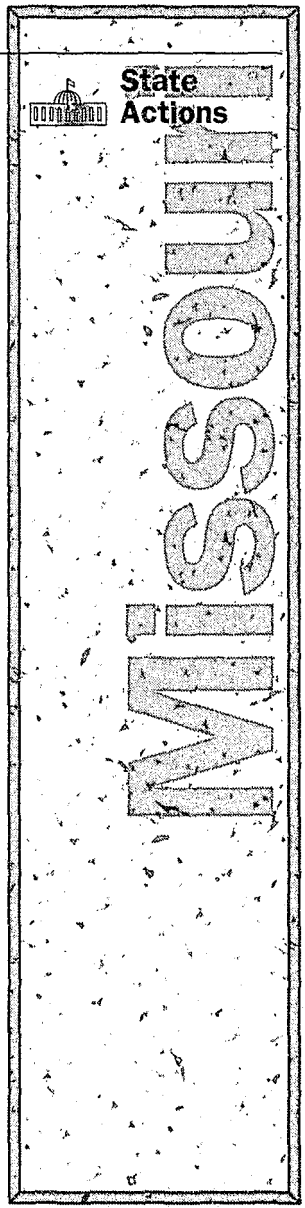
1. Develop an interagency plan for implementing improved health care services for incarcerated youth by January 1, 1992.

1. Participate in the development of state standards for health care of children.
2. Develop a monitoring protocol for health services delivered to incarcerated youth.

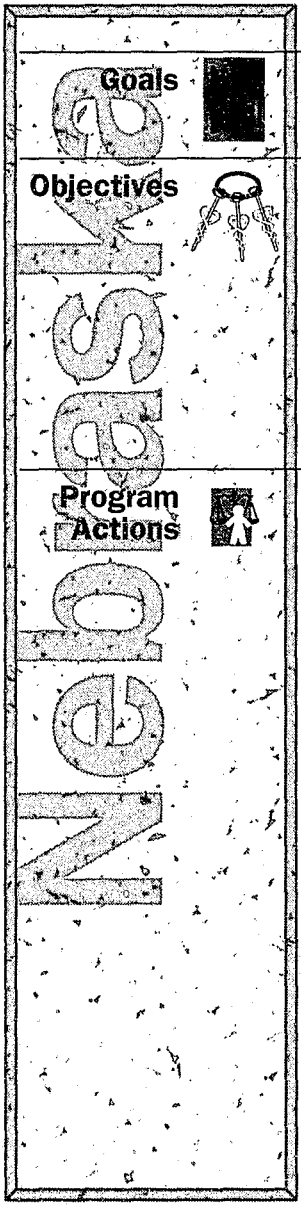
1. Initiate health care training programs for staff and youth in institutions.
2. Maximize EPSDT funding when delivering health care services to incarcerated youth.

1. Schedule bi-monthly meetings between Kansas Department of Health and Environment, Division of Family Health and Kansas Department of Social and Rehabilitative Youth Services to develop a plan for integrating health care initiatives for each agency.
2. Ensure that health care initiatives for incarcerated youth meet the Healthy People 2000 National Health Promotion and Disease Prevention Objectives.
3. Begin negotiations with the university to integrate/share services of social work, medicine, nursing and psychology services.
4. Explore funding resources for health care services delivered to incarcerated youth.

Goals 	*Bring definitive, comprehensive health care services to Missouri's high-risk and incarcerated youth in line with American Medical Association and American Corrections Association standards.*
Objectives 	1. By February 1992, develop an interagency plan for coordinated efforts between detention and placement facilities and child care agencies around the state toward minimal, comprehensive health care standards.
Program Actions 	1. Develop information education services for critical areas noted with youth: a. Parenting skills (youth and parents of youth); b. unwed mothers-prenatal care; c. abused children; d. nutritional standards; e. alcohol-tobacco (drugs); f. social disease; and g. dental health.
Community Actions 	1. Contact and involve assistance/participation of local university campuses. 2. Coordinate with local public health officials.



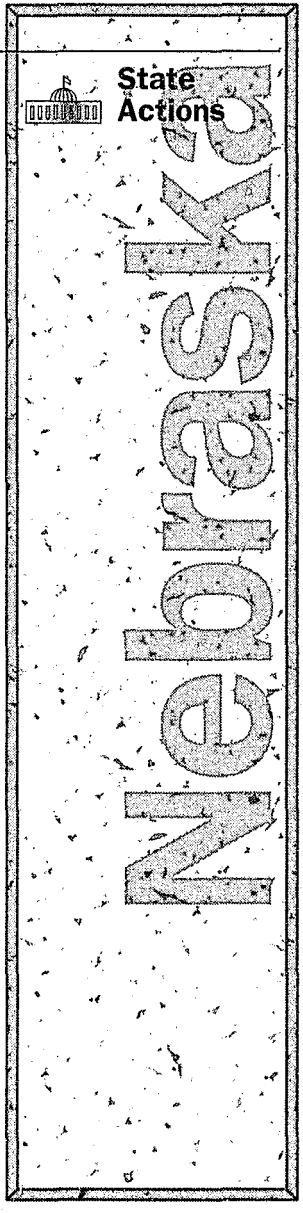
1. Contact director of state Department of Public Health to ascertain what is available and the status of programs (no reinventing the wheel).
   a. Designate chief or director of state services to youth (if there is not one on staff).
   b. Check status of state standards to conform to American Medical Association and American Corrections Association standards.
   c. Provide health services education and counseling.
   d. Provide health services, education and counseling.
2. Check with Missouri's Juvenile Justice Association.
   a. Tap into information exchange between states youth facilities (networking).



Effective interface between Nebraska Department of Health and the Nebraska Juvenile Justice System.

1. Provide health education by February 1992.
2. Provide HIV testing and counseling by February 1992.
3. Ensure that incarcerated youth health needs meet the Healthy People 2000 National Health Promotion and Disease Prevention Objectives by February 1992.

1. Contact Department of Health personnel (Centers for Disease and Control and county health departments). Designate subjects to be covered, noting who, when, where, and how, establish teaching methods and designate teachers.
2. Contact Nebraska Department of Health for nurses in Geneva and Kearney to draw blood and provide testing and counseling for HIV infection and to establish confidentiality requirements.
3. Develop interagency relationship with maternal and child health programs to set up health screening and education including immunizations, sexually transmitted disease testing, sex education, adolescent pregnancy, smoking, family planning and violence prevention. Apply for grant money.



1. Develop interagency planning committee to include state and community.

Colorado, Montana,
North Dakota, South Dakota,
Utah, Wyoming

Region VIII

Goals

Increase access to Medicaid to meet the health care needs of Colorado's adolescents.

Objectives

1. Access Medicaid funds for youth involved in the juvenile justice system by the start of FY 1993.

Program Actions

1. Determine a data base of the health needs of the targeted population, and conduct an analysis of the cost savings to the state by accessing Medicaid funds for the targeted population.

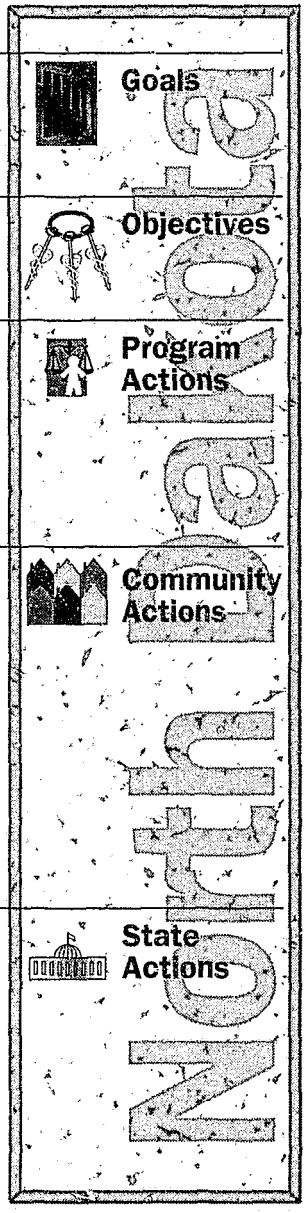
Community Actions

1. Lobby legislators to support the issue.

State Actions

1. Organize a state-wide task in order to develop strategies for accessing Medicaid funds.
2. Determine key players on the state and local levels.
3. Require task force to define the mission, goals, objectives and actions required for completing this project.
4. Interpret the federal requirement that restrict use of Medicaid funds for incarcerated youth.
5. Increase the EPSDT periodicity schedule for annual exams for adolescents.
6. Adjust state policies in order to assure access to Medicaid for eligible youth.

Goals 	*Enhance/develop mental health service delivery system for incarcerated youth population.*
Objectives 	1. Take advantage of existing available services and eliminate duplication of services if possible. 2. Develop minimal medical and psychological standards. 3. Enhance mental health/substance abuse needs assessment for incarcerated youth population.
Program Actions 	1. Identify and determine program voids and fiscal and geographical potential for resolution.
Community Actions 	1. Market "raise" issues with community constituency for support and other campaigning.
State Actions 	1. Utilize interagency coordination agency to network relevant state services (OSPI, DDI, SRS, etc.). 2. Develop interagency agreements insuring cooperation. 3. Aggressive persuance of university internship programs.



Collaboration between the North Dakota Division of Juvenile Services and the North Dakota Division of Maternal and Child Health.

Goals

1. Division directors/representatives to hold quarterly meetings to improve coordination and integration of services.

Objectives

1. Initiate assessments of health care being offered in individual agencies/institutions.
2. Review educational and nutritional services available.
3. Share training expertise.

