

RECOMMENDATIONS FOR JUVENILE JUSTICE REFORM

Second Edition

**American Academy of Child and Adolescent Psychiatry
Committee on Juvenile Justice Reform
October 2005**

Edited by:
Louis J. Kraus, M.D.
William Arroyo, M.D.

**American Academy of
Child & Adolescent
Psychiatry**

**American Academy of Child and Adolescent Psychiatry
Committee on Juvenile Justice Reform**

Louis J. Kraus, M.D., Co-chair
William Arroyo, M.D., Co-chair
Shiraz Butt, M.D.
William Buzogany, M.D.
Guido Frank, M.D.
Carol Kessler, M.D.
Richard Malone, M.D.
Joseph Penn, M.D.
Kenneth M. Rogers, M.D.

AACAP Staff Coordinators

Kristin Kroeger Ptakowski, Deputy Executive Director
Nuala Moore, Deputy Director of Government Affairs

Approved by Council – October 2005

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue, NW
Washington, DC 20016
www.aacap.org

© 2005 by the American Academy of Child and Adolescent Psychiatry

For reprint information, contact the AACAP Department of Government Affairs & Clinical Practice at 202.966.7300.

TABLE OF CONTENTS

	Page
FOREWORD.....	5
EXECUTIVE SUMMARY.....	6
Chapter I	
Juvenile Justice: Yesterday and Today	
Theodore Fallon, Jr., M.D., MPH and Dawn Dawson, M.D.	21
Chapter II	
Forensic Evaluations of Children and Adolescents	
Diane H. Schetky, M.D.....	27
Chapter III	
Prevalence of Mental Illness in the Juvenile	
Justice Population	
Shiraz Butt, M.D.....	33
Chapter IV	
Standards for Juvenile Detention and Confinement	
Facilities	
Louis J. Kraus, M.D. and Joseph Penn, M.D.....	40
Chapter V	
Health Care in the Juvenile Justice System	
Robert Morris, M.D.....	47
Chapter VI	
Females in the Juvenile Justice System	
Gabrielle Shapiro, M.D. and Louis J. Kraus, M.D.....	54
Chapter VII	
Disproportionate Minority Confinement	
William Arroyo, M.D.	60
Chapter VIII	
Seclusion and Restraint Standards in	
Juvenile Corrections	
Louis J. Kraus, M.D.	69
Chapter IX	
Meeting the Educational Needs of Incarcerated Youth	
Graeme Hanson, M.D.....	73

Chapter X	
Competency to Stand Trial	
Dawn Dawson, M.D. and Louis J. Kraus, M.D.	80
Chapter XI	
Transfer of Juvenile Cases to Criminal Court	
Christopher R. Thomas, M.D.	86
Chapter XII	
Juvenile Sex Offenders	
Wade C. Myers, M.D.	91
Chapter XIII	
Juvenile Death Sentences	
AACAP Policy Statement and USSC Roper v. Simons Summary	
Diane H. Schetky, M.D.	98
Chapter XIV	
Alternatives to Adjudication: Drug Courts, Mental Health Courts, and Peer Courts	
Carol Kessler, M.D.	101
Chapter XV	
A Model Program: The Island Youth Programs	
Christopher R. Thomas, M.D.	107
Chapter XVI	
Post-Adjudicatory Assessment	
Louis J. Kraus, M.D.	115
Chapter XVII	
Advocacy in Juvenile Justice	
William Arroyo, M.D.	119
Chapter XVIII	
Juvenile Aftercare	
Kenneth M. Rogers, M.D.	127

FOREWORD

The purpose of this monograph is to provide community leaders, policymakers, community agencies, government agencies, legislators, service providers, professional organizations, and child advocates with an overview of various areas in juvenile justice that require reform.

This work is a product of the Committee on Juvenile Justice Reform of the American Academy of Child and Adolescent Psychiatry (AACAP). The conceptual overview of each area of reform is addressed in a chapter format. Each chapter concludes with a list of specific recommendations. The executive summary briefly discusses each chapter and includes all of the recommendations for reform.

The Committee is composed of members of the AACAP, many of whom have expertise in an area relevant to juvenile justice. The following is a list of Juvenile Justice Reform Committee members: Louis J. Kraus, M.D., co-chair; William Arroyo, M.D., co-chair; Shiraz Butt, M.D.; William Buzogany, M.D.; Guido Frank, M.D.; Carol Kessler, M.D.; Richard Malone, M.D.; Joseph Penn, M.D.; and Kenneth M. Rogers, M.D..

The second edition of this monograph would not be possible without the continued support of the American Academy of Child and Adolescent Psychiatry and the support of staff, including Mary Crosby and Nuala Moore.

We also thank the Illinois Council of Child and Adolescent Psychiatry, who helped fund the publishing cost for the second edition of the monograph on Juvenile Justice Reform.

Editors
Louis J. Kraus, M.D.
William Arroyo, M.D.

EXECUTIVE SUMMARY

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY MONOGRAPH ON JUVENILE JUSTICE REFORM

The Committee on Juvenile Justice Reform of the American Academy of Child and Adolescent Psychiatry (AACAP) was established to draw national attention to numerous areas within the juvenile justice system that would benefit by various degrees and types of reform.

The mission of the Committee on Juvenile Justice Reform is *to improve the juvenile justice system so that it will become responsive to children and adolescents with mental disorders who are in the juvenile or adult justice system. It is imperative that a comprehensive continuum of medical and mental health services are accessible to this population, that the system be strongly community-based, family-centered, culturally competent, developmentally relevant, and well integrated with other child system components including health, education, and child welfare. Similarly, secure detention facilities, whether primarily juvenile or adult-oriented, must provide developmentally appropriate services.*

This executive summary discusses each chapter and identifies the series of recommendations that can serve as a basis of reform in each of these areas of juvenile justice.

Juvenile Justice: Yesterday and Today

This chapter summarizes the development of the juvenile justice system within the United States, starting with the Illinois Juvenile Court Act of 1899, which separated children and adolescents from the adults within the penal system. The primary mandate of juvenile court was to act as “kind parents,” seeking to educate and rehabilitate rather than to punish. This stems into the concept of a *parens patriae* versus police power model. The juvenile court remains a civil rather than criminal system. Juveniles are not charged with crimes and prosecuted; petitions seeking court action are filed. However, there is concern about the level of punishment that should be imposed upon juveniles. As such, many juvenile jurisdictions make it possible for adolescents to be referred to the adult court system. This chapter further summarizes some of the successes and concerns within the juvenile court system.

Forensic Evaluations of Children and Adolescents

Forensic evaluations of children and adolescents are quite different from those of adults, in large part due to the stage of the child's development. Forensic services are not to be confused with mental health treatment services; treatment is not an integral part of this forensic service. Specialized training in child-relevant areas is essential for those who endeavor to pursue this field of work. Relevant professional ethics guidelines have not been clearly established. Relevant statutes vary across states. Certain court procedures are not user-friendly to children, often lack a developmental context, and therefore may undermine the intention of the juvenile court.

Recommendations for Reform

1. Courts should require an opinion by a trained child mental health professional on the impact of face-to-face testimony on a child witness for each case in which a child is identified as a witness.
2. Courts should allow for expert testimony by either the plaintiff or defendant's side to rebut attempts to impeach a child's testimony.
3. Courtrooms should be modified to accommodate the developmental needs of a child and to lessen related fears, which may overwhelm a child who may be testifying.
4. Investigations of child abuse should be conducted in a fashion that accommodates the developmental needs of each individual child.
5. Interrogations of children should be conducted so as to avoid replication.
6. Court-appointed or independent trained child experts should determine the credibility of each potential child witness.
7. The court should solicit independent trained child mental health experts to determine the mental health needs of each child witness and whether or not the mental condition of the child may impact his or her testimony.
8. The determination of the understanding of Miranda rights by a child should be conducted in a developmental context.

Prevalence of Mental Illness in the Juvenile Justice Population

The juvenile justice system faces a significant challenge in identifying and responding to the psychiatric disorders of detained youth. Understanding the psychiatric disorders of juvenile detainees is an important step to meeting their needs. Like adult prisoners, juvenile detainees with serious mental

disorders have a constitutional right under the Eighth and Fourteenth Amendments to needed services.

The Northwestern juvenile project determined that 56.5% of females and 45.9% of males in juvenile corrections had two or more psychiatric disorders. Associated with this, there is also a high comorbidity for substance use disorders. Even when conduct disorder is excluded, recent studies indicate that nearly 60% of the male juvenile population and 70% of the female juvenile population meet diagnostic criteria for at least one psychiatric disorder.

There continues to be a significant need for further longitudinal studies in understanding psychiatric needs of detained youth.

Recommendations for Reform

1. We need to determine the most common pathways to comorbidity, critical periods of vulnerability, and how these differ by sex, race/ethnicity, and age. Longitudinal studies that identify the most common developmental sequences will demonstrate when primary and secondary preventive interventions may be most beneficial.
2. Understanding psychiatric morbidity and associated risk factors among delinquent females would help improve treatment and reduce the cycle of disorder and dysfunction.
3. Longitudinal studies are needed to examine why some delinquent youth develop new psychopathology and others do not, to investigate protective factors, and to determine how vulnerability and risk differ by key variables such as sex and race/ethnicity. Longitudinal data on the subjects described in this Bulletin are being collected. Future papers will address persistence and change in psychiatric disorders (including onset, remission, and recurrence), comorbidity, associated functional impairments, and how these disorders affect risk behaviors that may lead to rearrest.
4. Youth with serious mental disorders have a civil right to receive treatment while detained. Providing mental health services to youth in detention and redirecting them to the mental health system after release may help prevent their returning to the correctional system. However, providing services within the juvenile justice system poses a number of challenges.
5. Screening youth who need mental health services is an important first step. Experts recommend that youth be screened for psychiatric problems within 24 hours of admission to a juvenile facility. Many detention centers do not routinely screen for psychiatric problems (Goldstrom et al., 2001). Only

recently have specialized screening tools been developed to assess the needs of youth entering the juvenile justice system.

6. Detention centers should consistently train personnel to detect mental disorders that are overlooked at intake or that arise during incarceration.

Standards for Juvenile Detention and Confinement Facilities

Standards for juvenile health services and mental health services in juvenile detention confine have wide variations. There are two basic types of facilities: pre-adjudication and post-adjudication. Pre-adjudication facilities can vary from small-town holding areas, which may have only the occasional youth, to massive pre-adjudication facilities as seen in the major cities. Most state correction agencies have issued standards, but they may vary according to the duration of detention and confinement. A single set of national standards has not yet been adopted. Standards that incorporate developmental considerations are ideal as opposed to those that are generally applied to facilities designed for adults. A broad range of medical and mental health services in juvenile facilities is also essential.

Recommendations for Reform

1. Requirements for standardized credentialing are needed. Credentialing requirements should be reviewed by specialty organizations, including the American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics.
2. Although there are federal mandates for education, correctional facilities often fall below the requirements to meet basic educational needs of incarcerated youth. As such, it would be in the youth's best interest to have assessment of the schools as part of the credentialing process.
3. There should be minimal standards for preteens who are taken into custody and detained.
4. There must be separate and specific credentialing for teens placed in adult facilities.
5. National standards for detention and confinement facilities should be adopted by states. Health and mental health components of standards should be subject to review by national medical organizations.
6. National standards for detention and confinement facilities should meet developmental needs of preteens.
7. National standards for detention facilities that primarily house adults should address the developmental needs of adolescents.

Health Care in the Juvenile Justice System

Detained youth often present with a myriad of medical problems that without systematic examination would go undetected. In addition, basic health education is essential in such settings. Incarceration may present an isolated opportunity in the lives of detained youth to receive necessary health care. Healthy individuals are more likely to undergo successful rehabilitation than are youth with medical problems.

Recommendations for Reform

1. Systematically monitor conditions of detention and confinement facilities; provide resources to improve adverse conditions.
2. Establish partnerships between detention facilities and pediatric, internal medicine, and/or family practice academic centers in order to enhance quality improvement activities, to entice medical trainees to pursue juvenile corrections medicine, and to expand the pool of potential health care providers.
3. Fund research relevant to juvenile health and rehabilitation. Health risk behaviors, impulsive actions, and antisocial tendencies are not yet well understood by those who attempt to rehabilitate delinquents. The etiology of delinquent behavior needs further study. Child abuse, prenatal drug exposure, head trauma, unsafe environments, and learning disabilities are just a few poorly investigated areas which may affect children and teens. In addition, systematic scrutiny of various rehabilitation efforts must be accomplished in order to determine their efficacy.
4. Provide detainees with full access to all assessment and treatment modalities that are medically indicated.
5. Fund research in the area of health screening. Evaluation of screening tests for common medical problems found in detainees helps to determine the best methods of identifying youth with medical problems that require treatment. There is a great need for simple, cost-effective medical screening tests, which will greatly benefit incarcerated youth.
6. Establish clear, structured health education programs that have a primary focus on sexually transmitted diseases, HIV, and birth control.

Females in the Juvenile Justice System

The rate of females entering the system is increasing more rapidly than that of their male counterparts. In 1997, 748,000 girls were arrested, representing 26% of all juvenile arrests. In 2002 female juveniles represented 27% of all arrests. Juvenile justice systems, especially the detention and confinement components, were primarily designed to serve a male population.

Specialized programming that includes relevant services related to female

developmental needs, pregnancy, family planning, and sexually transmitted diseases (including HIV/AIDS) is essential. Such programming specific to this population has only recently been implemented in a few jurisdictions. The high prevalence rate of mental illness among incarcerated female youth is another area that requires focused planning.

Recommendations for Reform

1. Fund further longitudinal research in areas of gender-specific needs and services.
2. Establish gender-specific community programs for girls who have already been adjudicated.
3. Provide health education concerning sexually transmitted diseases, including HIV and birth control, for female delinquents.
4. Establish more community-based intervention programs for girls who have been victimized.
5. Establish gender-specific mental health programs for incarcerated females.

Disproportionate Minority Confinement

Disproportionate minority confinement (DMC) is the phenomenon of incarcerating youth of minority backgrounds at a higher proportion than their census representation in the local community. This practice is commonly found in many jurisdictions throughout the country. According to recent data, minority youth constituted about 32% of the youth population in the country yet represented 68% of the juvenile population in secure detention. This has primarily impacted the African American and Latino (Hispanic) communities. Another disparity in the juvenile justice system is that African Americans account for 46% of all youth transferred to adult criminal court.

The failure to reauthorize the Juvenile Justice and Delinquency Prevention Act (JJDPAct), which mandates states to address the problem of DMC, encourages jurisdictions to maintain this tragic and harmful practice.

Recommendations for State/County Reform

1. Examine decision-making policies and practices of police, prosecutors, courts, and probation to identify where racial disparities occur in the system.
2. Develop guidelines, such as detention criteria, which either reduce or eliminate racial disparities.
3. Develop, support, and expand delinquency prevention programs that target minority communities.
4. Increase the availability and improve the quality of diversion programs.

5. Develop community-based alternatives to secure detention and incarceration.
6. Provide training for juvenile justice system personnel in areas of child development and mental illness.
7. Incorporate cultural in policy and program development.
8. Review and change laws that encourage the disparate racial impact providing for prosecution of juveniles in the adult criminal system.
9. Declare a moratorium on building new juvenile detention and corrections facilities and adding new secure beds until the differential impact of the justice system on minority youth has been comprehensively addressed.
10. Clear offense records of youth for nonviolent and/or status offenses; these offenses undermine efforts to procure employment in young adulthood.

Recommendations for Federal Reform

1. Provide intensive technical assistance to states/local jurisdictions for compliance with the DMC requirement, especially in regard to the new requirement of “contact with the juvenile justice system” as opposed to merely “confinement.”
2. Support states’ efforts to systematically collect comprehensive data, to conduct analysis of data, and to develop research and data-based state DMC intervention plans.

Recommendations for National Organizations

1. Monitor the activities of the federal and state governments to address this issue, and report to their members and the general public.
2. Meet with legislators to provide input on how to reform the juvenile justice system.

Seclusion and Restraint Standards in Juvenile Corrections

Standards for the use of seclusion and restraints in detention and confinement facilities vary among jurisdictions. The purpose for their use by detention staff versus treatment (health and mental health) staff may also vary. Safety and therapeutic use of these methods are often confused. Effective use of these methods has been identified and should be promulgated among detention facility staff.

Recommendations for Reform

1. National policies concerning the use of seclusion and restraint on our youth in correctional facilities should be established. Indications for the various types of restraints – four-point leather supine restraints, chair restraints, shackles, soft restraints, handcuffs, blankets, etc. – should also be established. Safety must be a priority in these standards. Policy should be consistent with hospital standards.
2. Chair restraint should be used only with clear policy and training for staff, secondary to the possibility of positional asphyxiation.
3. National policy regarding duration of restraints should be established.
4. The role of psychiatrists, other physicians, and mental health professionals should be clearly delineated in such policies.
5. Close monitoring of confinement facilities regarding compliance with national policies on restraints should be conducted periodically.
6. Facilities must have clear written policies that comply with state statutes.

Meeting the Educational Needs of Incarcerated Youth

All children, whether incarcerated in juvenile or adult facilities, have the same right to an education. Unfortunately, the educational needs of incarcerated youth are assigned a lower priority than those of children in community-based school systems; resources and planning efforts may therefore be suboptimal. Only a few educational programs found in detention facilities are accredited by appropriate state or national entities that accredit schools in the general community.

Many incarcerated youth have a history of poor school attendance and poor academic performance. More than 11% of incarcerated youth have learning disabilities; this rate is much higher in urban communities. Such youth, whether in juvenile or adult facilities, are entitled to special education services (via the Individuals with Disabilities Act) provided by teachers with appropriate credentials and expertise.

The period of detention for incarcerated youth generally varies widely from a few days to months. Educational planning must account for this wide variation.

Recommendations for Reform

1. Meet the minimum standards set by federal and state laws for public school programs.
2. Develop stronger ties to public school programs within the community to ensure a smooth transition for youth returning to their community.