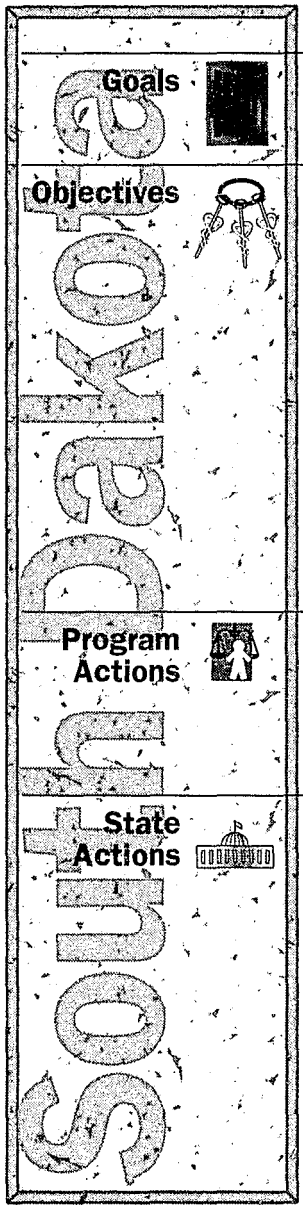
Program Actions

1. Collaboration between local public health agency, private community-based facilities, and juvenile probation staff.
2. Investigate local medical and nursing schools to assist in shared learning experiences through preceptorships.
3. Improve utilization of staff to avoid duplication of services.

Community Actions

1. Share services offered by state health department with individual juvenile facilities.
2. Investigate improving utilization of Medicaid funds for incarcerated youth.

State Actions



Goals

Improve the health care services for youth in South Dakota juvenile correction facilities.

Objectives

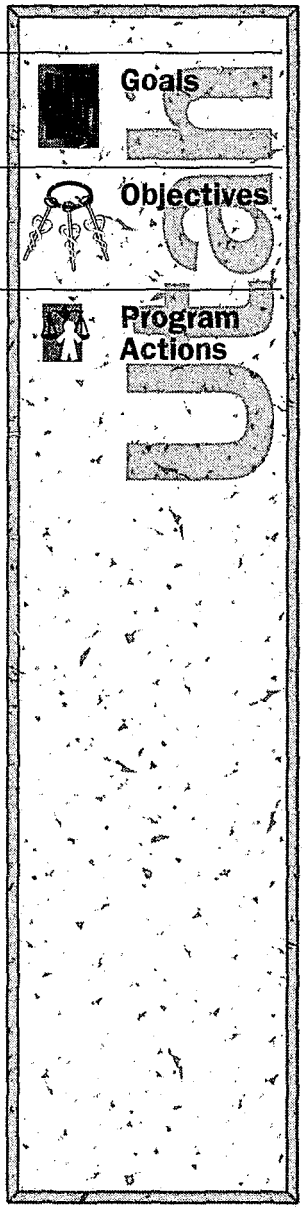
1. By July 1, 1992, conduct a self-assessment of facility compliance with the American Correction Association or National Commission on Correctional Health Care standards.
2. Begin to address deficiencies identified in the self assessment through interagency collaboration between the Department of Corrections, Department of Health, Department of Human Services and any other appropriate agencies.

Program Actions

1. Design and implement a health standards compliance assessment by juvenile facilities with the assistance of the Department of Corrections secretary's office.

State Actions

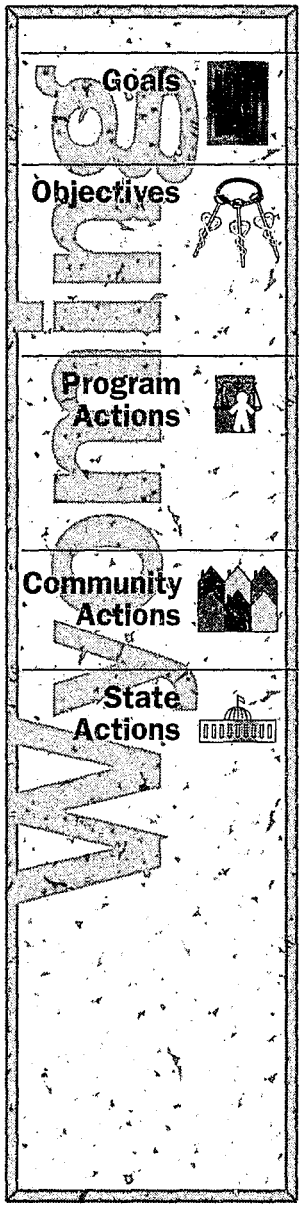
1. Identify the issue of health care for incarcerated youth as a high priority so that appropriate resources are devoted to addressing the issue.



Improve the coordination of health care services provided to incarcerated youth within the state of Utah.

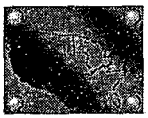
Utilize the current computerized juvenile information system to develop a health care tracking system component.

1. Meet with Division of Youth Corrections research, evaluation, and planning staff to discuss the design of a plan for medical information.
2. Determine type of health care services information to be maintained.
3. Meet with legal advisors for State Attorney General's Office to discuss legal concerns.
4. Determine budget needs and revenue sources.
5. Design a research component to consider (a) effectiveness of system in reducing duplication of services; (b) improved coordination of services; (c) improved data correction; and (d) identification of unmet health care needs.
6. Provide training on data entry to division of youth correction and health staff.



Goals	*Coordinate resources and services between the Department of Family Services and the Department of Health.*
Objectives	1. Review current activities in children's institutions and health programs affecting children. 2. Determine coordinated desired outcomes.
Program Actions	1. Link programs in Department of Family Services and with programs in the Department of Health. 2. Try to define who is responsible for what and how to work cooperatively.
Community Actions	1. Network with residential and group homes, regional mental health units and public health providers.
State Actions	1. Convene a workshop/meeting including department directors, superintendents and state program managers.

Arizona, California, Hawaii,
Nevada, Pacific Basin



Region IX

Goals

1. *Establish a network of communication between the personnel in juvenile corrections health services, state and county health departments and community agencies.*
2. *Identify health needs and available resources to meet those needs in the incarcerated youth population.*

Objectives

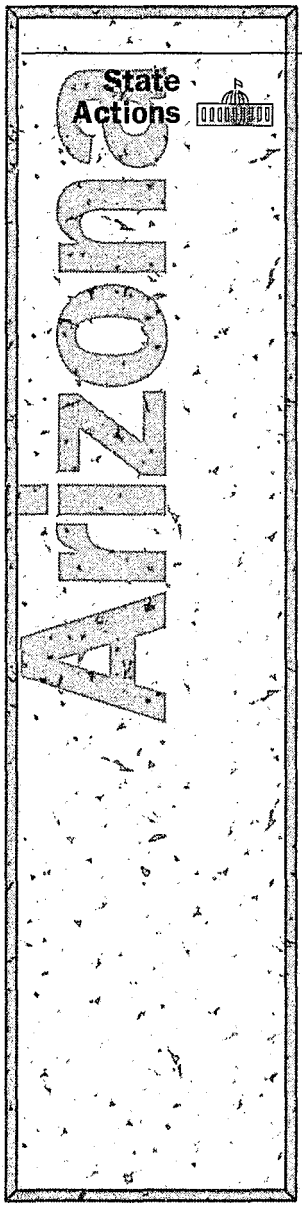
1. Initiate contact with appropriate personnel.
2. Provide quality health services to the incarcerated youth population.

Program Actions

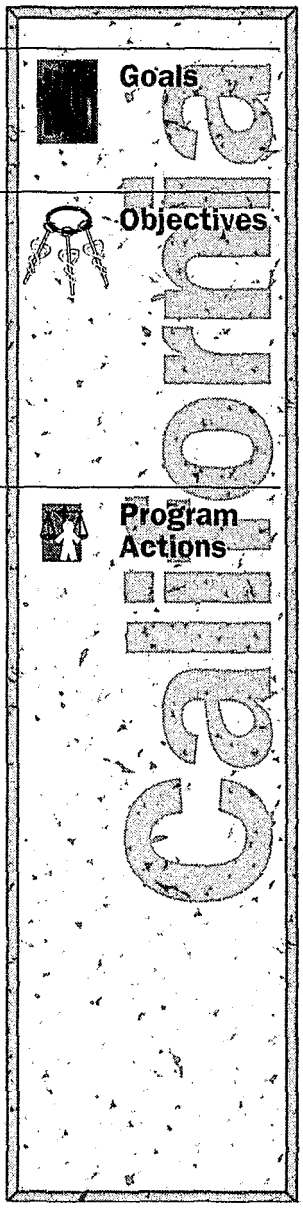
1. Obtain Arizona Department of Health Services Support to plan a meeting with representation from:
   a. Arizona Department of Health Services;
   b. county health departments;
   c. county juvenile correction health services; and
   d. community agencies.
2. Develop a planning committee.
3. Secure financial support
4. Schedule date, time and place for meeting.
5. Review health records and documents that identify physical and mental health needs.

Community Actions

1. Community agencies will provide information on existing resources.



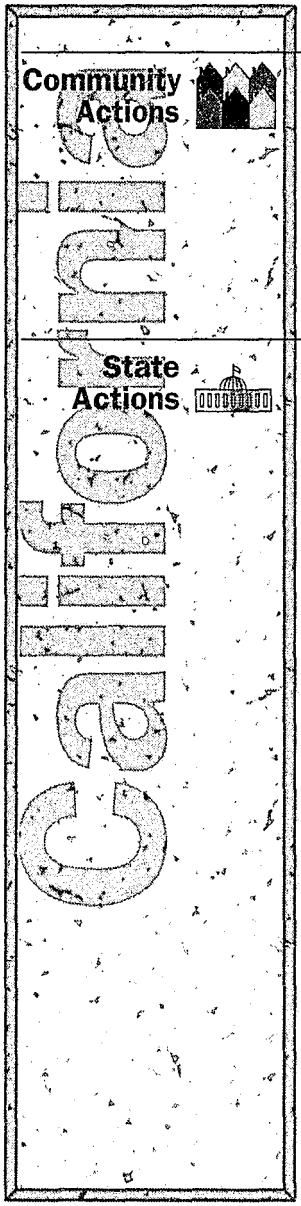
1. Implement the Adolescent Health Risk Appraisal with all new commitments to juvenile corrections.



Improve the quality of care for incarcerated youth to obtain better prevention and intervention services for all California adolescents.

1. Form a statewide network of informed individuals working on state regulations and national and state standards of care.
2. Develop expertise in finding funding for care.
3. Develop statewide coordination of adolescent health care.

1. Get information about standards and state regulations.
2. Designate a local representative at every facility.
3. Improve recruitment for nurses and doctors who will work to improve the quality of care.
4. Increase information and interest in accreditation.
5. Work to get eligible youths on medical reimbursement (NC 250, Child Health and Development Program, Crippled Children's Services, Supplemental Security Income).

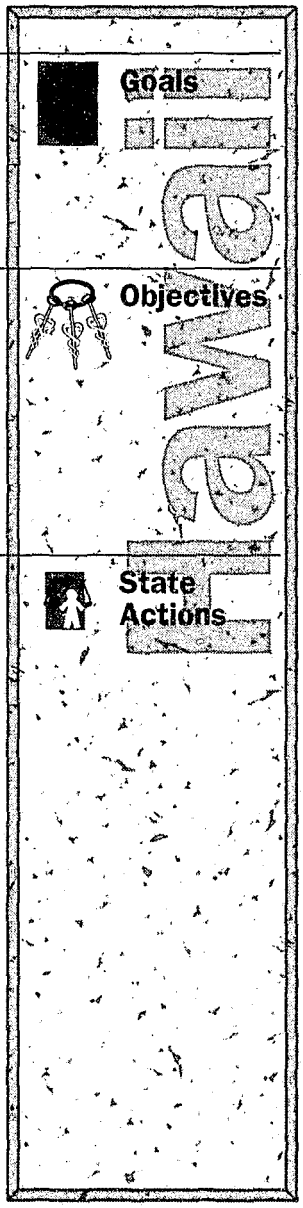


Community Actions

1. Get representative from all accredited counties (Yolo, Butte) to talk about accreditation process.
2. Form coalitions for applying for grants (intra- and interstate).
3. Work for Child Health and Development Program reimbursement at county level.

State Actions

1. Ask for funded representative from every county or region in California to annual juvenile justice meeting.
2. Get draft 5 of *correctional treatment regulations* for discussion.
3. Seek foundation support from Robert W. J. Rosenthal.
4. Staff health care at levels similar to probation.
5. Send group to Sacramento as advocates for incarcerated youth to meet with Steve Kessler, Dr. Shaw, Irv White, and Senator Pressley.
6. Change title of Maternal and Child Health Services (MCH) to Mothers, Child and Adolescent (MCHA) in an effort to get active involvement in health care for adolescents.
7. Report back to the regional meeting and federal "MCHA" program.



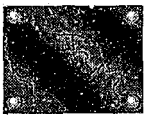
1. *Increase community awareness of the health issues of confined youth.*
2. *Begin statewide networking among juvenile corrections, health care providers and health planner in Hawaii.*

1. Create an ongoing task force to examine the health status and needs of confined youth in Hawaii and develop recommendations to better meet their needs.
2. Conduct a state conference on incarcerated youth for both the corrections and the health community.

1. Contact representatives of the departments of youth services, judiciary, health, human services and the University of Hawaii to come together as a task force on incarcerated youth.
2. Contact Kapeolarie Medical Center for Women and Children to ask for their help in sponsoring a statewide conference on incarcerated youth.

Goals 	*Improve the health care and medical follow-up systems for Nevada's incarcerated youth.*
Objectives 	Form an interagency work group to address health care needs.
Program Actions 	1. Department of Youth Services to serve as the lead agency to coordinate the work group. 2. Participation of correction facility nurses in community health nurse training/workshops conducted by the state health division.
Community Actions 	1. Increase communication between facility nurses, community health nurses and community health centers located in local population centers. 2. Promote involvement of Office of Rural Health.
State Actions 	1. Formation of work group by youth services division with representative from maternal and child health program from state health division. 2. Promote ties with the Governor's Juvenile Justice Advisory Group, Governor's Advisory Council on Youth and Governor's Maternal and Child Health Advisory Board.

Alaska, Idaho,
Oregon, Washington



Region X

Goals

Standardize data collection for all youth institutions and programs.

Objectives

1. Increase the number and track Alaskan youth in youth service programs.
2. Identify, avoid and eliminate overlapping of health services.
3. Identify "lack of information" areas in the health delivery system.

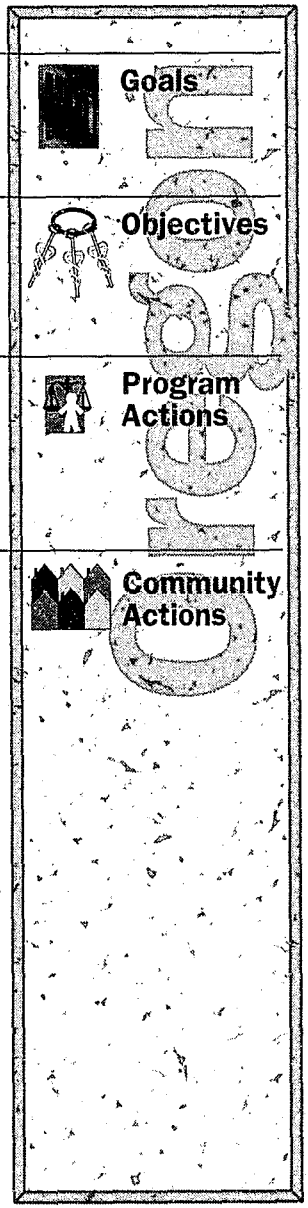
Community Actions

1. Locate and identify all systems delivering health care (dollars, services, education) to all Alaskan youth.

State Actions

1. Educate the Juvenile Justice Advisory Committee regarding the health care issues and needs of incarcerated youth.
2. Educate the Juvenile Justice Advisory Committee of the need to include health care issues as part of the juvenile justice agenda.
3. Identify all common data elements in youth institutions and youth services programs.

Goals	*Coordinate a health care initiative between bureaus of juvenile justice and maternal and child health.*
Objectives	1. Participate in education/enlightenment by departments, divisions, and bureaus of juvenile justice and maternal and child health. 2. Promote/encourage interagency collaboration. 3. Establish communication and collaboration between district health departments and regional juvenile justice systems.
Community Actions	1. Contact American Academy of Pediatrics Subcommittee for Incarcerated Youth. 2. Assign maternal and child health representative to regional juvenile justice advisory boards. 3. Contact county commissioners and legislators to raise awareness. 4. Establish linkage/liaison with universities.
State Actions	1. Conduct needs assessment statewide with a joint effort between juvenile justice and maternal and child health. 2. Arrange a bureau/divisional forum. 3. Contact youth commission/governor's office for participation in forum. 4. Put health care issues on juvenile justice agenda.

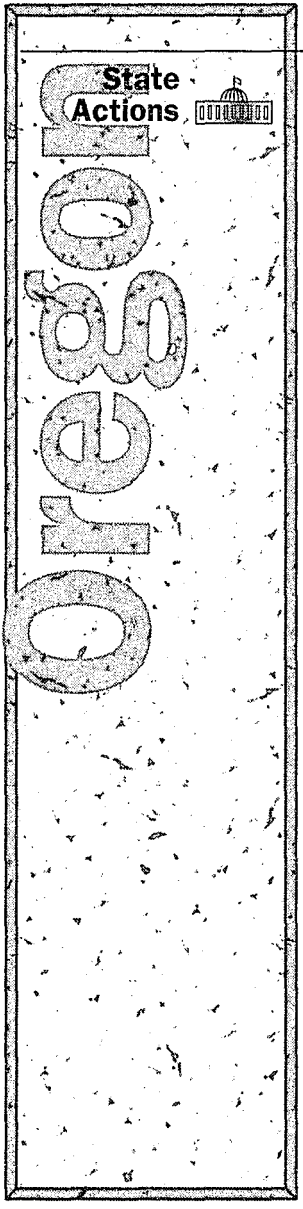


To establish statewide standards equivalent to the National Commission on Health Care for Correctional Facilities.

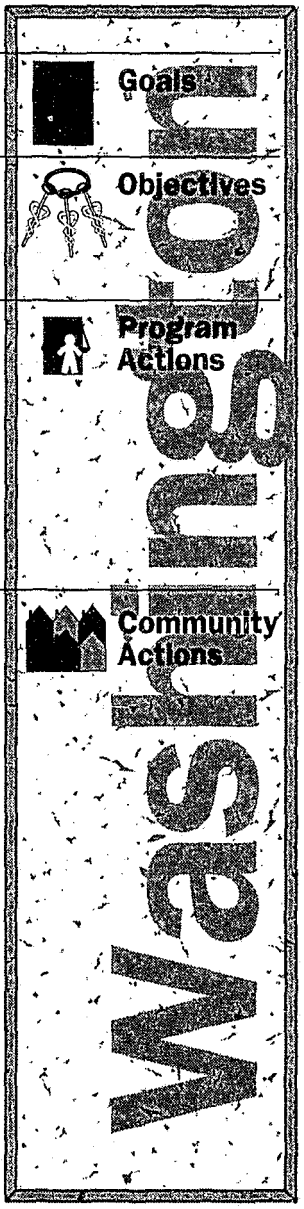
1. Coordination between juvenile justice and health division.
2. Ensure implementation of coordination on a countywide basis.