3. Provide a comprehensive educational and developmental screening, assessing the possibility of learning disabilities, emotional/behavioral disorders, or cognitive limitations that have an adverse effect upon learning for every youth entering the juvenile justice system.
4. Systematically identify all incarcerated youth who have special educational needs. Provide appropriate special education services regardless of whether the youth is confined in a juvenile or adult facility.
5. Provide flexible curricula that include academic, vocational, and social and daily living skills.
6. Maintain year-round education programs to allow for the variability of times when youth enter the facility and leave the facility.
7. Recruit and retain certified special education teachers in each juvenile facility.
8. Encourage the requirement for accreditation of educational programs by educational associations.
9. Maintain an educational program with budgetary and administrative autonomy so that relevant decisions are made primarily with a focus on the educational needs of confined children.
10. Provide incentives to school programs that meet improved standards.

Competency to Stand Trial

The concept of competency to stand trial as it pertains to adults is much clearer than that related to children, which tends to be very complex due in part to a child's development. Furthermore, the assessment for competency of children varies among jurisdictions and continues to evolve nationally. Various components of the competency assessment of children are essential to determine whether or not a child should be recommended to stand trial. The developmental context of each individual child is of paramount importance.

Recommendations for Reform

1. Establish national competency standards for juveniles that include a developmental framework.
2. Require training for judges, defense attorneys, prosecuting attorneys, and other court officials in the area of child development and then assist them

in understanding how the specific areas of development are related to competency.

3. If it is determined that a youth is incompetent, make better services available to help restore the youth to competency. Currently few programs are available that can help with this process in any consistent way.

Transfer of Juvenile Cases to Criminal Court

An increasing rate of transfer of juvenile cases to the criminal court designed for the adult population started in the early 1980s, in large part as a result of rising violence and crimes among youth. The overall increase of such transfers was from 6,800 in 1987 to 10,000 in 1996, which is nearly a 50% increase. Recent studies indicate that youth tried in adult criminal court have significantly higher rates of recidivism and are more likely to be physically or sexually assaulted than youth tried in the juvenile justice system.

Furthermore, there is no evidence that rates of delinquency have changed since the enactment of such laws, despite the premise that stiffer sentences would discourage law breaking.

Recommendations for Reform

1. Transfer to adult court should not be automatic or a presumption in the handling of juvenile cases. While further study is necessary, current research indicates that automatic transfer does not achieve the desired goals and may be potentially harmful to the community and the involved youth.
2. Any transfer to criminal court should consider the individual case and the community, and not be based solely on the type of offense. Consideration of the case should include the mental health of the youth and its bearing on the charges. This may require consultation from mental health professionals.
3. To develop a more effective juvenile justice system, further study must be devoted to exploring alternatives to transfer to criminal court.

Juvenile Sex Offenders

Juvenile sexual offenders are a very heterogeneous group with widely varying histories, offending behaviors, and treatment outcomes. A history of family dysfunction, personal victimization, mental disorders, deficits in social skills, and poor impulse control is common in this group. Victims are most often relatives or acquaintances of the offending youth. One study suggests that these youth are involved in much higher rates of general violent offenses than sexual offenses. A very broad range of treatment services and settings has

been used. Placement should be viewed in a developmental context; some judges are inappropriately applying the adult standard to juveniles routinely. Treatment results have been quite variable. Recidivism rates for sexual offending have not been clearly identified and are probably different from rates of general offending.

Recommendations for Reform

1. Funding for juvenile sex offender research should be increased in three key areas in order to (a) better define subtypes of juvenile sexual offenders, (b) identify those youth who are most likely to be amenable to treatment and those at greatest risk for reoffending, and (c) support further development and assessment of treatment programs and their effectiveness.
2. Placements for sexually offending youth should be tailored to meet their developmental needs and should include family participation.
3. Placement of minors in treatment programs where they could have contact with sexually offending adults should be avoided.
4. Legislative changes affecting juvenile sex offenders should be monitored to help ensure that modifications are based on reason and scientific evidence rather than on emotion and the desire for retribution.

Juvenile Death Sentences

The American Academy of Child and Adolescent Psychiatry adopted a position statement in 2001 that calls for an end to capital punishment for any individual who commits an offense at the time the individual is younger than 18 years old. This decision is rooted in prevailing developmental theory and current developmental research.

On March 1, 2005, the U.S. Supreme Court decided the case of *Roper v. Simmons* (543US, 2005). Simmons, at age 17, committed a capital murder and in 2000 was sentenced to death. The Missouri Supreme Court set aside his death sentence, instead giving Simmons a sentence of life imprisonment without probation or parole. The U.S. Supreme Court sided with the Missouri Supreme Court, noting the national consensus against the death penalty for minors and the developmental and maturity in juveniles which renders them as a class less culpable than the average adult criminal. The court opined that the Eighth and Fourteenth Amendments forbid the imposition of the death penalty on offenders who were under the age of 18 when their crimes were committed.

Alternatives to Adjudication: Drug Courts, Mental Health Courts, and Peer Courts

Innovative collaboration among juvenile justice, mental health agencies, alcohol and drug agencies, and advocates is being launched to better serve youth with mental illness and/or substance abuse problems in their respective communities. These youth would otherwise be incarcerated for nonviolent offenses. These efforts include “wraparound” services and system of care. Some of the more recently developed innovative components include (a) restorative justice efforts in which offenders compensate victims and/or their local community and (b) peer courts in which a nonviolent offending peer is “judged and sentenced” by the offender’s peers.

Recommendations for Reform

1. Federal law (Public Law 106-515) should be expanded to provide grants to develop youth mental health courts adapted from established mental health courts for adults, yet addressing the developmental, educational, and family needs of youth.
2. Availability of funds through federal law (Public Law 103-322) should be publicized so that the successful juvenile and family drug court model can be replicated.
3. A central database, resource center, and informational clearinghouse of juvenile and family drug courts should be established to facilitate exchange of resources and to provide training and support to newly developing programs.
4. Federal funding should be granted to establish a broader network of community-based treatment programs that have proven effective – i.e., Multisystemic Therapy and Wraparound.
5. Timely, culturally competent, gender-sensitive screening for mental illness, including substance abuse, should be provided upon arrest or upon confinement.
6. Mental health treatment should be supervised and continually monitored by the judge of a problem-solving court, to ensure service provision and client participation.

A Model Program: The Island Youth Programs

Island Youth Programs is a unique and innovative project to reduce youth violence in Galveston, Texas. During a period of five years it was able to

produce a decrease of all youth arrests by 65% and a decrease of violent offenses among youth by 78%, among other successes. This effort demonstrates the efficacy of strategic community planning in dealing with the problem of youth violence. The willingness and resource sharing among community leaders were key to this project's success.

Other promising programs have been identified in the battle against violence among youth, drug abuse among youth, and other serious types of offenses.

Recommendations for Reform

1. A public health approach should be used in developing community efforts dealing with youth crime and violence.
2. Community planning should occur at the local level and involve all agencies dealing with youth crime, including mental health.
3. Community programs must address the developmental and mental health needs of the youth they serve.

Post-Adjudicatory Assessment

The most complex and common assessments within juvenile court are post-adjudicatory evaluations. These evaluations must take into account a developmental framework, dependent on the age, cognition, and associated mental health of the youth being evaluated. In association with this, key issues such as recidivism, seriousness of offense, responsiveness to treatment, the family system the child is from, and the age of the child all need to be taken into consideration. These evaluations must always balance police power with a *parens patriae* model. At the present time, nationally, all youth do not have consistent evaluations. Most youth going through juvenile court in the United States do not have mental health evaluations. Before we are able to help these youth, we need to understand better what their needs are. This can be assisted with comprehensive assessments of all youth going through the juvenile court system.

Recommendations for Reform

1. The needs of delinquent children must be better understood. There is a need for continued longitudinal research.
2. Uniform mental health evaluations are needed, including educational assessments of all youth who are adjudicated within juvenile court. These assessments will assist the court in understanding the needs of the youth and to make appropriate recommendations, which will likely result in decreased recidivism.

3. Services within correctional facilities must be consistent with community norms.
4. Parameters for post-adjudicatory evaluations should be consistent.
5. Obtaining educational, social work, psychological, and child and adolescent psychiatric services for delinquent youth within the community should be consistent with community norms for delinquent youth.

Advocacy in Juvenile Justice

Advocacy refers to the group of actions that support, plead, or argue for a cause or a proposal. Children and youth in the juvenile justice system generally have very limited understanding of the consequences of their behavior, the impact of their behavior on all those and on their future, statutes pertinent to their offense, court proceedings, judicial decisions, their rights as individuals, and the complex setting of correctional institutions. This chapter will primarily address advocacy as it pertains to the general juvenile justice population as opposed to the advocacy that one may pursue on behalf of one's individual patient.

Juvenile Aftercare

For many years, the first time that mental health problems were identified in delinquent youth was in the juvenile justice system. One of the great challenges in moving youth from secure detention settings is determining how to transition them from the highly structured detention setting into a community setting with much less structure and the temptations that initially got them into trouble. Moving youth with mental illness from a juvenile justice placement to the community, where mental health may be the primary agency, can be complex. Unfortunately, aftercare is in reality often focused only on placing the youth back in the community, rather than on developing a plan for integration into the community with a focus on providing appropriate services. There is a need to develop multidisciplinary treatment planning and additional services within the community to assist with this process before, during, and after the release of the youth from a correctional facility.

This chapter reviews the challenges of reintegrating the youth into the community, as well as a model of integration.

Recommendations for Reform

1. Mental health clinicians should be better integrated into juvenile justice settings. Even if clinicians are contract providers, additional resources

should be made available for integrating them into the detention setting, including attending court and probation settings where the decisions about aftercare service are made.

2. Youth should be provided with a continuum of services, including mental health services, upon discharge from a detention facility so that they can receive more or less intense services dependent upon the severity of problems or level of need.
3. Mental health and substance abuse treatment, education, job training, and social services should be better integrated before, during, and after release from detention facilities. All appointments for treatment and follow-up should be coordinated; dates and times should be provided to youth and families prior to discharge from the detention facility.

Chapter I

Juvenile Justice: Yesterday and Today

By Theodore Fallon, Jr., M.D., MPH and Dawn Dawson, M.D.

A significant proportion of the children we formerly would have treated in clinics and hospitals are no longer there. They had gone to juvenile detention centers, correctional facilities, and prisons. We must follow them there....

Tom Grisso

Juvenile Justice in the United States formally began with the Illinois Juvenile Court Act of 1899, which separated children and adolescents from the adults within the penal system. The primary mandate of juvenile court was to act as “kind parents,” seeking to educate and rehabilitate rather than to punish. In accepting the task of caring for young offenders, the juvenile justice system has been given the most difficult youth to care for, many of whom have “graduated” from other child-caring systems. Originally, the juvenile justice system was designed to be a swift, confidential mechanism for obtaining the assistance that a youth needed to get back on developmental track. But from the beginning, the agencies and personnel working within the juvenile justice system have been influenced by strong opposing forces: the need of society to protect itself from those who cannot live within the law, and the need to help the children who grow up under less than optimal conditions created by society.

Even after a century of modifications, and broad variations from state to state, most juvenile justice laws and governmental structures specify that the juvenile justice system continue to act in the best interest of the youth. This is true even at the first point of contact, where police officers use the option that least restricts the juvenile’s freedom while at the same time protecting community safety. In most settings, the police officer on the beat has discretion to counsel and release a youth, take him to his parents or school, informally refer him to a community program, issue him a citation, or take him into custody and deliver him to a probation officer. If the police officer cites or arrests the juvenile, then – unlike an adult arrest – the matter is not usually referred to a district attorney for prosecution immediately (although juveniles cannot usually be detained in custody without a hearing). The juvenile court remains a civil rather than criminal system. Juveniles are not

charged with crimes and prosecuted; petitions seeking court action are filed. Juveniles are not found guilty; the petition is sustained or dismissed. Their case disposition is presumed to reflect the court's view of the best treatment to meet the child's needs.

At the same time, however, there is a sense that juveniles should be punished for their infractions, that punishment is the fitting response to transgressions, particularly by adolescents. Many juvenile courts themselves operate much like adult criminal courts. Services are scarce, and many inside and outside the juvenile justice system are unclear as to what treatments are available and what treatments are effective in preventing and stemming delinquent behavior. Juvenile court judges typically have much wider discretion than adult criminal court judges in disposition, which can often leave the adolescent languishing within the system without the legal protections even afforded to adults accused of major crimes. Many jurisdictions make it possible for adolescents to be referred to the adult court system, sometimes without much oversight from someone considering the best interest of the adolescent. A large percentage of adolescents who remain detained in the juvenile system will nonetheless be exposed to adult prisoners.

These conflicting attitudes, however, are not new. They are the same attitudes that led to the formation of the juvenile court system over a century ago. This contrast, as it is at the beginning of the 21st century, however, does lead to the question, How far have we come in a century with regard to our attitudes and handling of delinquent youth, and where are we going?

Current Successes

Those who see successes within the juvenile justice system can point to a number of significant gains. The crime rate has been dropping, particularly within the past decade. For people under 18 years old, the crime rate index, an overall number that considers all crimes, has dropped from 1,280 per 100,000 in 1993 to 802 per 100,000 in 2001. Violent crime and murder have dropped from 220 and 6.2 to 143 and 2.0 in those same years. These statistics are true even as the population of people under 18 years of age in this country has increased in the past decade from 63.6 million in the 1990 census to 72.3 million in the 2000 census.

In this past century, we have learned much about poverty, education, and child development and its deviations. We have devised some programs that go a long way to preventing delinquency, and other programs that help

adolescents get back on developmental track. In that time, we have also slowly made headway in exposing prejudice and hate crimes.

Current Concerns

At the same time, there are still many concerns. In 2002, the latest year for which statistics are available, 2.3 million youth under the age of 18 were arrested. Over one million of them had formal contact with the juvenile justice system and 500,000 were admitted to local juvenile detention facilities. Over 65,000 were admitted to long-term juvenile correctional facilities.

Approximately 7,500 youth are prosecuted as adults. Most of the decisions to prosecute youth in the adult criminal court are made by prosecutors or legislatures (85%), and not by judges (15%). Almost 67% of youth who are detained pretrial are held in adult jails. Youth held in adult jails are at serious risk of assault and suicide.

Although all youth in the juvenile justice system are faltering in their emotions and behavioral development and the vast majority of them have diagnosable mental disorders, many are not screened for mental health problems, either pre- or post-adjudication.

African American youth are twice as likely to be arrested and seven times as likely to be placed in detention facilities compared with white youth. An overwhelming majority of youth charged in adult criminal courts are minority youth. (See Chapter VII.)

Females in the juvenile justice system have often been overlooked. Female adolescent offenders have higher rates of depression, suicide attempts, drug use, and mental health problems compared with their male counterparts. These same girls report significantly more physical and sexual abuse than boys, and many are pregnant or teen parents. In the past decade, female adolescents have accounted for an increasing percentage of juvenile crime. The juvenile justice system has struggled to find effective ways to address adolescent juvenile delinquents.

Perhaps most concerning is the turning away from the public mental health of children and adolescents. Particularly in the past decade, we are spending less on education of our children, an increasing number of children and adolescents are falling below the poverty line, fewer resources are available to

prevention programs, and much of the money that is available cannot be spent on programs proven effective.

These statistics highlight the inadequacies in our juvenile justice systems and create motivation for change. Although the motivation for change is present, the direction in which to go has not always been as clear. There is a large body of knowledge in the field of mental health that speaks to the rehabilitative and educational goals for the youth in the juvenile justice system. In this context, concepts and knowledge from the field of mental health offer understanding and a framework for providing these youth with developmental assistance aimed at reaching those goals.

McHardy (1990) sums it up:

The American juvenile justice system continues to be an arena in which a myriad of varying values and practices come under constant challenge and close scrutiny, not only from those outside the system but particularly by those within the system, those on the front line - the judges, court administrators, prosecutors, defenders, police, social workers and probation officers who are responsible for the operation of the system. Every juvenile court and the personnel who work with it are faced with the difficult process of evaluating and adapting to multiple standards and the challenges of implementing effective changes within the parameters of varying systems and statutes.

Within each of these agencies in juvenile justice, there are varying perspectives on how to understand children, youth, and their families. Most juvenile justice personnel have minimal to no formal training in child development, let alone its deviations. Staff usually depends on their own personal experience to guide them rather than any formal conceptual framework.

Finally, to make matters more difficult, even when people attempt to discuss these differences, even using the same words frequently conveys completely different concepts to different personnel within the system. Sometimes words that are common in one set of agencies are not even in the lexicon of another agency. At least part of this may be due to different backgrounds and training. For example, judges were frequently lawyers within a political system, detention center personnel frequently have a limited formal educational background beyond high school, and administrators in the

detention center may be staff who have worked their way up through the ranks or political appointees with little hands-on experience.

For many in the mental health field, the convoluted complexities of the juvenile justice system elude them. For many within the juvenile justice system, the complexities are a fact of life that often cast discouragement and tacit resignation within a Byzantine structure.

Taken from the positive side, the complexity of the juvenile justice system can be seen as a manifestation of the amount of effort and resources available to assist seriously emotionally disturbed youth, their families, and their communities. The addition of mental health treatment and services offers the possibility that more resources can be brought to bear and create a broader, more effective continuum of care for what has historically been a most difficult population to assist. The challenge for society continues to be finding a way to allow every child to reach full potential as an adult.

References

American Bar Association, Juvenile Justice Committee (2005) Available at: . Accessed March 2005

Centers for Disease Control website, U.S. Dept. of Health and Human Services (2005). Available at: . Accessed March 2005

The Center on Juvenile & Criminal Justice (2005) Available at: . Accessed March 2005

National Youth Violence Prevention Resource Center (2005). Available at: . Accessed March 2005

Office of Juvenile Justice and Delinquency Prevention website, U.S. Dept. of Justice (2005), Available at: . Accessed March 2005

The Coalition for Juvenile Justice (2005) Available at: . Accessed March 2005

Authors

Theodore Fallon, Jr., M.D. MPH
2162 Miller Road

Chester Springs, PA 19425

Dawn R. Dawson, M.D.
1304 Chinook Lane
Pueblo, CO 81001

Chapter II

Forensic Evaluations of Children and Adolescents

By Diane H. Schetky, M.D.