1. Implement the necessary changes to comply with established standards and guidelines.
2. Maintain standards on a daily basis for monitoring purposes.

1. Implementation of standards and guidelines established by the state commission and health division.
2. Identify training and technical assistance needs.
3. Coordination between juvenile departments and county health departments.
4. Involve county level health officials and juvenile departments and directors association.



1. Delineate roles between the health division and the state Children and Youth Services Commission.
2. Adopt standards and guidelines through administrative rules process.
3. Establish a work group.
4. Mandate that state health division include in their county reviews the monitoring of juvenile detention facilities.
5. Establish provisions for technical assistance including training and financial resources.
6. Contact Kathy Page at OMA.

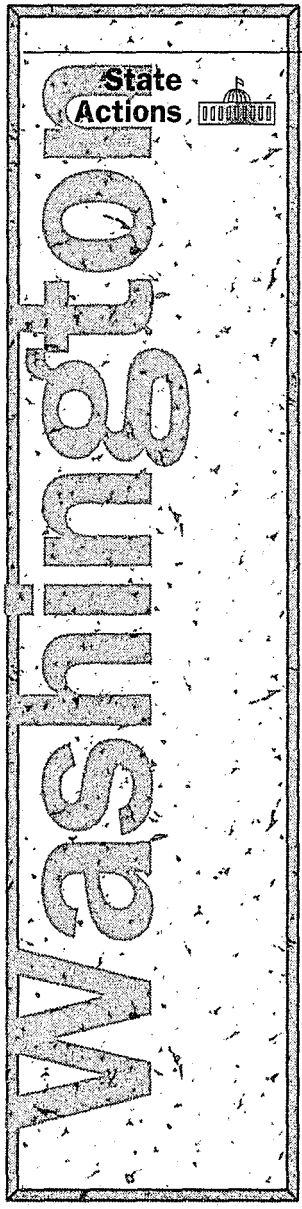


To improve the quality of health care for incarcerated youth in Washington state.

To improve collaboration and coordination among the systems in the state which impact on the care of incarcerated youth.

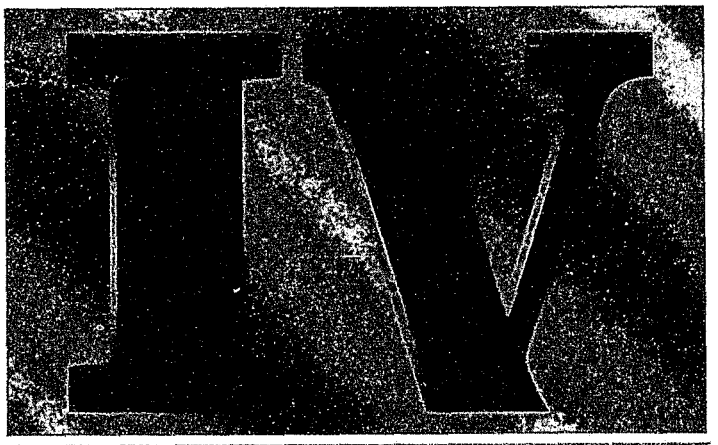
1. Ensure increased awareness of national health care standards at county and state facilities by making standards available to key people.
2. Increase utilization of national health care standards among health care providers at county and state facilities.

1. Identify needs of incarcerated youth to community service providers.
2. Increase awareness and utilization of community services currently available.



1. Identify roles and responsibilities of the health representative on the Juvenile Justice Advisory Committee.
2. Increase communication between social service, health care and educational systems by meeting with representatives of county detention and state correctional facilities.
3. Improve coordination between eastern and western Washington detention and correctional facilities regarding national standards implementation by discussing them at the annual statewide conference.
4. Increase attendance at the annual Division of Juvenile Rehabilitation conference by members of different provider groups.
5. Health care providers from MCH and the Division of Children, Youth, and Family Services will meet in order to share information about their respective systems.

Section



Appendices

Appendix

Western Regional Workshop Program

February 22–24, 1991 • San Diego, California

Friday, February 22, 1991

8:30–8:45 Welcome and Introductions

James Farrow, M.D.
University of Washington

Juanita Evans, M.S.W.
Maternal and Child Health Bureau

Betty Bassoff, D.S.W.
San Diego State University

8:45–9:15 The Forgotten Child in Health Care—History

Linda Thompson, M.S.N., Dr.P.H.
Johns Hopkins University

9:15–10:00 Model Programs

STATE MODEL

James Owens, M.D., M.P.H.
State of Washington Division of Juvenile Rehabilitation

COUNTY MODEL

Charles Baker, M.D.
Los Angeles County Health Services

10:00–10:30 Keynote Address

Rebecca Craig, R.N., M.P.A.
California Medical Association

Friday, February 22, 1991 (Continued)

11:00–11:30 Health Status

MEDICAL
Janet Shalwitz, M.D.
San Francisco Youth Guidance Center

NUTRITIONAL
Kate McBurney, Dr.P.H., R.D.
Public Health Consultant

11:30–12:00 Legal Issues

Elizabeth Jameson
Youth Law Center, San Francisco

12:00–1:30 Regional Recorders/Facilitators Lunch Meeting

1:30–3:15 Panel

MODERATOR
James Owens, M.D., M.P.H.
State of Washington
Division of Juvenile Rehabilitation

STANDARDS IMPLEMENTATION
James Owens, M.D., M.P.H.

ACADEMIC/UNIVERSITY INVOLVEMENT
Robert Deisher, M.D.
University of Washington,
Division of Adolescent Medicine

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES
Jana Ewing, Ph.D., M.A.
King County Department of Youth Services

CREATIVE FINANCING
Mike Brady, M.D., M.P.H.
Los Angeles County Juvenile Hall

INTERAGENCY PROGRAMMING
Janice Piepergerdes, R.N., M.A.
Department of Juvenile Corrections

Friday, February 22, 1991 (Continued)

3:45–5:30 Focused Discussion Groups A

STANDARDS IMPLEMENTATION

James Owens, M.D., M.P.H.
State of Washington, Division of Juvenile Rehabilitation

ACADEMIC/UNIVERSITY INVOLVEMENT

Robert Deisher, M.D.
University of Washington, Division of Adolescent Medicine

Dick Brown, M.D.
San Francisco General Hospital, Children's Health Center

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES

Jana Ewing, Ph.D., M.A.
King County Department of Youth Services

CREATIVE FINANCING

Mike Brady, M.D., M.P.H.
Los Angeles County Juvenile Hall

INTERAGENCY PROGRAMMING

Janice Piepergerdes, R.N., M.A.
Department of Juvenile Corrections

Fred Anderson
Children's Hospital of Los Angeles, University Affiliated Programs

Saturday, February 23, 1991

8:00–9:00 Breakfast Buffet

9:00–9:30 Plenary Session
James Farrow, M.D.

9:30–11:30 Focused Discussion Groups B
See Focused Discussion Groups A for topics and speakers

1:00–3:00 Work Groups by Region
Regions VII–X

3:30–4:30 Preliminary Reporting—Plenary

4:30–5:00 Recorders/Facilitators Meeting

Sunday, February 24, 1991

8:00–9:00	**Planning Committee Breakfast meeting**
9:00–10:30	**Work Groups by Region (Continued)** *Regions VII–X*
11:00–12:00	**Plenary—Reporting of State Plans**
12:00–12:30	**Follow-up/Evaluation/Proceedings** Juanita Evans, M.S.W., James Farrow, M.D.

B
Appendix

Eastern Regional Workshop Program

March 8–10, 1991 • Philadelphia, Pennsylvania

Friday, March 8, 1991

11:00–12:45 Opening Session

Greetings and Overview

Bernard Guyer, M.D., M.P.H.
Workshop Chair
Chair, Department of Maternal and Child Health, Johns Hopkins University

Juanita C. Evans, M.S.W.
Chief, Child and Adolescent Health Branch, Maternal and Child Health Bureau

Jesse Williams, Jr., M.Ed.
Executive Director, Division of Youth Services, City of Philadelphia

Linda Thompson, M.S.N., Dr.P.H.
Associate Faculty, Department of Maternal and Child Health, Johns Hopkins University

Friday, March 8, 1991 (Continued)

Keynote Session

Moderators:

Richard W. Friedman
Director,
Maryland Juvenile Justice Advisory Council

Marianne E. Felice, M.D.
Director of Adolescent Health,
University of Maryland-Baltimore

CRITICAL ISSUES IN HEALTH CARE OF INCARCERATED YOUTH: TWO PERSPECTIVES

Karen Hein, M.D.
Director, Adolescent AIDS Project,
Montifiore Medical Center

Barry A. Krisberg, Ph.D.
President,
National Council on Crime and Delinquency

2:30–4:00 Reaction Session and Resources Display

Saturday, March 9, 1991

8:45–10:15 Perspectives on Health Care: A Panel

Moderator:

Juanita C. Evans, M.S.W.
Chief, Child and Adolescent Health Branch,
Maternal and Child Health Bureau