The term *forensic* derives from the Latin *forum* meaning “of the forum.” Forensic evaluations are those done expressly for the purpose of aiding the court in rendering legal decisions rather than helping the patient, as is the case in most psychiatric evaluations. Thus, forensic evaluations differ in two important ways: there is no therapeutic relationship and confidentiality is limited. Another major difference is that the forensic examination involves extensive review of “discovery material,” which might include prior psychiatric, school, and police records. There is much more reliance on collateral material and other sources of information as the subject of the examination may be lacking in objectivity or may give a self-serving history, particularly when issues of financial gain or possible incarceration are involved.

Ethical Issues

Ethical issues in child and adolescent forensic psychiatry are not well delineated in the ethical guidelines of the American Psychiatric Association (APA) or the American Academy of Child and Adolescent Psychiatry (AACAP), and they are treated lightly in the American Academy of Psychiatry and the Law (AAPL) Ethical Guidelines (the last are in the process of revision). Members of AAPL are required to belong to the APA or AACAP and hence must adhere to the ethical guidelines of that organization; AAPL Ethical Guidelines are considered supplemental to these. There is general consensus regarding the need for objectivity, honesty, and respect for persons when practicing forensic psychiatry (Appelbaum, 1990). Striving for objectivity necessitates the awareness of biases that could possibly taint the expert’s opinion. In addition, the forensic psychiatrist is expected to maintain confidentiality to the extent possible in the legal context of the evaluation.

More controversial is the question as to whether or not forensic psychiatry constitutes the practice of medicine. As noted by Appelbaum (1990), medicine is governed by the ethical principles of *primum non nocere*, first do no harm, and beneficence which, if given primacy in forensic psychiatry, would interfere with objectivity and lead to skewing of data in order to help

the examinee. A second related issue arose in 1998 when the American Medical Association (AMA) passed a resolution stating, “expert witness testimony is the practice of medicine.” This has given rise to a requirement in some states that forensic psychiatrists be licensed in these states if they perform a forensic evaluation or testify in them. Currently, states remain divided on this issue (Reid, 2001). Clearly, small states would be at considerable disadvantage if they were not able to bring in experts with expertise in areas not possessed by in-state forensic clinicians or when physicians are loath to testifying against colleagues on issues surrounding the standard of care.

Testimony by Children or Adolescents

Several U.S. Supreme Court cases have addressed issues concerning child witnesses. *Maryland v. Craig* 497 U.S. 836 (1990) determined that the Sixth Amendment does not guarantee a criminal the absolute right to face-to-face confrontation with a witness who testifies against him or her and that there may be exceptions to be determined on a case-to-case basis. *Idaho v. Wright*, 430 U.S. 651 (1977) addressed the permissibility of introducing a child’s out-of-court statements in certain situations. The court may find it helpful to have the input of a qualified mental health professional concerning the impact of face-to-face testimony on a child witness and to assist the court in making determinations regarding whether or not a child should testify in court.

Miranda Rights

Experts with special training in child development and child mental health may also assist in determining whether a child or youth has understood Miranda rights. Attorneys often assume that children and adolescents are competent to testify, and the forensic examiner may need to bring up this issue particularly with youth who are seriously intellectually or psychiatrically compromised in their level of functioning. (See Chapter III.)

General Comments on Forensic Examinations

Many clinicians view forensic psychiatry as the last retreat from managed care and may be tempted to test the waters. The waters are not for novices and may contain unforeseen currents, hidden obstacles, fog, and foul weather that require skilled navigation. Much is at stake in these evaluations and legal decisions tend to be final, so there is no opportunity to redress mistakes. The forensic clinician who works with children and adolescents must have expertise in conducting these examinations and in the subject area being litigated, e.g., custody, personal injury, sexual abuse, or criminal

matters such as waiver, competency, or the insanity defense, and must understand what is expected of an expert witness in the courtroom and how to handle direct and cross examination. Specialized training in the area of child mental health is also essential. Psychiatrists are eligible for board certification in forensic psychiatry after a year of formal forensic training (or fellowship).

Inasmuch as the forensic examiners need to strive for objectivity, it is important that they have no prior relationship, either professional or social, with the party being evaluated and have access to a broad database of discovery material. Exceptions may sometimes exist in underserved areas where there may be a paucity of forensic examiners with child training. Clinical therapists are generally not qualified to testify as expert witnesses on behalf of their patients because of their role as an advocate for their patients. Therapists often lack the level of objectivity required for such testimony and often have not been exposed to “the other side of the story,” an essential facet of court proceedings. There is also a risk that the therapist’s testimony may inadvertently cause harm to the patient or to their therapy together. Parents who are dissatisfied with the therapist’s testimony may abruptly discontinue the child’s therapy, a particular hazard in child custody cases.

Similar conflicts may exist in the area of corrections. Child and adolescent psychiatrists working in correctional facilities need to be clear as to whether their role is therapeutic or forensic, and detainees or committed youth need to be informed about the psychiatrist’s role and the limits of confidentiality. Forensic psychiatrists also need to be vigilant about their boundaries with regard to their institutional affiliations and avoid taking cases in which they have social, professional, or institutional ties that might taint their objectivity (Gutheil, Schetky and Simon, 205).

Examinees should always be informed at the onset regarding for whom the examiner is working, the purpose of the evaluation, and with whom the results will be shared. Minors, unless emancipated, cannot give consent but should be given the opportunity to give informed assent.

The forensic examiner should keep current with screening and assessment tools that may complement the psychiatric forensic examination and should know when to refer an examinee for psychological testing to round out the evaluation (see Grisso et al, 2005).

When possible, fees should be obtained prior to initiating the forensic examination. This helps to ensure that one is being paid for one's time rather than one's opinion. Forensic fees are typically higher than therapy fees as more training is involved and these evaluations tend to be extensive and often stressful. Contingency fees are never acceptable as they create a vested interest in the outcome. Forensic fees tend to vary regionally and by experience. As to how much one should charge, a wise adage is to choose a fee that you would not be embarrassed to state in court (Gutheil, 1998).

Increasingly, there is the expectation that expert testimony be evidence based. Thus, opinions expressed in a forensic evaluation need to be based upon a reliable foundation as opposed to speculative or novel theories. This can be problematic for psychiatrists because much of what we rely upon is based on theory rather than science. Under *Daubert (Daubert v. Merrill Dow Pharmaceuticals, Inc.* 1993), the threshold of admissible testimony requires that it be both reliable and relevant to the case at hand. In addition, the judge now assumes the role of gatekeeper with regard to what expert testimony may be admitted. *Daubert* rules are binding in federal courts and have been adapted by many states as well. A subsequent case, *Kumho Tire Col., Ltd, v. Carmichael* (1999), addressed the issue of how courts would handle the admissibility of nonscientific testimony. The U.S. Supreme Court ruled that the court could use the same reliability factors that were outlined in *Daubert*.

Recommendations for Reform

1. Courts should require an opinion by a trained child mental health professional on the impact of face-to-face testimony on a child witness for each case in which a child is identified as a witness.
2. Courts should allow for expert testimony by either the plaintiff or defendant's side to rebut attempts to impeach a child's testimony.
3. Courtrooms should be modified to accommodate the developmental needs of a child and to lessen related fears, which may overwhelm a child who may be testifying.
4. Investigations of child abuse should be conducted in a fashion that accommodates the developmental needs of each individual child.
5. Interrogations of children should be conducted so as to avoid replication.
6. Court-appointed or independent trained child experts should determine the credibility of each potential child witness.
7. The court should solicit independent trained child mental health experts to determine the mental health needs of each child witness and whether or not the mental condition of the child may impact his or her testimony.

8. The determination of the understanding of Miranda rights by a child should be conducted in a developmental context.

References

American Academy of Child and Adolescent Psychiatry (1997), Practice parameters for the forensic evaluation of children and adolescent who may have been physically or sexually abused. *J Am Acad Child Adolesc Psychiatry* 36:423-442

American Academy of Child and Adolescent Psychiatry (2004), Practice parameters for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities. *J Am Acad Child Adolesc Psychiatry*(in press)

American Academy of Psychiatry and Law: Ethical Guidelines for Forensic Psychiatry, Revised 2005

American Psychiatric Association: Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, 1993

Appelbaum P (1997), A theory of ethics for forensic psychiatry. *J Am Acad Psychiatry Law* 25 (3)233-246

Appelbaum P (1990), The parable of the forensic psychiatrist: Ethics and the problem of doing no harm. *Int J Law Psychiatry* 13:249-259

Daubert v Merrill Dow Pharmaceuticals, Inc. 113 S Ct 2786 2786, 1993

Grisso, T, Vincent G and Seagrave, D: *Mental Health Screening and Assessment in Juvenile Justice*, NY: Guilford Press, 2005

Gutheil, T: The Psychiatrist in Court. Washington DC: American Psychiatric Press, Inc. 1998

Schetky DH (2002), Forensic Ethics. In *Principles and Practice of Child and Adolescent Forensic Psychiatry*, Schetky, DH and Benedek EP, Washington, DC: American Psychiatric Press

Schetky, DH: *Introduction to Forensic Evaluations*, Ibid.

Schetky, DH: Juveniles standing trial: Waiver to adult court. *Journal of Psychiatric Practice* 9(6):1-4, 2003

Author

Diane H. Schetky, M.D.
P.O. Box 220
Rockport, ME 04856-0220

Chapter III

Prevalence of Mental Illness in the Juvenile Justice Population

By Shiraz Butt, M.D.

Introduction

There has been a consistent increase in the juvenile detainee populations over the last few years. This growth parallels an increase in violence in the country's youth. Homicide remains the second leading cause of death in youth aged 15-24 years and is the only major cause of childhood mortality to increase in the last 30 years.

The juvenile justice system faces a significant challenge in identifying and responding to the psychiatric disorders of detained youth. In 2001, over 104,000 juvenile offenders were in custody in juvenile residential placement facilities. Despite the difficulty of handling such youth, providing them with psychiatric services may be critical to breaking the cycle of recidivism.

The U.S. Department of Justice estimates that each year there are 2.5 million juvenile arrests. It is well known that a significant proportion of youth in the juvenile justice system have psychiatric illness. However, despite the importance of psychiatric epidemiological data in juvenile detainees, there are very few empirical studies and little consistency in results.

Understanding the psychiatric disorders of juvenile detainees is an important step toward meeting their needs. Like adult prisoners, juvenile detainees with serious mental disorders have a constitutional right under the Eighth and Fourteenth Amendments to needed services. Without sound data on the prevalence of psychiatric disorders, however, defining the best means to use and enhance the juvenile justice system's scarce mental health resources is difficult.

Current Status

Although epidemiological data are key to understanding the psychiatric disorders of juvenile detainees, few empirical studies exist. These studies do not provide data that are comprehensive enough to guide juvenile justice policy. For example, only two studies examined psychiatric comorbidity among juvenile detainees. Furthermore, the results of the studies are inconsistent. For example, the prevalence of affective disorder in the studies

varied from 5% to 72%; substance use disorders from 20% to 88%, and psychosis from 16% to 45%. The inconsistency in results may be due to differences in methodology and/or sample size.

For example, some studies used random samples. Others, however, relied on nonrandom samples, for example, consecutive admissions over a specified time period. Only a few studies reported racial/ethnic differences, and some studies did not report the racial or ethnic composition of the sample. Females were excluded entirely from some investigations. Many of the studies sampled too few subjects to generate reliable rates, even for the more common disorders. Most studies did not have enough participants in key demographic subgroups to compare participants by sex, race/ethnicity, or age. Some studies used nonstandard or untested instruments, did not assess whether the disorder impaired the ability of juveniles to function, or reported data on only one category of diagnoses (e.g., substance use disorders, anxiety disorders, personality disorders).

The Northwestern Juvenile Project

The Northwestern Juvenile Project was designed to overcome these methodological limitations in two ways. First, it uses a random sample of juvenile detainees, 10-18 years old. Second, it uses a widely accepted and reliable measurement tool, the Diagnostic Interview Schedule for Children (DISC) Version 2.3, to measure alcohol, drug, and mental disorder diagnoses.

Subjects were a randomly selected sample of 1,829 male and female youth who were arrested and subsequently detained at the Cook County Juvenile Temporary Detention Center (Cook County Detention Center) between November 20, 1995, and June 14, 1998. The sample was stratified by sex, race/ethnicity (African American, non-Hispanic white, Hispanic), age (10-13 years old or 14 and older), and legal status (processed as a juvenile or as an adult). The final sample comprised 1,172 males (64.1%) and 657 females (35.9%), 1,005 African Americans (54.9%), 524 Hispanics (28.7%), 296 non-Hispanic whites (16.2%), and 4 from other racial/ethnic groups (0.2%). The mean age of participants was 14.9 years.

Like juvenile detainees nationwide, approximately 90% of the Cook County Detention Center detainees are male and most are racial/ethnic minorities: African American (77.9%), non-Hispanic white (5.6%), Hispanic (16.0%), and other racial or ethnic groups (0.5%). The age and offense distributions of center detainees are also similar to those of detained juveniles nationwide.

Although no single site can represent the entire country, the Illinois criteria for detaining juveniles are similar to those used by other states. Pretrial detention is allowed if a juvenile needs protection, is likely to flee, or is considered a danger to the community.

Findings

The Northwestern Juvenile Project showed that nearly two-thirds of males and nearly three-quarters of females met the diagnostic criteria for one or more of the disorders listed. Overall rates excluding conduct disorder were also calculated because many of its symptoms are related to delinquent behaviors. Excluding conduct disorder (with and without diagnosis-specific impairment criteria), overall rates decreased only slightly.

Prevalence Rates by Sex

The most common disorders among males and females were substance use disorders and disruptive behavior disorders (oppositional defiant disorder and conduct disorder). One-half of males and almost one-half of females met criteria for a substance use disorder, and more than 40% of males and females met criteria for disruptive behavior disorders.

More than one-fourth of females and almost one-fifth of males met criteria for one or more affective disorders. Females had significantly higher odds than males of having any disorder, any disorder except conduct disorder, any affective disorder, a major depressive episode, any anxiety disorder, panic disorder, separation anxiety disorder, overanxious disorder, and substance use disorder other than alcohol or marijuana. Significantly more females (56.5%) than males (45.9%) met criteria for two or more of the following disorders: major depressive, dysthymic, manic, psychotic, panic, separation anxiety, overanxious, generalized anxiety, obsessive-compulsive, attention-deficit/hyperactivity (ADHD), conduct, oppositional defiant, alcohol, marijuana, and other substance use.

Approximately one-fifth (17.3%) of females and males (20.4%) had only one disorder. Nearly one-third of females (29.5%) and males (30.8%) had both substance use disorders and ADHD or behavioral disorders; approximately half of these also had anxiety disorders, affective disorders, or both.

Significantly more females (47.8%) than males (41.6%) had two or more of the following types of disorders: affective, anxiety, substance use, and ADHD

or behavioral. Significantly more females (22.5%) than males (17.2%) had three or more types of disorders.

Prevalence Rates by Race/Ethnicity

Among males, non-Hispanic whites had the highest rates for many disorders and African Americans had the lowest. Compared with African Americans, non-Hispanic whites had significantly higher rates of most disorders, with the exception of conduct disorder and separation anxiety disorder. Hispanics had significantly higher rates than non-Hispanic whites of any anxiety disorder, including separation anxiety disorder.

Hispanic females had higher rates of generalized anxiety disorder than either African American or non-Hispanic white females. Compared with African American females, Hispanic females had higher rates of all disruptive behavior disorders, alcohol use disorder, substance use disorder other than alcohol or marijuana, and alcohol and drug use disorders.

Among females, significantly more non-Hispanic whites (63.1%) had two or more types of disorders than African Americans (42.6%). Among males, significantly more non-Hispanic whites (53.1%) had two or more types of disorders than African Americans (40.7%)

Prevalence Rates by Age

Among males, the youngest age group had the lowest rates of mental health disorders. This group had significantly lower rates than both older age groups of most disorders, with the exception of conduct disorder, generalized anxiety disorder, and all the substance use disorders.

Significantly more males aged 16 years and older (41.2%) had two or more types of disorders than males aged 13 years and younger (27.0%). Among females, there were no significant age differences in the overall prevalence of comorbid types of disorder.

Comorbidity of Substance Use Disorders and Major Mental Disorders

More than one tenth of males (10.8%) and 13.7% of females had both a major mental disorder (psychosis, manic episode, or major depressive episode) and a substance use disorder.

Rates of Substance Use Disorders among Youth with Major Mental Disorders

Compared with participants with no major mental disorder, both females and males with any major mental disorder had significantly greater odds of having substance use disorders. Among youth with major mental disorders (n=305), more than half of females and nearly three-quarters of males had any substance use disorder. Differences between females and males (and the corresponding odds ratios) were not statistically significant. This analysis is available from the authors.

Relative Onset of Major Mental Disorders and Substance Use Disorders

One-quarter of both females (27.2%) and males (25.0%) reported that their major mental disorder preceded their substance use disorder by more than 1 year. One-tenth of females (9.8%) and 20.7% of males reported that their substance use disorder preceded their major mental disorder by more than 1 year. Nearly two-thirds of females (63.0%) and 54.3% of males developed their disorders within the same year.

Summary

Even when conduct disorder was excluded, the Teplin study reported that nearly 60% of male and 70% of female juvenile detainees met diagnostic criteria and had diagnosis-specific impairment for one or more psychiatric disorders.

These findings suggest that on an average day, there may be as many as 72,000 detained youth with at least one psychiatric disorder; 47,000 detained youth who have two or more types of psychiatric disorder; and more than 12,000 detained youth who have both a major mental disorder and a substance use disorder. The juvenile courts, which the Department of Justice estimates manage 1,100,000 individuals per year, may process as many as 730,000 youth with at least one psychiatric disorder and 550,000 youth with psychiatric comorbidity per year.