STANDARDS FOR HEALTH CARE

B. Jaye Anno, Ph.D.
Vice President, National Commission on Correctional Health Care

COALITION BUILDING AT THE STATE LEVEL

Nancy S. Grasmick, Ph.D.
Special Secretary for Children, Youth and Families, State of Maryland

FINANCING HEALTH CARE FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM

Gary Shostak, M.P.H.
Director of Health Services,
Massachusetts Department of Youth Services

Saturday, March 9, 1991 (Continued)

MENTAL HEALTH SERVICES
Janice G. Hutchinson, M.D.
Medical Director, Child and Youth Services Administration, D.C. Department of Mental Health

COALITION BUILDING AT THE LOCAL LEVEL
Shelly D. Yanoff
Executive Director, Philadelphia Citizens for Children and Youth

10:30–12:00 Topic Discussion Groups

STANDARDS FOR HEALTH CARE
Ralph Fedullo, M.Ed.
Executive Director, St. Anne's Institute, Albany, New York

COALITION BUILDING AT THE STATE LEVEL
Nancy S. Grasmick, Ph.D.
Special Secretary for Children, Youth and Families, State of Maryland

FINANCING HEALTH CARE FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM
Thomas Lynch, M.S.W.
Ass't Commissioner, Division of Juvenile Services, New Jersey Department of Corrections

MENTAL HEALTH SERVICES
Frank Heron, M.B.A.
Branch Chief, Regional Program Consultant for MCH, DHHS Region III, Philadelphia

COALITION BUILDING AT THE LOCAL LEVEL
Christine Robinson, M.S.
Director, Div. of School Age and Adol. Health, Massachusetts Department of Health

1:30–3:15 Regional/State Meetings
Regions I–III

Sunday, March 10, 1991

8:45–9:20 **Continental Breakfast**
Regional/State Meetings (Continued)

9:30–11:30 **General Session**
Bernard Guyer, M.D., M.P.H., Workshop Chair
Chair, Department of Maternal and Child Health, Johns Hopkins University
Group Reports and Observations

FUTURE CHALLENGES IN HEALTH CARE FOR INCARCERATED YOUTH
Christine Robinson, M.S., Moderator
Director, Division of School Age and Adolescent Health, Massachusetts Department of Health
Ellen Schall, J.D.
President, National Center for Health Education

WRAP-UP

12:30 **Adjourment**

C Appendix

South/Central Regional Workshop Program

April 7–9, 1991 • Birmingham, Alabama

Sunday, April 7, 1991

1:30–3:00	**MCH Facilitator/Recorder Training**
3:30–3:40	**Opening Remarks and Introduction** Ronald Feinstein, M.D. *Director, Division of Adolescent Medicine, University of Alabama* Juanita Evans, M.S.W. *Chief, Child and Adolescent, Maternal and Child Health Bureau*
3:40–4:00	**The Health Care Needs of the Forgotten Child** Linda Thompson, M.S.N., Dr.P.H. *Director, Office of Occupational Medicine and Safety, Baltimore, MD*
4:00–4:45	**Keynote Presentation—Advocacy Issues** Sandra Ross *Judge, Family Court of Jefferson County, Alabama*
4:45–5:00	Break

Sunday, April 7, 1991 (Continued)

5:00–5:45 **Health Status and Characteristics of Incarcerated Youth**
Robert Brown, M.D.
Adolescent Health Services
Children's Hospital, Columbus, Ohio

5:45–6:30 **Legal Issues**
Michael J. Dale
Nova University Law School

Monday, April 8, 1991

7:30–8:30 **MCH Planning Committee Meeting**

8:30–10:30 **Panel Session**
Moderator:
George Phyfer, M.S.
Director, Alabama Deparment of Youth Services

STANDARDS
James Owens, M.D.
Staff Physician, Adolescent Clinic,
University of Washington

INTERAGENCY PROGAMMING/LINKAGES
David Braughton, M.S.S.A.
Executive Director, Lutheran Ministries of Florida

FINANCING
Carol Herrmann
Commissioner, Medicaid Agency of Alabama

MENTAL HEALTH AND SUBSTANCE ABUSE
Janice Hutchinson, M.D.
Medical Director, Child and Youth Services
Administration, Washington, D.C.

ACADEMIC AND UNIVERSITY INVOLVEMENT
Jean Ree Setzer, Ph.D.
Assistant Professor, University of Texas Health Center

10:30–10:45 **Charge for Workshops**
Linda Thompson, M.S.N., Dr.P.H.
Director, Office of Occupational
Medicine and Safety, Baltimore, MD

Monday, April 8, 1991 (Continued)

10:45–11:00 **Break**

11:00–12:30 **Focus Discussion Group, Session A**

1. Standards
2. Interagency Programming
3. Financing
4. Mental Health and Substance Abuse
5. Academic and University Involvement

2:00–3:30 **Focus Discussion Group, Session B**

For topics, see Focus Discussion Group A above.

3:45–5:00 **Regional Workshops**

Regions IV, V, and VI

6:30 **NCEMCH/Recorder/Facilitator Dinner Meeting**

Tuesday, April 9, 1991

7:30–8:30 **MCH Planning Committee Meeting**

8:30–10:30 **Regional Workshops**

(Develop regional/state action plans for Regions IV, V, and VI)

10:45–12:00 **Presentation of Regional Reports**

QUESTIONS AND ANSWERS
Moderator:
Carolyn Ellis, R.N.
Health Service Coordinator, Department of Youth Development, Nashville, Tennessee

12:00–12:15 **Closing Remarks—Future Follow-up Issues**

Ronald Feinstein, M.D.
Director, Division of Adolescent Medicine, University of Alabama

D
Participants List

E. Frederick Anderson
Director of Social Work Training
University Affiliated Program
Children's Hospital of LA
P.O. Box 54700 Box 53
Los Angeles, CA 90054-0700
Phone: (213) 669-2300

B. Jaye Anno
Vice President
National Commission on Correctional Health Care
2105 N. Southport, Suite 200
Chicago, IL 60614
Phone: (312) 528-0818
Speaker

Anne Arnesan
Director
Jail Removal Project
Wisconsin Council on Human Concerns
30 W. Mifflin Street, #401
Madison, WI 53703
Phone: (608) 258-4397
Fax: (608) 258-4407

Jean Athey
Chief, Public Health Social Work
Child and Adolescent Health Branch, DMICAH, MCHB
Parklawn Building, Room 9-31
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-4026
Fax: (301) 443-4842

Mildred Aukerman
Juvenile Justice Specialist
Kentucky Justice Cabinet
Bush Bldg., 2nd Floor
407 Wapping Street
Frankfort, KY 40601
Phone: (502) 564-3251
Fax: (502) 564-4840
Facilitator

Charles Baker
Medical Director
LA County Health Services Dept
Juvenile Court Health Services
1 st Floor, 1925 Daly Street
Los Angeles, CA 90031
Phone: (213) 226-8723
Speaker

Jakim Balli
Research Instructor
UTHSC at San Antonio
Department of Pediatrics
7703 Floyd Curl Drive
San Antonio, TX 78284-7818
Phone: (512) 692-3641
Fax: (512) 692-3650
Recorder

Betty Bassoff
Acting Chief
MCH Training Program
San Diego State University
6505 Alvarado Street, Suite 205
San Diego, CA 92120
Phone: (619) 594-4668
Speaker

Dana Baumgartner
Health Care Administrator
Minnesota Dept. of Corrections
450 N. Syndicate
300 Bigelow Bldg.
St Paul, MN 55104
Phone: (612) 642-0248
Fax: (612) 642-0223

Robert Bidwell
Assistant Professor, Pediatrics
Division of Adolescent Medicine
University of Hawaii School of Medicine
1319 Punahou Street
Honolulu, HI 96826
Phone: (808) 973-8387
Recorder

Erica Bisgyer
Medical Director
Special Programs for Youth
375 Woodside Avenue
San Francisco, CA 94127
Phone: (415) 753-7760

Lynwood Booth
Director
Alabama Youth Services
VACCA
3950 Roebuck Blvd.
Birmingham, AL 35206
Phone: (205) 833-2361

Paul Bracy
Violence Prevention Project Coordinator
The Medical Foundation
95 Berkeley Street
Boston, MA 02116
Phone: (617) 451-0049

Michael Brady
Physician Consultant
LACJH
175 East Sixth Street
Claremont,, CA 91711
Phone: (714) 621-8355
Speaker

David Braughton
Executive Director
Lutheran Ministries of Florida
3825 Henderson Blvd., Suite 204
Tampa, FL 33629
Phone: (813) 287-2373
Speaker

Richard Brown
Director, Children's Health Center
San Francisco General Hospital
Department of Pediatrics, 6E-9
1001 Potrero Street
San Francisco, CA 94110
Phone: (415) 821-8376

Robert Brown
Director, Adolescent Health Services
Children's Hospital
700 Children's Drive
Columbus, OH 43205
Phone: (206) 888-9797
Fax: (206) 888-4885
Speaker

Roberta Carnahan
Immediate Past Chair
Alaska State Juvenile Justice Advisory Board
2223 Jack Street
Fairbanks, AK 99709
Phone: (907) 452-2806

Mary Carpenter
Maternal and Child Health
Social Work Director
Virginia Department of Health
P.O. Box 2448
Richmond, VA 23218
Phone: (804) 786-7367

Cathy Chadwick
MCH Training
San Diego State University
6505 Alvarado Street, Suite 205
San Diego, CA 92120
Phone: (619) 594-4667
Recorder

Gwen Chunn
Director
Division of Youth Service
Dept. of Human Resources
705 Palmer Dr., Dobbin Bldg.
Raleigh, NC 27603-0675
Phone: (919) 733-3011