These findings may underestimate the prevalence among youth entering the juvenile justice system for two reasons. First, the sample included only detainees; it excluded youth who were not detained because their charges were less serious, because they were immediately released, or because they were referred directly to the mental health system. Second, underreporting of symptoms and impairments by youth is common, especially for disruptive behavior disorders.

The high rates of depression and dysthymia among detained youth are of particular concern. Depressive disorders, which are a risk factor for suicide and attempted suicide, are difficult to detect and treat in the corrections milieu. The comorbidity of substance use disorders is also of particular concern. Among the disorders assessed, detainees are more likely to have substance use plus ADHD or behavioral disorders than any other combination. Half of these detainees also have an affective or anxiety disorder.

Females had higher rates than males of many single and comorbid psychiatric disorders, including major depressive episodes, some anxiety disorders, and substance use disorders other than alcohol and marijuana (e.g., cocaine and hallucinogens). The youngest age group (13 and younger) had the lowest prevalence rates of most disorders, consistent with studies of youth in the general population).

Recommendations for Reform

1. We need to determine the most common pathways to comorbidity, critical periods of vulnerability, and how these differ by sex, race/ethnicity, and age. Longitudinal studies that identify the most common developmental sequences will demonstrate when primary and secondary preventive interventions may be most beneficial.
2. Understanding psychiatric morbidity and associated risk factors among delinquent females would help improve treatment and reduce the cycle of disorder and dysfunction.
3. Longitudinal studies are needed to examine why some delinquent youth develop new psychopathology and others do not, to investigate protective factors, and to determine how vulnerability and risk differ by key variables such as sex and race/ethnicity. Longitudinal data on the subjects described in this Bulletin are being collected. Future papers will address persistence and change in psychiatric disorders (including onset, remission, and recurrence), comorbidity, associated functional impairments, and how these disorders affect risk behaviors that may lead to rearrest.
4. Youth with serious mental disorders have a civil right to receive treatment while detained. Providing mental health services to youth in detention and redirecting them to the mental health system after release may help prevent their returning to the correctional system. However, providing services within the juvenile justice system poses a number of challenges.
5. Screening youth who need mental health services is an important first step. Experts recommend that youth be screened for psychiatric problems within

24 hours of admission to a juvenile facility. Many detention centers do not routinely screen for psychiatric problems (Goldstrom et al., 2001). Only recently have specialized screening tools been developed to assess the needs of youth entering the juvenile justice system.

6. Detention centers should consistently train personnel to detect mental disorders that are overlooked at intake or that arise during incarceration.

References

Aarons, GA, Brown, SA, Hough, RL, Garland, AF, Wood, PA (2001), Prevalence of adolescent substance use disorders across five sectors of care. *J Am Acad Child Adolesc Psychiatry* 40:419-426

Abram, KM, Teplin, L.A. and McClelland, GM (2003), Comorbid psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry* 60:1097-1108

Teplin, LA, Abram, KM, and McClelland, GM (1996), Prevalence of psychiatric disorders among incarcerated women: I. Pretrial jail detainees. *Archives of General Psychiatry* 53:505-512

Teplin, LA, Abram, KM, McClelland, GM, Dulcan, MK, and Mericle, AA (2002), Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry* 59:1133-1143

Author

Shiraz Butt, M.D.
Rush University Medical Center
1720 W. Polk Street
Chicago, IL 60612

Chapter IV

Standards for Juvenile Detention and Confinement Facilities

By Louis J. Kraus, M.D. and Joseph Penn, M.D.

Introduction

Standards for juvenile health services and mental health services in juvenile detention and confinement facilities have wide variations. There are two basic types of facilities: pre-adjudication and post-adjudication. Pre-adjudication facilities can vary from small-town holding areas, which may have only the occasional youth, to massive pre-adjudication facilities as seen in the major cities. These facilities can hold hundreds of youth. Their focus is typically short-term detainment until adjudication, and then the youth are placed in post-adjudication facilities.

Dependent on the state, post-adjudication confinement facilities also vary. In some states there are specialized facilities only for delinquent teens. Staff will have some level of training. There will be specialized education programs, mental health services, and medical services which will focus on the special needs of teens. There are other post-adjudication facilities that will place teens with adults. The services offered to these teens are quite variable. Often in the mixed adult/teen facilities, the focus is on punishment instead of rehabilitation. Many juvenile facilities focus on rehabilitation, including psychiatric interventions, counseling, educational interventions, and working with families.

It is the policy of the American Medical Association (AMA) to support model legislation addressing the physical and mental health care needs of detained and incarcerated youth and to work toward the implementation of such legislation on both the state and federal levels (RES. 229, A-90). The AMA also encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission of Correctional Health Care (CSA Rep.C, A-89).

There continues to be much conflict concerning accreditation of facilities due to the tremendous amounts of variability. The primary accrediting agencies

are the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC). The NCCHC has its roots in the AMA and was developed with AMA support. The NCCHC accredits health and mental health components in correctional facilities. The ACA will fully accredit institutions, but with a primary focus on security with a somewhat secondary focus on health and mental health issues. It has become a difficult balance, as facilities will not uncommonly look for a more security-focused accreditation that minimizes the potential high expense of mental health and health interventions.

Several years ago the ACA published a competency program which involves a number of video tapes and reading materials to help security in understanding some the developmental and mental health needs of teens. This is a useful competency tool but in some respects minimizes the need for qualified mental health staff.

Correctional staff's knowledge base, attitudes, and perceptions of the mental health needs, developmental tasks, and other challenges of incarcerated juveniles have not been studied empirically. Many correctional staff are receptive to increasing their knowledge of critical mental health issues. Additional studies of the retention and implementation of this new knowledge by direct care correctional staff over time and the optimal type and frequency of new staff training and continuing education are indicated.

Within adolescent facilities, there are a variety of specialized concerns, including adolescent developmental needs, sexually transmitted diseases, chronic illness, and a variety of mental health needs, including concerns over substance abuse, violent behavior, anxiety, affective disorders, attention-deficit/hyperactivity disorder, and significant family dysfunction.

The NCCHC standards for health services in juvenile detention and confinement facilities were developed in 1999. The juvenile standards were most recently revised in 2004.

Current Status

There are a variety of other accrediting agencies, including the ACA, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and others. Most major medical organizations, including the AMA, American Association of Community Psychiatrists (AACP), American Psychiatric Association (APA), and American Academy of Pediatrics (AAP), support

medical and mental health accreditation by the NCCHC. The standards for the NCCHC have nine sections.

Section A covers government and administration. This includes a facility's requirement to have clear-cut policies and procedures regarding access to care, responsible medical authority and medical autonomy, administrative meetings and reports, continuous quality improvement plan, emergency response plan, communication regarding special needs patients, privacy of care, procedure in the event of a juvenile death, grievance mechanism for health complaints, notification in emergencies, and federal sexual assault reporting regulations.

Section B focuses on the managing of a safe and healthy environment, including sanitation issues for food handlers, available first aid kits, environmental health and safety, detection of sexually transmitted diseases and blood-borne diseases, as well as an infection control program, including the need for medical isolation.

Section C focuses on personnel and training, including credentialing, clinical performance enhancement, continuing education for qualified health care professionals, training for child care workers, medication administration training, juvenile workers, staffing plans, health care liaison, and orientation for health staff.

Section D focuses on health care services and support, including pharmaceuticals, as well as hospital and specialized ambulatory care. Few, if any, juvenile facilities can offer all services for children. Often youth will need to be brought to a variety of ambulatory care facilities for specialty care, such as ophthalmology services and orthopedic services.

Section E focuses on juvenile care and treatment, including initial screenings, health assessments, mental health assessments and evaluation, oral care, nonemergency health care requests and services, emergency services, segregated juveniles, patient escort, nursing assessment protocols, continuity of care during incarceration, and discharge planning.

Section F focuses on health promotion and disease prevention such as health education, diet, recreational exercise, personal hygiene, and maintaining a tobacco-free environment.

Section G focuses on children with special needs and services, including special needs treatment plans, management of chronic disease, infirmary care, mental health services, suicide prevention programs, youth with alcohol and other drug problems, substance intoxication and/or withdrawal, management of chronic disease, infirmary care, family planning services, as well as focusing on specialty issues such as special needs treatment plans, procedure in the event of sexual assault, care of the pregnant female, management of terminal disease, and orthoses, prostheses, and other aids to impairment.

Section H focuses on the format, content, confidentiality, and specific information included in health records.

Section I focuses on medical-legal issues such as the use of mechanical restraint, emergency psychotropic medication, forensic information, informed consent, right to refuse treatment, and issues regarding medical and other research.

The NCCHC juvenile standards also have 10 appendix sections. These include the legal context of correctional health care for juveniles, compliance indicators and performance measures, continuous quality improvement, correctional health services resources and references, position statements, mental health considerations (a psychiatric lexicon for nonpsychiatrists and guidelines for the use of psychotropic medications with incarcerated youth), medical diets, NCCHC accreditation, and the certified correctional health professional program.

One particularly important area in juvenile justice settings is Appendix D, on suicide prevention. In view of the high prevalence of mental disorders and the high incidence of suicidal behavior in youth in juvenile correctional facilities, and in order to be NCCHC accredited, every juvenile justice facility must develop a suicide prevention program for identifying and responding to each potentially suicidal youth. It is therefore necessary for youth held in detention or correctional placements to receive continued monitoring and repeated assessment for emotional or behavioral problems during confinement. Two essential components of a successful suicide prevention program are properly trained staff and ongoing communication between direct-care personnel and clinical staff. Continued observation and reassessment is particularly important in the prevention of suicide for detained youth.

NCCHC guidelines can potentially be quite difficult for institutions to pass. However, staff from the national commission will work with institutions if they have difficulties, to assist with programming. This helps turn the focus of accreditation to a learning and training experience for the institution.

Currently there are a variety of issues concerning youth who are placed in adult facilities. Most accreditation agencies continue to use adult credentialing to assist with this process. However, doing this negates all of the specialized developmental, educational, and physical needs of teens. Accrediting agencies, such as NCCHC, are concerned that if they make the requirements too stringent, correctional agencies will be less likely to use their accrediting standards, as there are no minimum state or federal credentialing standards.

Summary

There continues to be much debate concerning services for teens placed in both pre-adjudication and post-adjudication facilities. There is much concern regarding states' decreased funding resources and prioritization for the rehabilitation, treatment, education, research funding, and implementation of evidence-based, multimodal interventions to address the unique needs of youthful offenders and their families, regardless of the treatment setting. Longitudinal studies concerning recidivism and success associated with specific confinement programming are still in dire need. Specifics concerning credentialing are dependent on the township, county, or state that one is in. There continues to be debate concerning the degree of specialist credentialing necessary to work with incarcerated teens.

There are no specialized credentialing programs for preteens. There has been increased concern for younger children taken into custody regarding appropriate standards for care. A number of states, including Illinois, place these children in mental health facilities or simply send them home or to a relative and ask for close court-ordered follow-up and wraparound services.

We cannot help our children by taking a solely punitive approach. This will lead to a greater risk to society and will only succeed in increasing recidivism. Credentialing juvenile facilities should be as stringent as, if not more stringent than, hospital accreditation.

Recommendations for Reform

1. Requirements for standardized credentialing are needed. Credentialing requirements should be reviewed by specialty organizations, including the American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics.
2. Although there are federal mandates for education, correctional facilities often fall below the requirements to meet basic educational needs of incarcerated youth. As such, it would be in the youth's best interest to have assessment of the schools as part of the credentialing process.
3. There should be minimal standards for preteens who are taken into custody and detained.
4. There must be separate and specific credentialing for teens placed in adult facilities.
5. National standards for detention and confinement facilities should be adopted by states. Health and mental health components of standards should be subject to review by national medical organizations.
6. National standards for detention and confinement facilities should meet developmental needs of preteens.
7. National standards for detention facilities that primarily house adults should address the developmental needs of adolescents.

References

AMA Policy Compendium. (1995) 60:982

AMA Policy Compendium. (1995) 60:986

Feinstein M.D. R (1993), Hard Time, Healing Hands—Developing Primary Health Care Services for Incarcerated Youth. *National Center for Education and Maternal and Child Health*. Arlington, VA. 3:37

Penn JV, Esposito CL, Stein LAR, Lacher-Katz M, Spirito A. (2005) "Juvenile Correctional Workers' Perceptions of Suicide Risk Factors and Mental Health Issues of Incarcerated Juveniles." *J Correctional Health Care* (in press)

American Academy of Child and Adolescent Psychiatry (2005), Practice parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities. *J Am Acad Child Adolesc Psychiatry* (in press)

Standards for Health Services in Juvenile Detention and Confinement Facilities. (2000) National Commission on Correctional Health Care (NCCHC). Second Printing

Standards for Health Services in Juvenile Detention and Confinement Facilities (2004). National Commission on Correctional Health Care (NCCHC).

Authors

Louis J. Kraus, M.D.
Chief, Child and Adolescent Psychiatry
Rush University Medical Center
1720 West Polk Street
Chicago, IL 60612

Joseph Penn, M.D.
Brown University
593 Eddy Street
Providence, Rhode Island 02903

Rhode Island Hospital
300 New London Avenue
Cranston, Rhode Island 02910

Chapter V

Health Care in the Juvenile Justice System

By Robert Morris, M.D.

Introduction

Adolescents are commonly viewed as healthy, with little need for medical intervention. Although there is some truth to this belief, individuals may suffer from a wide variety of illnesses and injuries that can have immediate and, in many cases, lifetime effects. Many teenagers coming to detention also have deferred medical needs because of barriers to access, including no or limited insurance, lack of parental involvement, chaotic lives, limited understanding of medical care systems, and ignorance of health issues.

Incarceration may provide the best chance to meet the medical requirements of a particularly vulnerable population. In addition, the act of detaining youth removes their ability to seek care voluntarily, thus placing a legal and moral imperative on the detaining authority to provide diagnosis and treatment that meets community standards. Resources expended on youth provide a cost-effective intervention by preventing serious sequelae requiring greater expenditures in the future. Finally, rehabilitation of delinquent youth proceeds most smoothly when they are free of disease, pain, and disability and their own welfare has been assured.

Goals of Medical Care

1. Identification and treatment of existing medical conditions. Some conditions may be severe and obviously require treatment whereas others (for example, acne), while not medically serious, substantially affect the quality of life. Offending adolescents come to detention with considerable personal, psychological, and medical traumas that must be addressed in the context of rehabilitation. Attention to medical ills such as sexually transmitted diseases begins the process of helping delinquent children identify and take responsibility for their own needs while simultaneously learning regard for others.
2. Preventive health care, such as providing immunizations, addressing obesity, family planning, dental education, and testing for tuberculosis, results in cost-effective interventions which save money in the long run.

3. Health education about healthy life styles and avoiding risky behaviors is essential for all adolescents. Since many detained teens have dropped out of school, this education is especially important to provide during detention while the youth are available.
4. Law and human morality mandate ongoing care for new injuries and illness acquired during detention. Detained persons cannot seek care themselves, so society must provide the needed care.
5. Dental care tops the list of deferred health care in many families but can have considerable health effects.
6. Health care providers should aim to give supportive, nonjudgmental care that allows youth to build trust with their health care workers. Providers must guard against taking on the demeanor and roles of the custodial staff that, in some cases, are characterized by many loud, negative interactions with the teens under their control.
7. There should be a multidisciplinary planning meeting that includes a pediatrician or adolescent medicine specialist as part of individual assessment for each delinquent. Because they are broadly trained, pediatricians/adolescent medicine specialists can have a comprehensive view of each child's needs and can synthesize the various aspects of the plan into a coherent whole. In order for this model to work, there must be sufficient funding to hire enough staff to do meaningful evaluations. Limits on available staff in many institutions can lead to perfunctory, useless meetings that dispense one-size-fits-all rehabilitation plans.
8. Health care services can be provided by university-affiliated health care providers. This expansion of potential health care providers may also serve to develop new advocates for detained youth in the form of health professionals. Finally, these physicians and other health care providers will become familiar with the juvenile justice system.

Standards of Care

The size and sophistication of juvenile detention facilities varies greatly depending on the number of inmates, the size of the responsible governmental agency, and the wealth of the community utilizing its services. Some jurisdictions use large pre-adjudication facilities, often called "juvenile halls," while others place offending youth in secure group homes. Home detention

may be used for lower-level offenders. Finally, large municipal governments will use various combinations of these detention methods.

Regardless of the size and structure of the detention facility, the services to maintain the health and welfare of the children housed in these units must meet minimal criteria. Some organizations such as the American Correctional Association (ACA) provide accreditation services for entire facilities, i.e., the detention, educational, medical, and psychiatric services. Health care accreditation by the National Commission on Correctional Health Care (NCCHC), which is supported by the American Medical Association (AMA), focuses solely on medical and psychiatric services in detention facilities. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) contracted with the Council of Juvenile Correctional Administrators (CJCA) to develop Performance-Based Standards for Correctional and Detention Facilities. The standards cover all aspects of facility operations including health and mental health. The aim of the standards is to provide measurable, meaningful outcomes that actually affect the welfare of detainees. The standards are being pilot-tested by 57 youth detention and correction centers in 21 states. Performance-based standards are being developed also by the ACA and NCCHC. These instruments and accrediting organizations provide verifiable methods of determining the adequacy of medical and mental health services for detained adolescents. Despite some facilities in the United States utilizing these services, most juvenile detention organizations remain unaccredited and unaccountable for the medical and mental health care within their walls.

Several factors can lead to insufficient health care. Detention facilities are closed and not generally amenable to outside oversight. Therefore, the public is often unaware of conditions within their juvenile confinement facilities. Occasional newspaper articles or television spots that result in momentary interest rarely create sustained concern and hardly ever generate enough ongoing motivation to lead to increased funding and improvement of services. Because the juvenile “clients” and families involved in the justice system have minimal political influence, public officials have little incentive to focus on their care. Therefore, improvements in health care often come from court-mandated orders that force correctional authorities and politicians to address the welfare of incarcerated youth through state legislation.

Research

Grossly inappropriate research involving incarcerated populations has resulted in stringent limits on studies involving prisoners in the United States.

However, prisoners have many legitimate medical and psychological research needs. Infections such as sexually transmitted infections and hepatitis C, and mental health problems including anxiety, impulsiveness, borderline personality traits and depression, can be addressed by studies designed to reduce the incidence of disease or improve its detection and treatment for those in confinement. Rigorous evaluation of rehabilitative programs is also in the best interests of imprisoned persons and society in general. Any attempt to study prisoners and their specific problems must be balanced so the welfare of individuals is not compromised. Governmental agencies advocate for appropriate research and have built-in safeguards for all research involving prisoners including stipulating the types of permissible research (United States Department of Health and Human Services, 45 CFR, 1991). Medical personnel at large facilities should be involved as primary investigators or as collaborators with other investigators. The significant problems of our youthful offenders cannot be solved unless and until we have made systematic efforts to study their treatments. Consent laws and regulation for participation in studies vary from jurisdiction to jurisdiction. Parental permission for youth participation in minimal-risk studies (studies with risk equal to everyday life, such as drawing blood for medical evaluation and answering questionnaires) can be expensive and difficult to obtain. A judicial or governmental agency may be vested with authority to give permission for these types of studies. Conducting sound ethical, targeted research will aid progress greatly in reducing the burden of crime and illnesses for juvenile delinquents. Cooperation is necessary among medical, custody, and judicial personnel to obtain funding for studies and to facilitate the conduct of research.

Conclusion

Youth who are detained have a right to care and can become partners in advancing their care when approached by ethical, caring providers. They also can benefit from research that targets their unique needs. University and medical training programs are logical groups to take the lead in improving care of detained juveniles.

The public's perception of teens in trouble will have to change from viewing them as bad kids who deserve only punishment to a broader understanding that these are our children who represent the future generation on which society will depend.

Recommendations for Reform

1. Systematically monitor conditions of detention and confinement facilities; provide resources to improve adverse conditions.
2. Establish partnerships between detention facilities and pediatric, internal medicine, and/or family practice academic centers in order to enhance quality improvement activities, to entice medical trainees to pursue juvenile corrections medicine, and to expand the pool of potential health care providers.
3. Fund research relevant to juvenile health and rehabilitation. Health risk behaviors, impulsive actions, and antisocial tendencies are not yet well understood by those who attempt to rehabilitate delinquents. The etiology of delinquent behavior needs further study. Child abuse, prenatal drug exposure, head trauma, unsafe environments, and learning disabilities are just a few poorly investigated areas which may affect children and teens. In addition, systematic scrutiny of various rehabilitation efforts must be accomplished in order to determine their efficacy.
4. Provide detainees with full access to all assessment and treatment modalities that are medically indicated.
5. Fund research in the area of health screening. Evaluation of screening tests for common medical problems found in detainees helps to determine the best methods of identifying youth with medical problems that require treatment. There is a great need for simple, cost-effective medical screening tests, which will greatly benefit incarcerated youth.
6. Establish clear, structured health education programs that have a primary focus on sexually transmitted diseases, HIV, and birth control.

References

American Academy of Child and Adolescent Psychiatry (2001), *Recommendations for Juvenile Justice Reform*, Arroyo W, Kraus LJ. Ed, American Academy of Child and Adolescent Psychiatry Task Force on Juvenile Justice Reform, Washington, DC

American Academy of Pediatrics (1989), Health Care for Children and Adolescents in Detention Centers, Jails, Lock-Ups, and Other Court-Sponsored Residential Facilities. *Pediatrics*:84(6):1118-1120

Costello JC, Jameson EJ. (1987) Legal and ethical duties of health care professionals to incarcerated children. *J Legal Med*:8:191-263

Council on Scientific Affairs (1990), Health Status of Detained and Incarcerated Youths. *JAMA*; 263(7):987-991

Feinstein RA, Lampkin A, Lorish CD et al. (1998), Medical Status of Adolescents at Time of Admission to a Juvenile Detention Center. *J Adolesc. Health*; 22:190-196

Morris RE (1995), Health risk behavior survey from thirty-nine juvenile correctional facilities in the United States. *J Adolesc Health*;17:334-344

Morris RE (1995), How to accomplish effective communication between juvenile delinquents and health care providers. *Journal of Correctional Health Care*, 2(2):150-168

Morris RE (2001), Health Care in the Juvenile Justice System. In: *Recommendations for Juvenile Justice Reform*. Arroyo W, Kraus LJ. Ed, American Academy of Child and Adolescent Psychiatry Task Force on Juvenile Justice Reform, Washington, D.C. American Academy of Child and Adolescent Psychiatry, pp 32-35

Morris RE (2001), *The Health of Youth in the Juvenile Justice Systems*. In: Alderman E, Brown RT (Eds). Adolescents, Families and Society in the New Millennium. *Adolescent Medicine: State of the Art Reviews*(AM:STARs) 12: 471-484

Performance-Based Standards for Juvenile Correction and Detention Facilities (2000), Council of Juvenile Correctional Administrators. Stonehill College, South Easton, MA

Society for Adolescent Medicine (2000), Position paper. Health Care for Incarcerated Youth. *J Adolesc. Health*;27:73-75

Standards for Health Services in Juvenile Detention and Confinement Facilities (2004), National Commission on Correctional Health Care. Chicago, IL

Wolf A, Funk SG (1985), Epidemiology of trauma in a population of incarcerated youth. *Pediatrics*;75:463-468

Author

Robert Morris, M.D.
UCLA
School of Medicine

Chapter VI

Females in the Juvenile Justice System

By Gabrielle Shapiro, M.D. and Louis J. Kraus, M.D.

Introduction

Traditionally there has been a minimization of concerns about female delinquency. There is a dearth of specialized programs for female delinquents. For instance, in Illinois there is only a medium-security facility for female delinquents, regardless of mental health issues or the seriousness of their crime. Even though current research has shown that female delinquents have more significant mental health issues than their male counterparts, programming and treatment remain minimal.

Current Status

The national arrest rate for females is steadily climbing; in 1983 it was 21% and in 2000 it was 27%. Arrests for violent crimes, such as aggravated and simple assault, increased to a total of 35% among girls between 1944 and 1998, compared with a negligible decrease in violent crime scores for boys.

Although statistics are showing an overall decrease in juvenile crime, there is a significant increase in the number of offenses by females. The national trend of violent juvenile crimes decreased but despite this trend, more girls are being arrested for violent acts. The National Center for Juvenile Justice reported that between 1992 and 1996 the number of arrests for female juveniles per violent crime index offenses increased by 25% compared with no increase in arrests for male juveniles.

Gang activity is one of several risk factors for delinquency and serious offenses in females. In the state of California, where urban gang activity is a constant concern, more girls than boys were arrested for murder, attempted murder, and carjacking in 1998.

The trend during the past decade is that the number of juvenile female offenders is increasing faster than the number of juvenile male offenders. Nationally, delinquent females represent an increasing proportion of delinquent youth and are being arrested more frequently for crimes against other persons. Between 1993 and 1997 the arrests of females for offenses

against families and children increased by 82%. Between 1993 and 1997 the arrests of girls for drug abuse violations more than doubled to 117%. Aggravated assault, the most frequent crime of female offenders, increased by 15%, while declining for boys by 10%. Between 1993 and 1997 arrests of boys for violent offenses declined by 9% while those of females increased by 12%. In 1997 58% of arrests of runaways were girls.

Interpersonal relationships seem to play an important role in a great number of incidents of female juvenile delinquency. Homicides by girls usually involve a relationship component such as an argument or a physical fight (79%). The victims of homicide by girls tend to be members of their own families (32% for girls vs. 8% for boys). Twenty-four percent of the girls' victims are under 3 years old; they are usually infant children. In a study of juvenile offenders in Virginia, where 24% of the girls' victims were under 3 years old, the importance of relationships in juvenile delinquency was identified.

Girls in the general population are likely to engage in relational aggression such as gossip, social exclusion, or bullying, whereas boys preferably employ physical aggression. However, when relational aggression by girls becomes violent, they usually target a known victim. Since girls tend to engage in relational aggression, this may account for the disproportionate victimization of families by girl offenders. Most of the research in risk assessment has only involved boys. Epidemiologically, we are observing that girls have more likely been physically and sexually abused and have been more frequently hospitalized for psychiatric problems than their male counterparts.

Factors associated with female delinquency include a history of abuse, family distress (including single-parent status), parental conflict and criminality, impoverished families, residential mobility, substance abuse, mental illness, teenage parenting, and academic failure. Recent studies have shown that female delinquents have more psychiatric morbidity and poorer outcomes than their male counterparts. In a California study of 3,600 juvenile offenders, Steiner et al. reported that girls, who made up 8% of the sample, ranged in ages from 9 to 17 years. Youth completing the Achenbach Youth Self-Report (which is used to measure the prevalence of disorders such as posttraumatic stress disorder, anxiety disorder, and major depressive disorder, as well as behaviors such as verbal aggression and delinquency) showed that girls score high on all dimensions. Girls experience more physical and sexual abuse and tend to have more psychopathology than boys, including posttraumatic stress

disorder, suicidal behaviors, dissociative disorder, and borderline personality disorder.

Steiner et al. reported that aggressive behaviors were four times more common in girls than boys. Their findings are similar to national trends. Typical juvenile female offenders are 14 to 16 years old, are from an ethnic minority, live in a poor neighborhood with a high crime rate, and have experienced a history of psychological, sexual, and/or emotional abuse. Other epidemiological characteristics that female offenders possess are poor academic performance, substance abuse, and lack of medical or mental health services. Substance abuse disorders are seen in the majority of female delinquents as the rule, not the exception.

McClelland et al. reported that substance abuse disorder in delinquents would return upon release to the community if no services were available. Teplin et al. found that posttraumatic stress disorder is more prevalent in youth in detention than in community samples; 56.5% met criteria for two or more for the following disorders: major depressive disorder; posttraumatic stress disorder; psychotic, panic, anxiety, manic, and separation disorders; conduct disorders; attention-deficit/hyperactivity disorder; alcohol and marijuana abuse; and other substance abuse disorders. The findings of Teplin et al. are consistent with the idea that the major health problems of detained juvenile youth are psychiatric.

Studies on gender specificity have been sparse because the majority have been conducted and focused on boys. However, the Teplin et al. study also shows an increased incidence of psychopathology in delinquent females, and they include recommendations to improve screening for psychiatric problems and to reduce barriers to service in the community. Future research should be focused on pathways to health care, evaluations of interventions, prevalence patterns, and outcomes of morbidity and patterns of disorders.

Other studies have suggested directions for future research being directed at studying the patterns and sequences of females in the juvenile justice system and focusing on understanding psychiatric morbidity and associated risk factors among delinquent females in order to improve treatment and reduce dysfunction. We must continue to focus on the need for long-term longitudinal studies and research until effective interventions for juvenile offenders have been identified.

Interventions

Peer mediation training, where girls are educated in listening respectfully and expressing verbally with the goal of solving specific problems, has shown promise. School interventions such as tutoring and mentoring have been good relationship-oriented interventions. Family- and community-oriented interventions such as parent advocacy education, family therapy, and community interventions for violence reduction have been effective. Several programs that are specific to girls have shown great promise.

Recommendations for reducing female delinquent behaviors have generally focused on the following: implementing programs that engage girls in healthy relationships and provide social skills training; providing forums for open and safe discussion on personal safety, abuse, and victimization; providing follow-up with treatment or referrals; addressing mental health and substance abuse needs; providing academic support services and encouraging school, community, and religious participation; providing positive adult role models; and implementing a wraparound approach by including families in treatment strategies. In the area of reproductive health and teenage parenting, additional recommendations would be to provide information concerning reproductive health, assistance with teenage parenting, additional parent training, and child care for arrested teenage mothers. Mental health screening and services while girls are in the pre-adjudication phase, as well as during incarceration, must be a consistent focus. Additionally, securing gender-specific mental health follow-up for female youth as they return to the community is an urgent need.

Recommendations for Reform

1. Fund further longitudinal research in areas of gender-specific needs and services.
2. Establish gender-specific community programs for girls who have already been adjudicated.
3. Provide health education concerning sexually transmitted diseases, including HIV and birth control, for female delinquents.
4. Establish more community-based intervention programs for girls who have been victimized.
5. Establish gender-specific mental health programs for incarcerated females.

References

Abram, KM, Teplin LA, Charles, Dr., Longworth, SL, McClelland, GM, Dulcan, MK (2004), Posttraumatic Stress Disorder and Trauma in Youth in Juvenile Detention. *Arch Gen Psychiatry* Vol 61

Abram, KM, Teplin, LA, McClelland, GM, Dulcan, MK (Nov 2003), Comorbid Psychiatric Disorders in Youth in Juvenile Detention. *Arch Gen Psychiatry*, Vol 60

Acoca, Leslie (October 1999), Investing in Girls; A Twenty First Century Strategy. OJJDP Bulletin, U.S. Dept. of Justice. Vol VI –No.1,3-13

Chesney-Lind M. and Sheldon R.G. (1998) Girls, Delinquency, and Juvenile Justice. Belmont, CA.

Lewis DO, Yeager CA, Cobhan-Portorreal CS, Klein N, Showalter C, Anthony A (1991) A Follow-up of Female Delinquents; Maternal Contributions to the Perpetuation of Deviance. *J Am Acad Child Adolesc Psychiatry* 30;197-201

Marian, Daniel (October 1999), Investing in Girls; A Twenty First Century Strategy. OJJDP Bulletin, U.S. Dept. of Justice. Vol. VI-No.1,13-20

McClelland, GM, Elkington, KS, Teplin LA, Abram, KM (2004), Multiple Substance Use Disorder in Juvenile Detainees. *J Am Acad Child Adolesc Psychiatry* 43:10

Poe-Yamagata E, Butts JA; (1996) Female Offenders in the Juvenile Justice System, U.S. Dept. of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, Washington, DC

Teplin LA, Abram KM, McClelland GM; (1996) Prevalence of Psychiatric Disorders Among Incarcerated Women; 1. Pretrial Jail and Detainees. *Archives of General Psychiatry* 53;505-512

Teplin LA, Abram KM, McClelland GM (1997) Mentally Disordered Women in Jail; Who Receive Services? *American Journal of Public Health* 87;604-609

Authors

Gabrielle Shapiro, M.D.
3030 Children's Way
Suite 101

San Diego, CA 92123

Louis J. Kraus, M.D.
Chief, Child and Adolescent Psychiatry
Rush University Medical Center
1720 West Polk Street
Chicago, IL 60612

Chapter VII

Disproportionate Minority Confinement

By William Arroyo, M.D.

Until 2002, when the Juvenile Justice and Delinquency Prevention Act (JJDPAct) (Public Law 93-415, 42 U.S.C. 5601 *et. seq.*) was reauthorized, DMC was the acronym for disproportionate minority confinement, which refers to a pattern of detaining or confining in secure detention facilities, secure correctional facilities, jails, and lockups a proportion of minority youth that exceeds their group's proportion in the general population. The recent reauthorization expanded the DMC initiative from "confinement" to "contact," which refers to all decision points along the juvenile justice system continuum. The 2002 amendments also require multipronged intervention strategies including not only juvenile delinquency prevention efforts, but also system improvement efforts to "reduce, without establishing or requiring numerical standards or quotas, the disproportionate number of juvenile members of minority groups, who come into contact with the juvenile justice system." Minority youth in many states are overrepresented and receive disparate treatment at the various major decision points of the juvenile justice process including arrest, prosecution, adjudication, transfer to adult court, and, especially, secure confinement. Minority populations as per the JJDPAct, which was originally passed in 1974, refer to African Americans, American Indians, Asians, Pacific Islanders, and Hispanics (or Latinos).

This disparate treatment of minority youth was first brought to national attention by the Coalition for Juvenile Justice in 1988. Later that year, Congress amended JJDPAct, asking states to address DMC. In 1992, DMC was elevated to a core requirement of JJDPAct along with three others, namely, deinstitutionalization of status offenders, removal of juveniles from adult jails and lockups, and separation (elimination of all visual and auditory exposure) of juvenile offenders from adults in secure institutions. The DMC core requirement of the amended law mandates states which receive funding via the U.S. Department of Justice to (1) identify the extent to which DMC exists, (2) assess the reasons for DMC if it exists, and (3) develop an intervention plan to address these identified reasons. Compliance with this core requirement or any other of the three core requirements was tied to future

funding. JJDPA was reauthorized in 2002, broadening the requirement to disproportionate minority contact.

Current Status

Arrests

Arrest data from 1998–1999 indicated that although African American youth accounted for only about 16% of the juvenile population nationwide, they represented 25% of all juveniles arrested (Sickmund, 2004).

Secure Confinement

According to the most recent national data (1999), minority youth constituted about 34% of the juvenile population on a nationwide basis but represented 62% of the juveniles detained and 67% of those committed to secure juvenile correctional facilities. These figures reflect significant increases over 1983, when minority youth represented 53% of the detention population and 56% of the secure juvenile corrections population. This disparity is highest for youth of African American descent among culturally diverse populations; this group of youth aged 10–17 years comprises 15% of their age group in the United States and yet constitutes 46% of youth in correctional institutions, making them seven times more likely to be placed in a detention facility.

The number of Latino children and youth in the United States has mushroomed faster than the number of any other racial or ethnic group, increasing from 9% of the juvenile population in 1980 to 16% of the total U.S. child and youth population in 2000. Research from some states demonstrates that Latino youth are overrepresented at arrest and other decision points. Some states combine data relevant to Latino youth with that of white youth, and therefore it is impossible to make a determination of whether or not DMC operates in these states. Furthermore, it may falsely suggest that DMC does not exist or it may be minimized (Villaruel and Walker, 2002).

The Census of Juveniles in Residential Placement (CJRP) from 1997 (OJJDP, 1998, 2001) indicates that American Indian youth constituted 2% of youth in correctional facilities nationwide but were only 1% of the national youth population. Some state data suggest much higher rates than twice the expected rate. The actual levels may be higher since tribal agencies do not report arrest, referral, and detention-related data for inclusion in state statistics.