Mercedes Cintron
Executive Director
Administration of Juvenile Institutions
Box 19175 Fernandez Juncos Station
San Juan, PR 00910
Phone: (809) 728-7763

Spencer Clark
Chief of Adolescent Substance Abuse
Service
N.C. Division of MH/DD/SAS
325 N. Salisbury Street
Raleigh, NC 27603
Phone: (919) 733-0696
Fax: (919) 733-7447

Andre Cooper
Program Coordinator
Adolescent Diagnostic Treatment
Woodbourne Center
1301 Woodbourne Avenue
Baltimore, MD
Phone: (301) 443-1000

Rebecca Craig
Manager, Corrections and Ambulatory
Health Care Programs
P.O. Box 7690
San Francisco, CA 94120-7690
Phone: (415) 882-5132
Speaker

Henry Crawford
Police Youth Services Supervisor
Stamford Connecticut Police
805 Bedford Street
Stamford, CT 06901
Phone: (203) 977-4640

Michael Dale
Nova School of Law
3100 SW 9th Avenue
Fort Lauderdale, FL 33315
Phone: (305) 760-5737
Fax: (305) 767-8108
Speaker

William Daniel
Emeritus Professor
Dept. of Pediatrics, U of AL School of Medicine
1437 Midlane Ct.
Montgomery, AL 36109-0710
Phone: (205) 265-0495

Allan Davis
Superintendent
Pine Hill School for Boys
P.O. Box 1058
Miles City, MT 59301
Phone: (406) 232-1377

Charles Day
Coordinator
CASSP
200 Interstate Parkway
P.O. Box 3710
Montgomery, AL 36109-0710
Phone: (205) 271-9261

Simmonne deGlee
Child Health Program Coordinator
Bureau of Maternal and Child Health
Idaho Department of Health and Welfare
450 W. State Street, 4th Floor Towers
Boise, ID 83702
Phone: (208) 334-5957

Robert Deisher
Department of Pediatrics
Child Development Center, WJ-10
University of Washington School of Medicine
Seattle, WA 98105
Phone: (206) 685-1274
Speaker

Elaine Denny
Director
Pitt Regional Detention Center
N.C. Division of Youth Services
Route 15, Box 1
Greenville, NC 27834
Phone: (919) 756-6134

Mark Doherty
Director, Denial Service
Dorchester House
1353 Dorchester Avenue
Dorchester, MA 02122
Phone: (617) 288-3230 ext. 244

Paul Dyment
Chief of Pediatrics
Maine Medical Center
Portland, ME 04102
Phone: (207) 871-2439

Steve Emerson
Social Services Coordinator
for Juvenile Justice
Division of Family and Children's Services
Department of Health & Welfare
450 W. State Street
Boise, ID 83720-5450
Phone: (208) 334-6565

Carolina Endert
Assistant Professor of Social Work
Department of Pediatrics
The Children's Hospital
University of Alabama at Birmingham
1600 7th Avenue South, CHT 157
Birmingham, AL 35233
Phone: (205) 934-5253
Fax: (205) 934-1150

Vonnie Ereth
Community Health Nurse
State Department of Health
221 N. Fifth, P.O. Box 5503
Bismarck, ND 58502
Phone: (701) 222-6512

Juanita Evans
Chief, Child and Adolescent Health
Branch, DMICAH, MCHB
Maternal and Child Health Bureau
Parklawn Bldg., Room 9-21
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-4026
Fax: (301) 443-4842

Doris Evans-Gates
Manager, Child/Adolescent Health
Department of Health Services
Office of Maternal & Child Health
1740 W. Adams Street, Room 200
Phoenix, AZ 85007
Phone: (602) 542-1880

Jana Ewing
Mental Health Services Coordinator
Medical Clinic
King County Department of
Youth Services
1211 E. Alder Street
Seattle, WA 98112
Phone: (206) 343-2631
Speaker

James Farrow
Director, Division of Adolescent Medicine
Department of Pediatrics
Child Development Center, WJ-10
University of Washington
Seattle, WA 98195
Phone: (206) 685-1249
Fax: (206) 543-5771
Regional Coordinator

Ralph Fedullo
Executive Director
Saint Anne Institute
160 North Main Avenue
Albany, NY 12206
Phone: (518) 489-7411
Facilitator

Burke Fitzpatrick
Deputy Director
Office of Criminal Justice,
Division of Public Safety
Governor's Office
1205 Pendleton Street
Columbia, SC 29210
Phone: (803) 734-0423

Ronald Feinstein
Director, Division of Adolescent Medicine
Department of Pediatrics
The Children's Hospital
University of Alabama at Birmingham
1600 7th Avenue South, CHT-157
Birmingham, AL 35233
Phone: (205) 934-5262
Fax: (205) 934-1150
Regional Coordinator

Marianne Felice
Professor and Vice Chair
Department of Pediatrics
University of Maryland
31 S. Green Street, 3rd Floor
Baltimore, MD 21201
Phone: (301) 328-6495
Fax: (301) 328-8742

John Foley
Director
Juvenile Division
Oklahoma County D.A. Office
5905 N. Classen Blvd
Oklahoma City, OK 73118
Phone: (405) 840-4976

Mary Jane Frank
Cluster Coordinator
ODHS-Family, Children & Adult Services
30 E. Broad St., 30th Floor
Columbus, OH 43266-0423
Phone: (614) 466-1213
Fax: (614) 466-9247
Facilitator

John Franz
Attorney
Project Asst. : Jail Removal
Wisconsin Council on Human Concerns
30 W. Mifflin Street, #401
Madison, WI 53703
Phone: (608) 258-4397
Fax: (608) 258-4407
Recorder

Richard Friedman
Director
MD Juvenile Justice Advisory Council
301 W. Preston Street, 15th Floor
Baltimore, MD 21201
Phone: (301) 225-4817

Barbara Gagneaux
Director
Nursing Services
Juvenile Reception & Diagnostic Center
Post Office Box 116
Baton Rouge, LA 70714
Phone: (504) 774-7720

Mary Gardner
President
Marel, Inc.
Box 158
Brookeville, MD 20833
Phone: (301) 792-0668

Donna Gay
Coordinator of Juvenile Courts
Administration Office of the Courts
Post Office Box 1437
Little Rock, AK 72203-1437
Phone: (501) 376-6655
Fax: (501) 682-6877

Nancy Grasmick
Special Secretary for Children,
Youth and Families
Office for Children, Youth & Families
301 W. Preston Street, Suite 1502
Baltimore, MD 21201
Phone: (301) 333-6751
Speaker, Facilitator

Henrietta Gray
Sr. Juvenile Detention Officer
Jefferson County Youth Detention Ctr
140 2nd Court North
Birmingham, AL 35211
Phone: (205) 325-5437

Margaret Gregory
Coordinator, Child Health Program
N.J. State Dept. of Health
363 West State Street
Trenton, NJ 08625
Phone: (609) 292-5616

Patricia Griffin
Coordinator of
Community Forensic Services
Department of HIS-ADM
1317 Winewood Blvd, Bldg. 66, Room 161
Tallahasee, FL 32399-0700
Phone: (904) 487-1301
Fax: (904) 487-2239

Mary Guthrie
Staff Nurse I
Alabama Youth Services - VACCA
3950 Roebuck Blvd
Birmingham, AL 35206
Phone: (205) 833-2361

Bernard Guyer
Department of Maternal and
Child Health
School of Hygiene and Public Health
Johns Hopkins University
624 N. Broadway, Room 182
Baltimore, MD 21205
Phone: (301) 955-3384
Regional Coordinator

Chris Hagg
Adolescent Health Coordinator
State Department of Public Health
Bureau of Child and Adolescent Services
434 Monroe Street
Montgomery, AL 36130-1701
Phone: (205) 242-5760
Fax: (205) 240-3097
Facilitator

DeEtte Hall
Director, Teen & Young Adult Health
Department Human Services
Division Maternal & Child Health
State House Station 11
Augusta, ME 04333
Phone: (207) 289-3311

Edward Harrison
Vice President
Director of Juvenile Programs
National Commission on Correctional Health Care
2105 North Southport, Suite 200
Chicago, IL 60614-4017
Phone: (312) 528-0818
Fax: (312) 528-4915
Speaker

Bill Hartley
Psychological Program Manager
Western Youth Institution
P.O. Drawer 1439
Morgantown, NC 28635
Phone: (704) 437-8335
Fax: (704) 438-9033

Karen Hein
Director, Adolescent AIDS Program
Albert Einstein College of Medicine
Montefiore Medical Center
111 East 210th Street (NW674)
Bronx, NY 10467
Phone: (212) 920-6612
Speaker

Frank Heron
Chief
Maternal and Child Health Branch
R.O. 111, Public Health Services
3535 Market Street
Philadelphia, PA 19104
Phone: (215) 596-6686
Facilitator

Diane Hinkle
Registered Nurse
Davis Center-Division of Corrections
Blackwater Falls Road
Davis, WV 26260
Phone: (304) 259-5241

J. Bart Hodgens
Assistant Professor of Psychology
Division of Adolescent Medicine
Department of Pediatrics
CHT-157, UAB Station
Birmingham, AL 35294
Phone: (205) 934-5253
Fax. (205) 934-1150
Recorder

Elizabeth Hoffman-Yoshihara
Program Manager
Family Planning/Adolescent Health
Oregon State Health Division
1400 S.W. Fifth Street
Portland, OR 97201
Phone: (503) 229-6229

Dawne Hood
Medical Director
Medical Clinic
King County Department of Youth Services
1211 East Alder Street
Seattle, WA 98112
Phone: (206) 343-2630
Facilitator