The least-studied racial/ethnic groups are the Asians and the Pacific Islanders. The 1997 CJRP data (OJJDP, 1998, 2001) indicate that Asian youth constituted 4% of the national juvenile population and represented only 2% of youth in secure corrections. State data suggest that these two groups are underrepresented in populations of confined youth at both the state and county levels. However, in some local jurisdictions, such as Los Angeles County, there are indications that Asian youth are overrepresented.

In California, African American youth offenders are 18.4 times more likely, Asian youth offenders are 4.5 times more likely, and Latino youth offenders are 7.3 times more likely than white youth offenders to be sentenced by an adult court to California Youth Authority (CYA) confinement. Compared with white youth of similar crimes, minority youth offenders are somewhat more likely to be sentenced to CYA facilities by juvenile courts (minorities constitute 77% of violent crime arrestees and 84.5% of CYA sentencing despite a minority youth composition in the state of 54%). Minority youth are much more likely to be sentenced to CYA facilities after transfer to adult courts (77% of arrests, but 91.1 % of CYA sentencing). CYA is a state confinement system for more serious offenders than those housed in the county detention/confinement facilities (Poe-Yamagata and Jones, 2000).

Transfers to Adult Court

In 1997, 75% of the new 7,400 admissions to adult prisons who were younger than 18 years of age were of minority background.

In Los Angeles County, where 25% of the youth population is white, 51% Latino, 13% African American, and 11% Asian and other races, the Latino youth was 6 times more likely, the African American youth 12 times more likely, and the Asian/other youth 3 times more likely than the white youth to be found unfit for juvenile court and waivered to criminal court in 1996. African American and Asian youth tried in criminal court were imprisoned more often than Hispanic or white youth (Poe-Yamagata and Jones, 2000).

The reasons originally cited to promulgate the practice of transfer, namely, to deter youth from committing crimes, to decrease recidivism, and to improve public safety, have not been borne out by research. In fact, some research concludes that the degree of severity of offenses among transferred youth has been greater compared with nontransferred youth.

Efforts to Resolve DMC

National

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) has provided technical assistance directly to states and has supported such assistance through private contracts. OJJDP has also sponsored national conferences on DMC. Between 1987 and 2002, approximately 80 technical assistance efforts were provided to states as a result of requests. A DMC Initiative was launched by OJJDP in 1991 in which five states (Arizona, Florida, Iowa, North Carolina, and Oregon) were competitively selected to test various approaches to assessing DMC and experiment with approaches to reducing DMC. OJJDP has developed various tools for states to examine and address DMC including *DMC Technical Assistance Manual (2nd edition)* (OJJDP, 2000) and a Compliance Determination Checklist. OJJDP also developed a DMC page on OJJDP's website (www.ojjdp.ncjrs.org/dmc), established a compliance determination process to guide/enhance state DMC efforts, and established a library of state DMC reports. In 2002, OJJDP spearheaded an expansion of qualified DMC research consultants and a new DMC research agenda.

OJJDP has also supported review of literature regarding DMC and summary publications (Pope, Lovell, and Hsia, 2002). Through one of its contractors, Research and Evaluation Associates (www.reducingdmc.com/index.html), OJJDP has supported intensive technical assistance to five states (Delaware, Kentucky, Massachusetts, New Mexico, and South Carolina) beginning in 2000 and three more states (Alaska, California, and South Carolina) in 2001. These latter efforts include identification of other experts to provide technical assistance, a training of trainers, a full DMC progress review of all states in order to identify needs, and a plan to restructure/refine the DMC intensive technical assistance process. Another DMC technical assistance provider, the Juvenile Justice Evaluation Center (JJEC) (<http://www.jrsainfo.org/jjec/about/index.html>), has assisted OJJDP in building capacity in states, especially as the efforts relate to projects and initiatives funded by the Title II, Part B, State Formula Grants Program. These activities include publications; short-term, state-specific consultation; and grants to develop evaluation partnerships. Also, OJJDP has contracted with a third technical assistance center, Development Services Group (www.dsgonline.com).

The Building Blocks for Youth initiative (www.buildingblocksforyouth.org) is a partnership of organizations in the fields of law, justice, communications,

and public policy. The partners include Youth Law Center (lead partner), the American Bar Association Juvenile Justice Center, the Justice Policy Institute, the Juvenile Law Center, Minorities in Law Enforcement, the National Council on Crime and Delinquency, and the Pretrial Services Resource center. The primary goals of the initiative are to protect minority youth in the juvenile justice system and promote equitable and effective juvenile justice system policies. The activities of the initiative include conducting new DMC research, analyzing the decision-making processes in juvenile justice, building broad-based constituencies (state and local leaders, child welfare, policymakers, potential local DMC leaders), and developing communications strategies (media outreach, surveys on public attitudes).

In 2003 at a DMC Peer Review meeting, the method for calculating disproportionality was reviewed and changed from the method of using the Disproportionate Representation Index (DRI), which has been used since 1988, to the use of the DMC Relative Rate Index (RRI). Regional trainings on the RRI were held in 2004.

The Youth Law Center was awarded a grant in 2004 to develop a focus on Latino youth and DMC.

States

In order to garner JJDPA grants, a state must first identify whether DMC is an issue for that state. A state must examine the treatment of minority and nonminority youth at various decision points in the juvenile justice system, and then implement strategies designed to reduce DMC. The degree to which states have been able to comply with these requirements varies across states.

A survey of states, based on the states' self-assessment, was conducted in 2000 to examine factors contributing to DMC (Hsia, Bridges, McKale, 2004). The most frequently identified factors were in the juvenile justice system, the educational system, socioeconomic conditions, and the family. Within the factor of the *juvenile justice system*, contributing were (1) racial stereotyping and cultural insensitivity on the part of police and other decision makers within the system, along with the demeanor and attitude of minority youth, which often contributed to negative treatment and a more severe disposition; (2) lack of alternatives to detention and incarceration, especially in urban areas, where detention centers simply become "convenient" placements for urban minority youth; (3) misuse of discretionary authority in implementing

laws and policies by police, probation officers, and even school system personnel; and (4) lack of culturally and linguistically appropriate services. Contributing to the *educational system* factor were the failure of schools to engage students/families, failed school dropout prevention strategies, and failure of students/families to participate in the educational system. The *socioeconomic conditions* included poverty, substance abuse, poor job market, local high crime rates, targeting of high-crime areas by law enforcement, limited good role models for youth, more serious crimes committed by minority youth, and very limited community resources to support normal youth development. The *family* factor was evidenced by disproportionate number of minority youth from single-parent households in which the parent had unsteady and low-paying employment, family disintegration, diminished traditional family values, parental substance abuse, insufficient family/adult supervision, and noncompliance by minority youth with diversion requirements.

States have resorted to several actions to address DMC. The most frequently adopted strategies have been community-based prevention, intervention, diversion programs, and cultural sensitivity training.

Examples of community-based prevention and intervention efforts in minority communities include establishing a minority family advocate, probation advocate, parenting projects for Spanish-speaking parents, Latino case managers in elementary schools to improve school attendance, an Elder-Mentor program for American Indian families, and many after-school and evening programs. Alternatives to incarceration include home detention, intensive supervision, electronic monitoring, emergency shelters, and transition and aftercare programming.

Attempts to address cultural competency include cultural sensitivity training for personnel of all relevant agencies, recruitment of minority staff and promotional efforts relevant to minority staff, establishing minority internship programs, publication of relevant materials in other languages, recruitment of minority representatives to community accountability boards, reduction of barriers to advocacy, adding juvenile court probation staff in tribal juvenile courts, and annual state conferences on DMC. Community empowerment efforts include supporting better relationships between juvenile justice system and minority communities and engagement of minority communities in planning services. In order to combat racial bias, some states have adopted standardized screening instruments to achieve more objective decision-

making; they have also adopted standardized risk and needs assessment classification systems, designed model intake screenings, mandated prosecutorial standards, and standardized diagnostic tools. Some states have strengthened state leadership by establishing DMC subcommittees at high state levels, strategies to prioritize funding to reduce DMC and establish state DMC coordinator positions. Some states are systematically collecting and monitoring DMC data. Two states, Oregon and Washington, have institutionalized efforts through legislation. Oregon passed a law requiring cultural competency of all state agencies. Washington state has adopted prosecutorial standards, developed experimental programs implementing prosecutorial guidelines to reduce racial inequality in the prosecution of youth, established a requirement for state agencies monitoring youth to report annually on minority representation, and established local juvenile justice advisory committees to monitor and report annually on proportionality and to review/report on citizen complaints regarding bias or disparity within the juvenile justice systems.

Challenges for states remain. These include the following: some states not having identified factors contributing to DMC, inadequate data systems, ongoing state monitoring of DMC efforts and trends, limited systems change in order to reduce DMC, and limited institutionalization of mechanisms to ensure reduction of DMC.

Recommendations for State/County Reform

1. Examine decision-making policies and procedures of police, prosecutors, courts, and probation to identify where racial disparities occur in the system.
2. Develop guidelines, such as detention criteria, which either reduce or eliminate racial disparities.
3. Develop, support, and expand delinquency prevention programs that target minority communities.
4. Increase the availability and improve the quality of diversion programs.
5. Develop community-based alternatives to secure detention and incarceration.
6. Provide training for juvenile justice system personnel in areas of child development and mental illness.
7. Incorporate cultural competency competency in policy and program development.
8. Review and change laws that encourage the disparate racial impact providing for prosecution of juveniles in the criminal justice system.

9. Declare a moratorium on building new juvenile detention and corrections facilities and adding new secure beds until the differential impact of the justice system on minority youth has been comprehensively addressed.
10. Clear offense records of youth for nonviolent and/or status offenses; these offenses undermine efforts to procure employment in young adulthood.

Recommendations for Federal Reform

1. Provide intensive technical assistance to states/local jurisdictions for compliance with the DMC requirement, especially in regard to the new requirement of “contact with the juvenile justice system” as opposed to merely confinement.”
2. Support states’ efforts to systematically collect comprehensive data, to conduct analysis of data, and to develop research and data-based state DMC intervention plans.

Recommendations for National Organizations

1. Monitor the activities of the federal and state governments to address this issue, and report to their members and the general public.
2. Meet with legislators to provide input on how to reform the juvenile justice system.

References

Hsia, H.M., Bridges, G.S., and McHale R (2004). *Disproportionate Minority Confinement, Update 2002*. US Department of Justice, Office of Juvenile Justice and Delinquency Prevention, Washington, DC

Office of Juvenile Justice and Delinquency Prevention, (1998, 2001). *Census of Juveniles in Residential Placement 1997 and 1999*. Office of Justice Programs, U.S. Department of Justice, Washington, DC

Office of Juvenile Justice and Delinquency Prevention (2004).

Disproportionate Minority Confinement, 2002 Update. Washington, DC: U.S. Department of Justice, Office of Justice Programs NCJ 201240

Office of Juvenile Justice and Delinquency Prevention (2000).

Disproportionate Minority Confinement Technical Assistance Manual (2nd Ed.) Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention

Office of Juvenile Justice and Delinquency Prevention (2005)
Disproportional Minority Contact (DMC) Chronology: 1988 to Date.
Washington, DC: U.S. Department of Justice, Office of Justice Programs.
Available at: <http://www.ojjdp.ncjrs.org/dmc/about/chronology.html>

Poe-Yamagata, E., and Jones, M. (2000) *And Justice for Some: Differential Treatment of Minority Youth in the Justice System.* Washington, DC: Youth Law Center

Pope, C.E., Lovell, R., Hsia, H.M. (2002) *Disproportionate Minority Confinement: A Review of the Research Literature From 1989 Through 2001.* Bulletin. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention

Sickmund, M. (2004). *Juveniles in Corrections.* Bulletin. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention

Villaruel F.A. and Walker, N.E. (2002). *Donde Esta la Justicia? A Call to Action on Behalf of Latino and Latina Youth in the US Justice System.* Washington DC: Building Blocks for Youth. Washington DC

Author

William Arroyo, M.D.
Child and Family Services Bureau
Department of Mental Health, 3rd Fl.
550 S. Vermont Avenue
Los Angeles, CA 90020

Chapter VIII

Seclusion and Restraint Standards in Juvenile Corrections

By Louis J. Kraus, M.D.

Protocols for seclusion and restraint within departments of corrections remain variable. They are complicated by an overlap of rules for both seclusion and restraint covering general medical security and mental health treatment and safety for the patient and for others.

Seclusion

Seclusion is defined as removing a child from the general population, whether in isolation or not. Within corrections, there are three primary avenues for seclusion. These are:

1. Medical seclusion. This is almost always an isolation process for infectious disease, but it may also be used for a transition when a child is returned from the hospital secondary to illness or injury.
2. Security/administrative seclusion. This may or may not be in isolation. The use of this type of seclusion is typically for aggressive, gang-related, or oppositional (refusal of a direct order) behavior.
3. Mental health seclusion. The use of isolation versus simply removal from the general population is variable. This type of seclusion is typically used for youth who are at an acute risk of harm to self or, related to their mental illness, at risk of harming others.

Types of mental health diagnoses may include depression, bipolar disorder, attention-deficit/hyperactivity disorder, psychosis, or a variety of anxiety disorders such as posttraumatic stress disorder. Children who have previously acted self-destructively or have had other mental health issues are not uncommonly victimized and minimally are an at-risk population. Mental health seclusion should be in the continuous view of staff. It is used to pull a child away from the precipitating agents that might result in more significant behavioral difficulties resulting typically in self-harm. Often, when these children are removed from the precipitating etiologies, their behavior will improve. Seclusion can often allow the child to spend additional time with a

mental health professional and other interested staff including security, teachers, and nurses.

Restraint

Restraint involves the restriction of movement of a patient and can be achieved by the use of physical or chemical means. There are some who feel that restraints are used too frequently and at times allege that this can be cruel and unusual punishment. Again, there are times when security's use of certain types of restraints may potentially overlap mental health use of restraints, which is of significant concern. In addition, there are facilities that do not have the level of mental health interventions necessary to safely and therapeutically use restraints, and as such some of these facilities will rely on security and others to briefly place the child in restraints until they can be placed at a more appropriate therapeutic facility for further assessment and intervention.

Some juvenile justice systems use chemical restraint. Amnesty International and the Child Welfare League do not support this practice. Chemical restraint is defined as using a medication without a therapeutic purpose, but for the sole purpose of sedation and by that immobilizing the patient. There is much overlap with therapeutic use of benzodiazepines and neuroleptics for acutely agitated patients.

There are a variety of examples of security's use of restraints that for the most part go unquestioned. For example, youth who have had prior violent behavior are typically placed in shackles during acute episodes and sometimes when being transferred from a seclusion area to another part of the facility such as to nursing or other required areas. In addition, it is common practice when youth are transferred out of a facility to place them in shackles. The point here is that shackles are clearly a form of restraint. They greatly limit a person's movement. The level of restraint and the type of shackles used determine limitations of movement.

Many correctional facilities have in-services and practice deescalation techniques to avoid restraint. Within hospital settings deescalation programs have been shown to be helpful in decreasing restraint use.

Most facilities use four-point therapeutic restraints. Some use a chair restraint, which has an increased risk for positional asphyxiation. Asphyxia is the most common cause of death in restraint. Therapeutic restraints should be

used only by qualified mental health professionals when there are no less restrictive alternatives. Morbidity associated with restraints include fractures, nerve compression, and soft tissue contusions; associated mortalities primarily occur when a youth is being placed prone. Occasionally a decision must be made to place a child in restraints when a mental health professional is not present. A physician, preferably a psychiatrist, must be contacted in as timely a manner as possible, as per the state's mental health code for residential settings. Consideration should be given as to whether correctional facilities' guidelines should follow the guidelines used in hospital settings. Therapeutic restraints should be used when a child is at acute risk of harm to self, related to self-mutilating behaviors, suicidal intent, acute agitation, or a significant level of delirium or psychosis. At times this decision may be debatable, depending on a specific facility or individual. This needs to be explored further. By far, hospital-based therapeutic facilities will offer us the greatest amount of information concerning restraint and seclusion. The specific amount of time that a child can be in restraints before being evaluated by a qualified mental health professional and a physician is typically addressed by one's state mental health code, with which institutions must minimally comply. Most correctional facilities do not feel hospital requirements for restraint should apply to them, which places youth at risk.

Summary

There continues to be much debate and at times conflict concerning the use of seclusion and restraint. In fact, many differ on their definition of seclusion and restraint, who should be allowed to use seclusion and restraint, how it should be implemented, whether there should be written rules concerning implementation, documentation concerning implementation, morbidity and even mortality assessments concerning implementation, effects on the youth, and looking at alternatives. We need to clearly define differences in the use of seclusion and restraint by security and mental health staff. If this is not done, children who are incarcerated will continue to be at risk for harm and even death due to the inappropriate use of restraint and seclusion.

Recommendations for Reform

1. National policies concerning the use of seclusion and restraint on our youth in correctional facilities should be established. Indications for the various types of restraints – four-point leather supine restraints, chair restraints, shackles, soft restraints, handcuffs, blankets, etc. – should also be established. Safety must be a priority in these standards. Policy should be consistent with hospital standards.

2. Chair restraint should be used only with clear policy and training for staff, secondary to the possibility of positional asphyxiation.
3. National policy regarding duration of restraints should be established.
4. The role of psychiatrists, other physicians, and mental health professionals should be clearly delineated in such policies.
5. Close monitoring of confinement facilities regarding compliance with national policies on restraints should be conducted periodically.
6. Facilities must have clear written policies that comply with state statutes.

References

American Academy of Child and Adolescent Psychiatry (2004), Practice parameters for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities. *J Am Acad Child Adolesc Psychiatry*(in press)

American Academy of Child and Adolescent Psychiatry (2000), Talking Points on Seclusion and Restraint (S&R) of Children and Adolescents

Masters, K. De-escalation Programs: The Whole Enchilada? *AACAP News*. June 106-107

McDonnell, AA, Sturmey, P. (2000) The Social Validation of Three Physical Restraint Procedures: A Comparison of Young People and Professional Groups. *Research and Developmental Disabilities*. Vol 21(2)Mar-Apr, 2000, 85-92. Elsevier Science, Netherlands

Mohr, WK, Petti, TA, Mohr, BD (June 2003), Adverse Effects Associated with Physical Restraint. *Can J Psychiatry* Vol.48, No. 5, 330-337

Petti, TA (2002) Seclusion and Restraint: A Paradigm Shift for the Millennium, *AACAP News* 1:24-27

Author

Louis J. Kraus, M.D.
 Chief, Child and Adolescent Psychiatry
 Rush University Medical Center
 1720 West Polk Street
 Chicago, IL 60612

Chapter IX

Meeting the Educational Needs of Incarcerated Youth

By Graeme Hanson, M.D.

Students with disabilities are overrepresented in the Juvenile Justice system. Youth with learning disabilities and emotional disturbances are arrested at higher rates than nondisabled students and in each category constitute approximately 40% of incarcerated youth. The exact numbers of youth in need of special education services are difficult to determine; many youth with learning disabilities and/or emotional disabilities are not identified or evaluated, especially once incarcerated. More than one third of youth entering correctional facilities have previously received special education services.

It is especially important in the early phases of the legal proceedings involving youth with identified or potential special education needs that these needs be thoroughly evaluated. Information about the youth's learning difficulties and emotional problems can influence the outcome of the legal proceedings. Juvenile courts have flexibility in deciding how to proceed with cases, and the outcome can be significantly influenced by the court's understanding of the child's particular educational and psychological needs. A juvenile court judge could decide to continue the case if the judge determined that the special educational needs of the youth could be best met in the child's community.

If the juvenile court petition involves a youth with an identified or suspected disability, juvenile justice professionals should first consider whether school-based special education proceedings could provide services or other interventions that would obviate the need for juvenile court proceedings. (Special Education in Juvenile Delinquency Cases, *Juvenile Justice Bulletin*, July 2000)

Alternatively, first-time offenders whose alleged offenses are not very serious could be placed in diversion or informal supervision programs with specific requirements, which may allow for the youth to complete special education proceedings and obtain needed services that could eliminate or modify the need for juvenile court proceedings. It may be important for the youth to remain in the community in order to obtain an appropriate evaluation of

his/her educational needs or to continue to receive special education services that cannot be replicated in the juvenile justice system; this would be especially true if remediation of the child's learning problems along with court-mandated supervision could result in the youth's achieving a positive adaptation to the community.

Youth who are incarcerated in juvenile detention facilities, as well as in adult jails, are in need of, and in fact are entitled to, educational programs to facilitate their cognitive and social development, their rehabilitation, and their reentry into the community. *A Desktop Guide To Good Juvenile Detention Practice*, developed by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), provides the following set of rationales for the provision of appropriate educational services to these youth:

Most youth admitted to detention have a history of poor academic performance. They are at higher risk for learning disabilities and emotional disabilities than their community-based counterparts. The detention experience often occurs during a period of crisis for youth, which can serve as a catalyst for change.

State and federal regulations require that all youth up to a minimum age attend school and that their basic educational needs be met. When they have an identified disability/eligibility, they must have an Individual Education Plan (IEP) to meet their educational needs.

Appropriate educational services provide youth enrolled in school with an opportunity to keep current with their studies and facilitate their return to school when discharged. Academic and/or vocational successes help to enhance the youth's chances of employment following release.

Academic success helps youth to see themselves differently, which can lead to enhanced self-esteem and improved problem-solving abilities. It provides youth who are not enrolled in school or who are not interested in education with opportunities to explore a general equivalency diploma (GED), survival skills or life skills, and career or vocational opportunities. (OJJDP, 1999).

Institutional education has a clear, positive effect in reducing recidivism and increasing post release success in employment and other life endeavors. For youth with disabilities, special

education and related services provided through institutional schools are crucially important to that success. (Youth with Disabilities in Institutional Settings, *Juvenile Justice Bulletin*, July 2000)

However, the quality of educational opportunities provided in juvenile detention facilities varies greatly across the country, and from state to state, ranging from relatively comprehensive programs to those that are drastically inadequate. The 1999 Annual Report of the Coalition for Juvenile Justice, titled, *Ain't No Place Anybody Would Want to Be*, describes the deplorable set of conditions in many juvenile facilities, including woefully inadequate educational opportunities.

Many youth advocates, such as Mark Solar of the Youth Law Center, report that in the rush to build more prisons and to incarcerate more juveniles, we are neglecting not only basics such as housing and health care, but also much needed educational and psychological services. (Coalition for Juvenile Justice, 1999).

Success in academic achievement, provided through a good school program in a juvenile facility, should enhance the student's self-esteem, as well as provide capacities and tools for more successful reentry into the community. However, many youth in the juvenile justice system come into the system inadequately educated, and they are often deficient in basic academic skills and abilities. For many of these youth, their previous experience in school has been frustrating and disappointing, leading to a sense of hopelessness and lack of commitment to the educational process.

OJJDP strongly recommends that the educational program be developed jointly by the juvenile justice facility and the local school authority. However, there is a built-in tension between the mandates of the two agencies: one for correction and detention, and the other to provide an education. Smooth collaboration between the two authorities is essential to a successful program and requires intensive oversight and monitoring to ensure that the competing interests are dealt with in a way that does not jeopardize the educational program. OJJDP recommends a liaison be designated to oversee the collaboration between the two authorities.

It is strongly recommended that an interagency agreement between the local school district and the agency that operates the juvenile detention facility be

developed; the different responsibilities of the two groups should be clearly defined in this memorandum of understanding. A number of special issues need to be dealt with in the interagency agreement, including how the program would be funded, what role correctional staff has in providing the discipline and disciplinary actions, and the number of instructional hours per day and days of the year. Basic issues such as materials, equipment, supplies, and space need to be collaboratively worked out. Clarity of reporting lines is essential for school personnel and correctional facilities personnel in those areas where there is some joint responsibility for the day-to-day management of the youth.

IDEA and Incarcerated Youth

All children and youth with disabilities in this country are guaranteed special education as provided first by the Education for All Handicapped Children Act (PL94-142), which was reconfigured and reauthorized in 1997 as the Individuals with Disabilities Education Act (IDEA). Section 504 of the Rehabilitation Act of 1973 protects individuals with disabilities from discrimination and guarantees provisions to assist handicapped individuals in obtaining an education. These statutes guarantee that youth with disabilities shall be provided a free and public education with services provided to enable youth to participate in educational programs. “Congress has made it clear that the responsibility of educating youth with disabilities does not terminate upon incarceration” (Robinson and Rapport, 1999). It is important to bear in mind that special education in correctional facilities is a relatively new field and that there is no single right way to provide special education services, which need to be individualized for each particular student. Yet deliberate indifference is not an acceptable excuse.

Essentially, under IDEA, students with disabilities are entitled to several basic services:

1. Students are entitled to screening, identification, and referral.
2. Each student is entitled to a comprehensive evaluation to determine the extent of the disability and to evaluate what educational services would be necessary for that student.
3. Each student is entitled to an IEP that is developed by a special team that evaluates the student’s particular needs and devises specific interventions to address those needs.
4. Each student is entitled to individually tailored services; the educational services need to be provided in the least restrictive environment.

5. Students with disabilities may also receive “related services,” which help the student with a disability to benefit from special education.
6. IDEA provides procedural protections that ensure that the special education process is fair and proceeds according to statute.
7. IDEA requires that a transition plan be put in place and services be provided when a student transitions from one level of care to another.

Estimates of the prevalence rates for emotional/behavioral disturbances in juvenile justice populations vary widely. A conservative estimate is that somewhere between 20% and 30% of juvenile offenders have diagnosable emotional disturbances. Delinquent youth with emotional disturbances show several characteristics that seem highly correlated with delinquent behavior, including problems in school, disrupted homes, inadequate parental supervision, alcoholism in the family, and low verbal intelligence. The estimate for incarcerated youth who have a degree of mental retardation is estimated to be around 13%; again, this is a strikingly high and discrepant figure in proportion to the general population. Overall, then, nearly 40% of incarcerated youth have some form of disability that significantly interferes with their capacity to learn. Whatever the cause of the disability and the ultimate reason for the delinquent behavior, all of these youth are in need of and are entitled to special education services.

However, there are significant barriers to providing adequate special education services in detention centers, including basic issues such as poor physical facilities, lack of trained and certified special education teachers, and insufficient collaboration between the juvenile justice system and the educational system, especially the special education system. There is a remarkable lack of adequate screening in most facilities, so that many youth enter the system and are never identified as having special education needs. In addition, since many youth who enter the system have had spotty and inconsistent attempts at schooling, their school records are frequently insufficient and not informative to provide sufficient data to lead to an understanding of the child’s particular difficulties.

It is estimated that between 20% and 30% of inmates in adult correctional facilities are youth, and this number is rising. Special education services are even less accessible in adult correctional facilities.

Also, there is inadequate provision for transitional services when a child is leaving the juvenile justice system and reentering the community. There is little preparation and few formalized mechanisms to provide transitional assistance for the youth as they leave the juvenile justice system.

Recommendations for Reform

The proposed recommendations take into account that some youth enter a detention system and are there temporarily, sometimes for a matter of days or weeks only; other youth are incarcerated either in juvenile or adult facilities for extensive periods. Recommendations must address both circumstances.

1. Meet the minimum standards set by federal and state laws for public school programs.
2. Develop stronger ties to public school programs within the community to ensure a smooth transition for youth returning to their community.
3. Provide a comprehensive educational and developmental screening, assessing the possibility of learning disabilities, emotional/behavioral disorders, or cognitive limitations that have an adverse effect on learning for every youth entering the juvenile justice system.
4. Systematically identify all incarcerated youth who have special educational needs. Provide appropriate special education services regardless of whether the youth is confined in a juvenile or adult facility.
5. Provide flexible curricula that include academic, vocational, and social and daily living skills.
6. Maintain year-round education programs to allow for the variability of times when youth enter the facility and leave the facility.
7. Recruit and retain certified special education teachers in each juvenile facility.
8. Encourage the requirement for accreditation of educational programs by educational associations.
9. Maintain an educational program with budgetary and administrative autonomy so that relevant decisions are made primarily with a focus on the education needs of confined children.
10. Provide incentives to school programs that meet improved standards.

References

Ain't No Place Anybody Would Want To Be. (1999) *Coalition for Juvenile Justice, Annual Report*. Washington, DC

Desktop Guide to Good Juvenile Detention Practice. (1996) Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice

Robinson T.R. and Rapport M.J.K. (1999) Providing Special Education in the Juvenile Justice System. *Remedial and Special Education*, 20, 19-26

Rutherford R.B., Sales B.D., and Reid W.H. (2000) Treating Offenders with Educational Disabilities. Treating Adult and Juvenile Offenders with Special Needs. American Psychological Association. Washington, DC

Special Education in Juvenile Delinquency Cases (July 2000), Juvenile Justice Bulletin. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice

Special Education in Correctional Facilities. (1999) The National Center on Education, Disability and Juvenile Justice

Sikorski J (1991), Learning Disorders and the Juvenile Justice System. *Psychiatric Annals*, 742-747

Author

Graeme Hanson, M.D.
1 Mono Street
San Francisco CA 94114

Chapter X

Competency to Stand Trial

By Dawn Dawson, M.D. and Louis J. Kraus, M.D.

The roots of competency can be traced at least to the 17th century. The English courts were faced with defendants who stood mute rather than make the required plea. The court would then have to decide whether the defendant was “mute of malice” or “mute by visitation of God.” If the court thought malice, then increasingly heavier weights were placed on the individual’s chest to force a plea.

The concept of juvenile competency received little attention during the first 60 years of the juvenile justice system’s history. It was not thought to be necessary because the proceedings were not adversarial. In the 1960s, the U.S. Supreme Court’s decisions in *Kent v. U.S.* (1966) and *In re Gault* (1967) required that juvenile courts begin providing many of the same due process rights in delinquency proceedings as in adult criminal proceedings. These cases were silent on juvenile competency. However, in the 1980s, one-third of states had recognized, by statute or state law, the legal concept of competency to stand trial in juvenile court.

Current Status

The idea that persons in a trial must be able to defend themselves in a court of law is integral to preserving the integrity of the court. The concept of competency to stand trial recognizes that a person’s mental state or disability may interfere with that person’s right to a fair trial. Fundamental fairness requires that defendants who truly are disabled in their ability to mount a defense should not be placed in jeopardy.

The U.S. Supreme Court has on several occasions stated that the right of an incompetent defendant to avoid trial is “fundamental to an adversary system of justice.” These holdings have been based on the due process clause but also involve the Sixth Amendment, which guarantees criminal defendants the right to effective counsel, confront their accusers, and present evidence. Competency is fundamental to our justice system, which is a trial between evenly matched adversaries, and through this discourse, facts relevant to the case emerge.

The legal standard of competency to stand trial may be best understood by a review of the law. In *Dusky v. United States* (1960), the U.S. Supreme Court set forth a definition of competency to stand trial that is the usual standard in federal court and many state jurisdictions. The Court stated, “The test must be whether he (the defendant) has sufficient present ability to consult with his attorney with a reasonable degree of rational understanding and a rational, as well as factual, understanding of proceedings against him.” *Drope v. Missouri* states, “A person lacks competency to stand trial if he or she lacks capacity to understand the nature and object of the proceedings, to consult with counsel, and to assist in preparing his or her defense.” The issue of juvenile competency is evolving and varies from state to state.

An intelligent guilty plea requires not only an understanding of the legal process and the ability to communicate information, but also the capacity to make a decision in light of that understanding.

Two key facets of the construct of competency suggest which abilities to consider in the assessment of an individual’s competency. The first is the trial context, which may vary among cases, and necessary abilities or demands on an individual, which may also vary from case to case. Competency may also be viewed in a relationship context in which the individual’s ability to communicate and understand one’s counsel in order to assist with one’s defense determines competency. In general, competency to stand trial focuses on ability to understand information and to reason with it, for example, plea-bargaining.

The U.S. Supreme Court has held that the trial court must order an inquiry into competency if a “bona fide doubt” exists as to the defendant’s competency. In deciding whether any doubt exists, the trial court must take into account and weigh any factor suggestive of mental illness. In general, the defense, the prosecution, or the judge may raise the question of a defendant’s competency at any stage in the criminal proceeding. Judges are allowed considerable latitude in determining whether there is a “bona fide doubt” of competency.

When the competency evaluation is requested, typically a psychologist or psychiatrist is appointed by the court to perform the examination. However, judges do not use “experts” in all competency evaluations. Sometimes brief screening procedures are used, the defendant is put into an inpatient setting for the evaluation, or the defendant is evaluated as an outpatient.

The examiner has an ethical and legal obligation to inform the defendant prior to the examination about the purpose of the evaluation, the potential uses of disclosures made during evaluation, conditions under which the prosecutor will have access to information from the evaluation, and the consequences of the defendant's refusal to cooperate in the evaluation.

Judicial practice does not always require a formal hearing on the defendant's competency. The expert offers psychological evidence about a defendant's mental condition or abilities, but the judge determines the ultimate legal question of a defendant's ability to stand trial. Federal Rules of Evidence permit mental health experts to testify to the ultimate legal question of a defendant's pretrial competency.

With regard to disposition and provision of treatment, *Jackson v. Indiana* (406 U.S. 715, 1971) is a great influence. The ruling in Jackson was that incompetent defendants could not be held for treatment longer than the nature of their disorder warranted. When the disorder cannot be treated, the defendant cannot be committed or tried on the criminal charges. The state must either drop the charges or initiate commitment proceedings under that state's civil commitment statute. If the disorder is treatable, usually the defendant is committed to a state mental hospital or forensic treatment facility.

CompetencyCompetency differs from credibility and criminal responsibility. Competency is a question that arises before considering the evidence given by the witness. Credibility concerns the quality in a witness that renders his evidence worthy of belief. Criminal responsibility involves an investigation of the defendant's thought processes and behavior before and during the alleged crimes.

Neither mental illness, mental retardation, nor amnesia for the alleged event automatically represents incompetency. These may be circumstances under which competency should be assessed. Others might be age of 12 years or younger, prior treatment for mental illness, record of learning disability, or observed behaviors that strongly suggest deficits in memory or interpretation of reality.

Forensic experts argue as to whether competency in children should be dealt with differently from competency in adults. Although for adults competency

seems to be somewhat well understood, this is not the case for children. There is tremendous variation in how judges in different districts and different states view competency of children. Some believe that a child is competent to stand trial if he or she simply knows who the judge is, the charges, the attorneys involved, and the repercussions of the trial. Other judges and courts have stricter definitions of competency. If a juvenile, in particular a young juvenile, is found not to be competent to stand trial, various issues pertaining to children and placement must be resolved, including those related to best interests of a child, *parens patriae*, the determination of risk to society, and conditions of placement as to whether or not competency can be obtained within a 1-year period.

The Supreme Court is consistent with the concept that competency assessments for children and adults should not be different (re: Gault). However, when one goes to almost any juvenile court, one can see a strong difference. There is tremendous variation in competency assessments. Typically the requirements for juvenile competency are not as stringent as those for adult competency. Developmentally, juveniles may have less abstract reasoning ability but still may be able to understand the key concepts necessary for competency. This is particularly important when a juvenile is found to be competent to stand trial in juvenile court and then because of transfer or waiver is sent into adult court. As such, juveniles should be, but typically are not, reassessed for competency to stand trial in adult court, which would have more stringent requirements. This could result in using adult competency principles to justify reverse waiver; that is, it may be possible that a child could be assessed competent to stand trial in juvenile court but perhaps not competent to stand trial in adult court. This is an area that has not been significantly studied, but is one that needs to be addressed.

Grisso et al. showed that children under the age of 14 have the strongest likelihood of not being competent to stand trial. Other issues related to an increased likelihood of incompetency would include lower IQ, significant learning disabilities, developmental immaturity, deficits in abstract reasoning ability, impulsiveness, and significant psychopathology.