Janice Hutchinson
Medical Director
Department of Human Services
Child and Youth Services
1120 19th Street, N.W., Suite 700
Washington, DC 20036
Phone: (202) 673-7784

Jean Jackson
Training Specialist
SD Department of Health, MCH Program
118 West Capitol
Pierre, SD 57501
Phone: (605) 773-4439

Elizabeth Jameson
Youth Law Center
114 Sansome Street, Suite 3820
San Francisco, CA 94104-3820
Phone: (415) 543-3379
Speaker

Kenneth Jaros
Assistant Professor of
Public Health Social Work
Graduate School of Public Health
222 Parran Hall
University of Pittsburgh
Pittsburgh, PA 15261
Phone: (412) 624-3102
Fax: (412) 624-3146

Corinne Jensema
President
Conference Center, Inc.
Center for Disabilities, Research and
Training
12407 Kemp Mill Road
Silver Spring, MD 20902
Phone: (301) 622-7795

Jeremiah Jeremiah
Chief Judge of Family Court
Rhode Island Family Court
One Dorrance Plaza
Providence, RI 02903
Phone: (401) 277-3310

Emory Johnson
MCH Social Work Consultant
Room 10140 Mail Stop 14
P.O. Box 13716
3535 Market Street
Philadelphia, PA 19107
Phone: (215) 596-6686

David Kaplan
Chief, Adolescent Medicine
University of Colorado-HSC
Children's Hospital
1056 East 19th Avenue
Denver, CO 80218
Phone: (303) 861-6133

Lynn Kiernan
Assistant Director,
Office of Children's Services
N.J. Division of
Mental Health & Hospitals
CN 727, Capital Center
Trenton, NJ 08625-0727
Phone: (609) 777-0707

Joan Kinlan
Acting Chief
Youth Forensic Psychiatry Unit
Commission of Mental Health
605 G Street, NW
Washington, DC 20016
Phone: (202) 724-4377

Barry Krisberg
President
National Council on
Crime & Delinquency
685 Market Street
San Francisco, CA 94105
Phone: (415) 896-6223
Speaker

David Kuker
Jail Removal Coordinator
Division of Children, Youth and Families
Lucas State Office Building
Des Moines, IA 50319
Phone: (515) 281-8078

Linda Ladehoff
Pediatric Nurse Consultant
Kansas Department of Health &
Environment
Bureau of Family Health
900 S. W. Jackson, 10th Floor
Topeka, KS 66612-1290
Phone: (913) 296-1300

Tim Lane
Adolescent Health Consultant
Lukas Building/State Capitol
Des Moines, IA 50319-0057
Phone: (515) 281-7833

Marilyn Lanphier
Director, Adolescent Section
Oklahoma Department of Public Health
8908 Aaron Drive
Oklahoma City, OK 73132
Phone: (405) 728-3024
Facilitator

Gitte Larsen
University of Washington
1821 25th Avenue E.
Seattle, WA 98122
Phone: (206) 328-6154
Recorder

Joyce Lebron
Acting Director
Maternal Child Health and Children with
Special Health Care Needs
Virgin Islands Deptartment of Health
P.O. Box 752
St. Thomas, VI 00804
Phone: (809) 776-7723

Claudia Lee
Acting Director Interagency
Prevention Projects
New York State Dept of Health,
AIDS Institute
Empire State Plaza
Agency Building #4, 6th Floor
Albany, NY 12237
Phone: (518) 474-1135

Lynn Letarte
Supervisor
Adolescent and School Health
Connecticut Dept. of Health Services
150 Washington Street
Hartford, CT 06106
Phone: (203) 566-2057

Al Lick
Director
Division of Juvenile Services
P.O. Box 1898
Bismarck, SD 58502-1898
Phone: (701) 221-6390

Richard Lindahl
Juvenile Justice Specialist
Office of Juvenile Justice Program
New Mexico Youth Authority
435 St. Michael's Drive
Santa Fe, NM 87501
Phone: (505) 827-7545
Fax: (505) 827-7522
Facilitator

George Lorato
Managing Program Consultant
Department of Family Services
Hathaway Building, 3rd Floor
Cheyenne, WY 82002
Phone: (307) 777-5831

Catherine Lucas
Program Development Specialist
Office of Policy Analysis & Planning
N.J. State Department of Corrections
CN 863
Trenton, NJ 08625
Phone: (609) 292-9424

Thomas Lynch
Assistant Commissioner
Dept. of Corrections,
Division of Juvenile Services
CN 863
Trenton, NJ 08625
Phone: (609) 292-5858
Facilitator

Penny Madry
Bureau of Maternal and Child Health
Ohio Department of Health
246 N. High Street, 6th Floor
P.O. Box 0118
Columbus, OH 43266-0118
Phone: (614) 644-5332
Fax: (614) 644-9850

Ricka Markowitz
Governor's Office on Children and Youth
301 West Preston Street
15th Floor
Baltimore, MD 21201
Phone: (301) 225-4160

Ray Mastracco
Deputy Director
Programs Department of Youth and Family Services
P.O. Box 3 AG
Richmond, VA 23208-1108
Phone: (804) 371-0706

Jeanne Matics
Director Pediatric Program
Division of Maternal & Child Health
West Virginia Department of Health and Human Resources
1411 Virginia Street
East Charleston, WV 25301
Phone: (304) 348-5388

Kathleen McBurney
Public Health Consultant
535 Pierce Street, #154
Albany, CA 94706
Phone: (415) 524-2159
Speaker

Anthony McClain
Program Manager
Department of Mental Health Children's Services
24 Staniford Street
Boston, MA 02114
Phone: (617) 727-5500

Robert McCluskey
Correctional Trainer
Tennessee Correctional Institute.
Volunteer Plaza, Suite 750
500 James Robertson Pkwy
Nashville, TN 37243-1420
Phone: (615) 383-8830
Facilitator

Kathleen McElligott
Director
Teen Mother and Child
965 Northcliffe
Salt Lake City, UT 84103
Phone: (801) 581-3729

Kevin McLain
Special Assistant
Department of Corrections
523 E. Capitol, Suite 405
Pierre, SD 57501
Phone: (605) 773-3478

Eleanor McLean
Coordinator, SED Programs
Office of Mental Health
Division of Community Services
P.O. Box 7851
Madison, WI 53707
Phone: (608) 266-6838
Fax: (608) 266-0036

Katherine Miller
Consultant
Bureau of Community Services-ERD
Michigan Department of Public Health
P.O. Box 30195
Lansing, MI 48909
Phone: (517) 335-8906
Fax: (517) 335-8560

Lynn Milroy
Nursing Supervisor
Pine Bluff Youth Services Center
Route 8, Box 970
Pine Bluff, AK 71601
Phone: (501) 879-0661
Fax: (501) 682-6571

Karen Mowery
Corrections Nurse
Nevada Youth Training Center
P.O. Box 469
Elko, NV 89801
Phone: (702) 738-7182

George Nakama
Regional Social Work Consultant
Public Health Service/DHHS
50 United Nations Plaza
San Francisco, CA 94102
Phone: (415) 556-4926
Facilitator

Anne Nelsen
Assistant Director
Division of Youth Corrections
120 N. 200 W., Room 422
Salt Lake City, UT 84103
Phone: (801) 538-4325

George Noren
Interim Chief of Pediatrics
Department of Pediatrics
Hannepin County Medical Center
701 Park Avenue South
Minneapolis, MN 55415
Phone: (612) 347-2677
Fax: (612) 347-2438
Facilitator

Carl Nowell
State Supervisor
Children's Rehabilitation Services
2129 East South Boulevard
Montgomery, AL 36111
Phone: (205) 281-8780
Fax: (205) 281-1973

Bonnie Nuuanu
Hawaii Youth Correctional Facility
42K-477 Kalanianaole Highway
Kailua, HI 96734
Phone: (808) 261-0858

Barbara Olsen
Adolescent Health Consultant
Arizona Department of Health Services
1740 W. Adams Street, #200
Phoenix, AZ 85007
Phone: (602) 542-1880

James Owens
Medical Director
Division of Juvenile Rehabilitation,
Echo Glen Children's Center
33010 S.E. 99th St.
Snoqualmie, WA 98065
Phone: (206) 888-9797

Dan Palmer
Chief of Medical Services
Department of Youth Authority
4241 Williamsbourgh Drive
Sacramento, CA 95823
Phone: (916) 427-4870

Patsy Patton
State Supervisor
Program Development
Children's Rehabilitation Services
2626 Sixth Avenue South
Birmingham, AL 35233
Phone: (205) 939-5900

Emily Pendleton
Supervisor Medical Services
Alabama Youth Services-VACCA
3950 Roebuck Boulevard
Birmingham, AL 35206
Phone: (205) 833-2361

Jesse Pennington
Special Assistant to the Attorney General
State Attorney General's Office
P.O. Box 220
Jackson, MS 39205
Phone: (601) 359-6780

JoAnne Perkins
Superintendent
Illinois Youth Center
Department of Corrections
P.O. Box 550
Warrenville, IL 60555
Phone: (708) 983-6231

Ronald Phole
Superintendent of Detention
22nd Judicial Circuit of Missouri
3847 Enright Avenue
St Louis, MO 63108
Phone: (314) 531-3600

George Phyfer
Director
Department of Youth Services
P.O. Box 66
Mt. Meigs, AL 36057
Phone: (205) 272-9100
Fax: (205) 271-9100
Speaker

Janice Piepergerdes
Administrator, Health Services Bureau
Department of Juvenile Corrections
P.O. Box 35000
Phoenix, AZ 85069
Phone: (602) 869-9050
Speaker

Daniel Prince
Chief of Planning & Programs
Nevada Youth Services
505 E. King Street, Suite 101
Carson City, NV 89710
Phone: (702) 687-5982

C. Ann Quinones
Nurse Consultant
Adolescent Family Life Program,
MCH Branch
Family Health Services, Department of
Health
714 P Street, Room 750
Sacramento, CA 95814
Phone: (916) 327-8171

Patricia Reams
Chief Physician
Department of Youth & Family Services
P.O. Box 3AG
Richmond, VA 23208-1108
Phone: (804) 746-2135

Launa Ritch
Health Educator
Nevada State Health Division
505 East King St., Room 205
Carson City, NV 89710
Phone: (702) 687-4885

Barbara Ritchen
Director, Adolescent Health
Colorado Department of Health
4210 E Eleventh Avenue
Denver, CO 80220
Phone: (303) 331-8372

Christine Robinson
Director
Division of School Age and Adolescent Health
Department of Public Health
150 Tremont Street; 3rd Floor
Boston, MA 02111
Phone: (617) 727-0944
Facilitator

Jan Robinson
Child Health Nursing Consultant
Division of Family Health Services
Utah Department of Health
288 N. 1460 W.
Salt Lake City, UT 84116-0650
Phone: (801) 538-6140

Bette Rosenzveig
Program Director
Juvenile Justice Coordinator Council
Suite 410, 10 Park Place South
Atlanta, GA 30303
Phone: (404) 656-1725

Robert Ross
Children's Counselor
13th District Court
Stepping Stone Group Home
2506 Grove Avenue
Richmond, VA 23223
Phone: (804) 780-6199

Sandra Ross
Juvenile Judge
Jefferson County Family Court
120 2nd Court North
Birmingham, AL 35201
Phone: (205) 325-5538
Speaker

Amy Rossi
Executive Director
Arkansas Advocates for Children & Family
931 Donaghey Building
103 East 7th Street
Little Rock, AK 72201-4531
Phone: (501) 371-9678
Facilitator

Tommy Rouse
Director
Jefferson County Youth Detention Center
140 2nd Ct. N.
Birmingham, AL 35211
Phone: (205) 325-5438

Marjorie Sable
Perinatal and Child Health
Missouri Department of Health
P.O. Box 570
Jefferson City, MO 65102
Phone: (314) 751-6215

Susan Salmons
Program Specialist
W.V. Dept of Health and Human Resources
Office of Social Services
3135 16th Street Road
Huntington, WV 25701-9985
Phone: (304) 528-5800

Susan Saperstein
Assistant Secretary for Program Services
MD State Department of Juvenile Services
321 Fallsway
Baltimore, MD 21202
Phone: (301) 333-6766

Pamela Schaefer
Research Associate
American Probation and Parole Association
c/o Council of State Governments
P.O. Box 11910 Iron Works Pike
Lexington, KY 40578-1910
Phone: (606) 231-1951

Ellen Schall
President
National Center for Health Education
30 East 29th Street
New York, NY 10012
Phone: (212) 689-1886
Speaker

Judy Schoder
Public Health Nurse Consultant
Parent-Child Health Services
Bureau of Parent & Child Health
Mail Stop LC-12D
Olympia, WA 98506
Phone: (206) 586-1255

Jean Setzer
Assistant Professor
UTHSC at San Antonio
Department of Pediatrics
7703 Floyd Curl Drive
San Antonio, TX 78284-7818
Phone: (512) 692-3641
Fax: (512) 692-3650
Speaker

Janet Shalwitz
Special Programs for Youth
Youth Guidance Center
375 Woodside Avenue
San Francisco, CA 94127
Phone: (415) 753-7780
Speaker

Paula Sheahan
Conference Coordinator
National Center for Education in Maternal and Child Health
38th and R Streets, N.W.
Washington, DC 20057
Phone: (202) 625-8400
Fax: (202) 625-8404

John Sheridan
Administrator
Bureau of Residential Services
Division for Children & Youth Services
45 South Fruit Street
Concord, NH 03301
Phone: (603) 271-5945

James Sherman
Director of Juvenile Center
Medical/Psychiatric Services
Bexar County Medicine/Psychiatric Dept.
600 Mission Road
San Antonio, TX 78210
Phone: (512) 531-1090
Fax: (512) 531-1026

Gary Shostak
Director of Health Services
M.A. Dept. of Youth Services
Fort Point Place
27-43 Wormwood Street
Boston, MA 02210
Phone: (617) 727-7575
Speaker

Maxine Smith
Administrative Assistant
Division of Adolescent Medicine
CDMRC, WJ-10
University of Washington
Seattle, WA 98195
Phone: (206) 543-8705

Armond Start
Associate Professor
HS-Med, Rm 3839
Family Clinic/Wingra Center
777 S. Mills Street
Madison, WI 53715
Phone: (608) 263-1326
Fax: (608) 263-5813
Facilitator

Mark Steward
Director
Division of Youth Services
P.O. Box 447
Jefferson City, MO 65102-0447
Phone: (314) 751-3324

Ann Strand
Director
Development Youth Center
4525 Bakers Ferry Road
Atlanta, GA 30331
Phone: (404) 696-1020
Fax: (404) 699-4487

Marsha Sturdevant
Medical Fellow
Adolescent Health Program
University of Minnesota
1867 Taylor Avenue
St Paul, MN 55104
Phone: (612) 626-2820
Fax: (612) 626-2134

Stuart Swayze
Social Work Consultant
Habilitative Services Branch,/DSCHN
Maternal and Child Health Bureau
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-2370
Fax: (301) 443-4802

Derius Swinton
Child and Adolescent Mental Health Consultant
Deparment of Mental Health
Mental Retardation and Substance Abuse Services
P.O. Box 1797
Richmond, VA 23214
Phone: (804) 786-2991

Paul Targoff
Director, Medical Services
Division of Youth Services
4255 S. Knox Court
Denver, CO 80236
Phone: (303) 420-5346
Recorder

Gloria Thomas
Assistant Chief
Nursing and Auxillary Services
WI Bureau of Correctional Health
149 E. Wilson Street
Madison, WI 53703-7925
Phone: (608) 267-1731
Fax: (608) 267-0923

Linda Thompson
Director, Office of
Occupational Medicine and Safety
23 Gay Street
Baltimore, MD 21202
Phone: (301) 396-3788
Fax: (301) 727-3265
Regional Coordinator, Speaker

Patricia Tompkins
Chief
Office of Maternal and Child Health
Commission of Public Health
1600 L Street, N.W.
Suite 907
Washington, DC 20036
Phone: (202) 673-4551

James Trast
Director
Juvenile Offenders Programs
Smith-Wilson Building
300 S.W. Oakley
Topeka, KS 66606
Phone: (913) 296-4648

Thea Uhug-Ruff
Health Services Administrator
MD Department of Juvenile Services
321 Fallway
Baltimore, MD 21202
Phone: (301) 333-3878

Tom Vaughan, Jr.
Medical Director
Vaughan Psychiatric Services
The Children's Hospital
1600 7th Ave. So.
Birmingham, AL 35233
Phone: (205) 939-9193

Jerry Walsh
Chairman
Juvenile Justice Advisory Group
1832 Pearce Street
Magnolia, AK 71753
Phone: (501) 682-8756
Fax: (501) 682-6571

Susan Wayne
Executive Director
Justice Resource Institute
132 Boylston Street
Boston, MA 02116
Phone: (617) 482-0006

C. J. Wellington
Maternal and Child Health Consultant
1660 L Street, N.W. Suite 913
Washington, DC 20036
Phone: (202) 673-6969

David Wells
Medical Authority
Division of Youth Services
State of Colorado
8284 N. Sunburst Trail
Parker, CO 80134
Phone: (303) 361-8879
Facilitator

Genie Wessel
Consultant
School/Adolescent Health
Maryland Dept. of Health and Mental Hygiene
201 W. Preston Street Rm 321A
Baltimore, MD 21201
Phone: (301) 225-6748

Elizabeth Westover
MCH Coordinator, C &Y
Department of Health
301 Centennial Mall S.
P.O. Box 95007
Lincoln, NE 68509
Phone: (402) 471-0197

Priscilla White
Project Director
South Carolina Partnership
United Way of South Carolina
2711 Middleburg Drive, Ste 210
Columbia, SC 29204
Phone: (803) 252-9101
Fax: (803) 256-8347
Facilitator

Robert Whitson
Department of Correctional Services
Nebraska State Penitentiary
Box 2500
Lincoln, NE 68502
Phone: (402) 479-3425

Susan Wible
CJTP Manager
Juvenile Corrections
Office of Juvenile Services
P.O. Box 97527
Baton Rouge, LA 70874-7527
Phone: (504) 774-7720

Candy Wimmer
Juvenile Program Planner
303 North Roberts
Helena, MT 59620
Phone: (406) 444-3604

Gina Wood
Manager
Juvenile Justice Programs
Community Children & Youth Services Commission
530 Center Street, N.E., Suite 300
Salem, OR 97310
Phone: (503) 373-1283

Shelly Yanoff
Executive Director
Philadelphia Citizens for
Children of Youth
7 Benjamin Franklin Pkwy
Philadelphia, PA
Phone: (215) 563-5848
Speaker

Rachel Yoskowitz
Director Office of Adolescent Health
Delaware Division of Public Health
P.O. Box 637
Dover, DE 19903
Phone: (302) 739-4787

Mary Yunker
Health Administrator
Division of Youth Services
Tennessee Department of
Youth Development
2601 Brittan Court
Nashville, TN 37206
Phone: (615) 741-1384