Competency assessments should include participation by parents, a developmental context with specific focus on cognitive abilities, a determination of how a present mental condition may impact cooperation with legal counsel or testimony, a review of school records, and a review of legal records.

Many children who are in the juvenile justice system are found to be incompetent to stand trial for a variety of reasons. Many of the deficits and developmental delays that have resulted in a child's being determined not competent to stand trial can be helped. However, treatment and restoration to competency programming are often superficial and, at best, may offer a holding environment for the child or allow the child to memorize certain operating procedures of the court. It is important that these programs also attempt to address areas of deficit and developmental needs for the child.

Recommendations for Reform

1. Establish national competency standards for juveniles that include a developmental framework.
2. Require training for judges, defense attorneys, prosecuting attorneys, and other court officials in the area of child development and then assist them in understanding how the specific areas of development are related to competency.
3. If it is determined that a youth is incompetent, make better services available to help restore the youth to competency. Currently few programs are available that can help with this process in any consistent way.

References

Black's law Dictionary, Sixth Edition, West Publishing Co.

Grisso T, Vincent G. (2005), Mental Health Screening and Assessment. Guildford Publications

Grisso T (1988), Competency to Stand Trial Evaluations: A Manual for Practice. *Professional Resource Exchange*

Grisso T (1986), Evaluating competencies, Forensic Assessments and Instruments, Perspectives in Law and Psychology, Plenum Press

Grisso T (1988), Forensic Evaluation of Juveniles. *Professional Resource Exchange*

McKee GR, Shea, SJ, (1999), Competency to Stand Trial in Family Court: Characteristics of Competent and Incompetent Juveniles. *J Am Acad Psychiatry Law* 27:65-73

Melton G, Petrila J, Poythress NG, Slobogin C (1997), Psychological Evaluations for the Courts: Second Edition, Guilford Press

Author

Dawn Dawson, M.D.
1304 Chinook Lane
Pueblo, CO 81001

Louis J. Kraus, M.D.
Chief, Child and Adolescent Psychiatry
Rush University Medical Center
1720 West Polk Street
Chicago, IL 60612

Chapter XI

Transfer of Juvenile Cases to Criminal Court

By Christopher R. Thomas, M.D.

Introduction

One of the more important changes in juvenile justice over the past decade was the modification and increasing use of transfer of juvenile cases to adult criminal courts. Where transfers were previously handled on a case-by-case basis, most are now required. *The mandatory transfer of cases undermines a principal tenet of juvenile justice, that an individualized approach is the best way to handle youth offenses.*

Background

Beginning in the 1980s, states changed the handling of juvenile cases to facilitate transfer from juvenile to criminal courts in response to rising youth violence and crime. This was in part based on beliefs that juvenile courts did not work and that more serious and violent juvenile offenses would be better handled as adult cases in criminal courts.

There are several methods in which cases can be transferred, including judicial waivers, prosecutor discretion, and statutory exclusion.

Judicial waiver is accomplished by three means: discretionary, presumptive, and mandatory. Discretionary judicial waiver permits the judge to transfer the case after certain criteria have been satisfied. In most cases, the prosecutor initiates this process and bears the burden of proof. The criteria usually include consideration of the juvenile's age, charges, history of offenses, chance for rehabilitation, and public safety, established by *Kent v. United States*. Presumptive judicial transfer represents a major modification that shifts the burden of proof from the prosecutor to the juvenile. In other words, the defense must prove why a judge should not have the case transferred to criminal court and that the youth would best be handled in the juvenile court. Mandatory judicial waiver removes any opportunity to argue the merits of transfer, requiring the judge only to determine whether the case meets criteria set by law for waiver.

Concurrent jurisdiction (also referred to as prosecutor discretion or direct file) is another means by which the prosecutor is allowed the decision to file a case

in juvenile or adult criminal court. Laws establish jurisdiction for certain types of offenses in both courts and permit the prosecutor to determine which court will try a specific case. While it is similar to mandatory judicial waiver, it removes judicial review from the transfer process.

Statutory exclusion laws require juvenile defendants to be tried in adult criminal courts when charged with certain offenses. Most often, this transfer is for serious or violent offenses and will specify additional restrictions, such as age or prior offense record.

These changes have contributed to an overall increase in the number of cases transferred from 6,800 in 1987 to 10,000 in 1996 (Stahl), and the number of youth in adult prisons has doubled in the past decade (Austin et al.). Where previously the majority of cases were transferred by judicial waiver, most are now by statutory exclusion. Research on the impact of these changes indicates that they have not improved the handling of delinquents and that there are many unintended consequences. One extensive review of long-term outcome for youth tried in criminal courts compared with those tried in juvenile courts found that transfer resulted in extensive delay of case processing without necessarily providing longer sentences (Fagan). A study on the impact of new transfer laws in Pennsylvania found that many cases that would have been previously handled in juvenile court were now sent to criminal court, such as younger offenders or ones with less serious offense histories. However, half the cases targeted for exclusion were either returned to juvenile justice or dismissed. The end result was that the change produced longer delays (Snyder & Sickmund). Independent of new transfer laws, the use of judicial waiver has changed. Studies have found that the use of judicial waiver has increased and that petitions for transfer are more likely to be granted (Snyder & Sickmund). Recent studies find that youth tried in adult criminal court have significantly higher rates of recidivism and are more likely to be victimized, physically and sexually, than youth tried in the juvenile justice system (Elliot et al.). A 5-year study in Florida of 475 matched pairs of young offenders found that those handled by the criminal court had higher rates of felony recidivism and that the second offense was more serious (Florida Department of Juvenile Justice). Minority youth are disproportionately affected by transfer to criminal court. A California study found that minorities comprised 95% of youth transferred to criminal court and that minority youth were twice as likely to be transferred for violent offenses as white youth (Males & Macallair). The same study found that among youth tried in criminal court, black and Asian youth were more likely to be imprisoned than white youth.

Transfer to criminal court can also result in youth being exposed to adult criminals and having access to fewer services that address their needs. There is also no evidence of any deterrent effect with adult criminal court waiver statutes. Several studies have found no change in rates of delinquency following enactment of such laws (Singer et al.)

Alternatives

Some states have provided judges with the option of using sentences from both the juvenile and criminal system. One method allows judges to select the system that is most appropriate for disposition based on the individual case. Another approach allows judges to impose concurrent or sequential sentences from both systems. While this option preserves the flexibility and resources of the juvenile system, it is relatively new and there is no information about its use or impact.

Other states have enacted reverse waiver laws that allow the criminal court to transfer direct file or excluded cases back to juvenile court for adjudication or disposition, usually on a motion from the prosecutor. While reverse waiver might offer the option of individual protection in excluded cases, there is no guarantee that it will be exercised, and even when used it will result in additional delays.

Summary

Clearly, the boundary between juvenile justice and criminal courts has changed for youth in the past decade. There is no evidence that automatic or mandatory transfer to criminal court improves community safety or reduces recidivism. Nor does it provide the individualized approach and services of juvenile justice. Transfer to adult criminal court also contributes to delays in sentencing and potentially exposes youth to adult criminals. The opportunity for rehabilitation in juvenile justice requires that the sentence fit the youth, not the crime. Rather than increasing the restrictions on juvenile justice with mandatory transfer to adult criminal court, greater options should be created to improve the ability to respond to each youth on an individual basis.

Recommendations for Reform

1. Transfer to adult court should not be automatic or a presumption in the handling of juvenile cases. While further study is necessary, current research indicates that automatic transfer does not achieve the desired

goals and may be potentially harmful to the community and the involved youth.

2. Any transfer to criminal court should consider the individual case and the community, and not be based solely on the type of offense. Consideration of the case should include the mental health of the youth and its bearing on the charges. This may require consultation from mental health professionals.
3. To develop a more effective juvenile justice system, further study must be devoted to exploring alternatives to transfer to criminal court.

References

Austin, J, Johnson, K, Gregoriou, M (2000), Juveniles in adult prisons and jails: a national assessment. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention

Elliot, D., Hatot, N., Sirovatka, P (eds.) (2001), Youth Violence: a Report of the Surgeon General, Washington, DC: US Public Health Service

Fagan, J (1996), The comparative advantage of juvenile versus criminal court sanctions on recidivism among adolescent felony offenders. *Law & Policy* 18:77-113

Florida Department of Juvenile Justice (2002), A DJJ success story: trends in transfer of juveniles to adult criminal court

Griffin, P, Torbet, P, Szymanski, L (1998), Trying juveniles as adults in criminal court: an analysis of state transfer provisions. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention

Males, M, Macallair, D (2000), The color of justice: an analysis of juvenile adult court transfers in California. Washington, DC: US Department of Justice, Office of Justice Programs

Singer, S (1996), Recriminalizing delinquency: violent juvenile crime and juvenile justice reform. Cambridge: Cambridge University Press

Snyder, H, Sickmund, M, Poe-Yamagata, E (2000), Juvenile transfers to criminal court in the 1990's: lessons learned from four studies. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention

Stahl, A (1999), Delinquency cases waived to criminal court, 1987-1996. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention

Author

Christopher R. Thomas, M.D.
UTMB/Department of Psychiatry
301 University Blvd.
Galveston, TX 77555

Chapter XII

Juvenile Sex Offenders

By Wade C. Myers, M.D.

Background

Juvenile sex offenders are a heterogeneous group – more so than their adult counterparts because of developmental influences – with widely varying etiologies, acts, and outcomes (Kaplan, 1999). Their behaviors are a significant concern to American society. For instance, it is estimated that youth under the age of 18 account for 17% of forcible rape arrests (FBI, 2002), 17% of other sex crimes (Greenfield, 1997), and up to 50% of child molestations (Hunter, 2000). The typical juvenile sexual offender is an adolescent male who also has a history of nonsexual offenses. In about one-half to three-quarters of cases, he himself will have been sexually abused (Hunter and Becker, 1998). Victims are usually younger females that are relatives or acquaintances of the perpetrator.

Etiology

Research findings point to a number of commonalities among juvenile sex offenders that likely contribute to their expression of sexual aggression. Purported causal factors include a history of impaired family functioning, self-esteem deficits, poor social skills, decreased impulse control, mental disorders, substance abuse, school difficulties, learning disorders, lack of empathy, deviant sexual interests, and sexual and physical abuse (Becker and Hunter, 1993; Shaw, 1999). Additionally, violent male role models and exposure to pornography have also been implicated. None of these factors in and of themselves explain sexual offending, and many youth with these characteristics do not sexually offend.

Management and Treatment

As noted above, juvenile sex offenders are a heterogeneous group and consequently there is no single management or treatment approach applicable to them as a whole. A carefully designed, multimodal treatment plan developed from a thorough assessment of the individual child is ideal. Depending on the type of offender, the treatment may be limited or extensive in scope. In some instances a short-term, community-based program will be deemed adequate and safe. For other youth, their management and treatment will be a long-term undertaking involving their removal from the community

to attend years of intensive residential treatment (Hunter, 1999). As a general rule, treatment of the juvenile sex offender should address all factors that contribute to antisocial behavior, not just those that appear directly related to the sexual offending.

The mainstay of most juvenile sex offender treatment programs has been group therapy. Also commonly employed are cognitive-behavioral psychotherapeutic approaches, behavioral therapy to reduce deviant sexual arousal and increase appropriate sexual arousal, family therapy, psychoeducation, social skills training, empathy awareness training, substance abuse treatment, and community-level interventions (e.g., academic assistance, juvenile justice supervision). There is also a growing body of research on the use of pharmacological therapies. For instance, selective serotonin reuptake inhibitors can help control the obsessive thinking patterns and compulsive behaviors of sexual offenders, and antiandrogens can be useful by decreasing the sexual drive and thus paraphilic urges and behaviors. Efforts to decrease the offenders' level of denial and to promote acceptance of responsibility for their sexual offenses are also important ingredients. Additionally, external motivation from the court system, such as suspended adjudication in exchange for treatment completion, can also be useful in appropriate cases. Treatment programs typically employ some combination of the therapeutic interventions listed above.

What About Recidivism?

A significant number of youth who commit sexual offenses develop a course of chronic, more serious offending (Hunter, 1999), although this is an elusive figure to determine with confidence. Working backward, it is generally held that most chronic adult sexual offenders experienced deviant sexual thoughts and committed sexual crimes as juveniles (Abel, Becker, Cunningham-Rathner, Mittelman, Murphy, & Rouleau, 1987; Berliner, 1998).

One of the difficulties in assessing treatment outcomes is accurately determining rates of recidivism. Rearrest rates are spuriously low indicators of recidivism rates. First, most offenders are not caught and arrested for any given offense, so many crimes go undetected. Second, self-report measures are dependent on the reporter answering honestly and thus can be unreliable, as the average respondent will face at least some trepidation in admitting he or she has committed a sex crime given the legal consequences for such behavior. This is especially true in a population that has an increased risk for antisocial attitudes and thus deceitfulness.

Treatment results for juvenile sexual offenders have been variable, with recidivism rates generally in the range of 10% to 15% at follow-up intervals of 1 to 6 years depending on the study (Becker, 1990; Bremer, 1992; Hunter, 1999; Sipe, Jensen and Everett, 1998). However, in a study of 19 sexually assaultive male juveniles who were incarcerated without treatment, 37% sexually reoffended one or more times during the 8-year follow-up period (Rubenstein, Yeager, Goodstein, and Lewis, 1993). Moreover, 89% of them had been rearrested for other kinds of violent offenses.

Based on these and related studies, we can expect differing recidivism rates for youth related to both the presenting sexual offense and underlying offender characteristics. What is increasingly evident is that sex offender treatment for youth, while not eliminating their risk of future sex crimes, does lower the rate of recidivism (Borduin, Henggeler, Blaske and Stein, 1990; [Hanson and Bussiere, 1998](#); Worling and Curlen, 2000). Not unexpectedly, youth who drop out or otherwise do not finish sex offender treatment are at increased risk compared with completers. Juveniles with violent sex offenses, multiple past sex offenses, elevated levels of psychopathy, and sexual sadism or other paraphilic disorders are considered to be at greatest risk for becoming serial sex offenders.

Legislative Issues

The U.S. Supreme Court upheld the constitutionality of violent sexual predator commitment proceedings for prisoners who have completed their penal sentences (*Kansas v. Hendricks*, 1997). This proceeding results in some offenders being placed in state civil facilities for an undetermined period of treatment rather than being paroled into the community if they are deemed to still pose a serious danger to society. Statutory language commonly refers to whether the person suffers from a “mental abnormality or personality disorder” that makes him likely to commit sex offenses if not confined in a secure setting for long-term control, care, and treatment.

Certainly juvenile sex offenders must be held accountable for their actions. Nonetheless, the blanket application of sexual predator laws to juvenile sexual offenders raises concerns. At a minimum, the appropriateness of such an intervention for a particular youth should be viewed from a developmental standpoint along with familial, peer, and community influences taken into account that may have been contributory at the time of the crime. Moreover, juvenile sexual offenders are still developing their psychosexual identity,

have immature personality formation, and are psychologically dependent on their family systems. Therefore, they may be more amenable to community treatment. Less restrictive alternatives that would better facilitate their reentry into the community, and not placing them around older, more sophisticated adult sexual offenders in facilities, should be considered whenever possible.

Another legislative issue concerning juveniles is community notification laws that allow law enforcement to notify the public of the whereabouts of sex offenders. These laws generally have not applied to minors adjudicated in juvenile court, where records are sealed, whereas juveniles convicted in adult court for qualifying offenses are subject to adult sex offender registration programs. Momentum for changes in this area is likely given the current uproar by the public and legislative bodies over the recent spate of nationally publicized heinous sex crimes involving children. For instance, Wisconsin recently changed its statutes by enacting the 2005 “Amie’s Law.” Joshua Wade was 14 when he sexually assaulted 8-year-old Amie. After serving time at a boys’ school he was released back to the community and registered as a sex offender. However, the police could not warn anyone about him because he was a juvenile when he assaulted Amie. At the age of 23 Wade was charged with four felony counts of sex crimes against children. Amie’s family was outraged and moved to lobby for the new legislation. Under this legislation, law enforcement officials in Wisconsin can now notify the public about juvenile offenders whom they deem to be dangerous. Other states are also reconsidering notification laws as they apply to minors.

Summary

The research literature to date on juvenile sex offenders remains limited. Current efforts to manage and treat these youth still rely to a significant degree on interventional strategies used for adult offenders. Future studies on etiology, typology, assessment, treatment, and recidivism in youthful populations are needed. Society with its limited resources will be best served if mental health professionals can improve their ability through information from well-designed research studies to identify and provide treatment for those youth most likely to benefit from therapeutic intervention.

Recommendations for Reform

5. Funding for juvenile sex offender research should be increased in three key areas in order to (a) better define subtypes of juvenile sexual offenders, (b) identify those youth who are most likely to be amenable to treatment and those at greatest risk for reoffending, and (c) support further

development and assessment of treatment programs and their effectiveness.

6. Placements for sexually offending youth should be tailored to meet their developmental needs and should include family participation.
7. Placement of minors in treatment programs where they could have contact with sexually offending adults should be avoided.
8. Legislative changes affecting juvenile sex offenders should be monitored to help ensure that modifications are based on reason and scientific evidence rather than on emotion and the desire for retribution.

References

Abel G, Becker JV, Cunningham-Rathner J, Mittelman MS, Murphy, WD, Rouleau JL (1987), Self-reported sex crimes of nonincarcerated paraphiliacs. *Journal of Interpersonal Violence* 2, 3-25

Becker JV (1990), Treating adolescent sex offenders. *Professional Psychology: Research and Practice* 21, 362-365

Becker JV, Hunter JA (1993), Aggressive sexual offenders. *Child and Adolescent Psychiatric Clinics of North America* 2, 477-487

Berliner L (1998), Juvenile sex offenders: Should they be treated differently? *Journal of Interpersonal Violence*, 13, 645-646

Borduin C M, Henggeler S W, Blaske, D M, Stein R J (1990), Multisystemic treatment of adolescent sexual offenders. *Journal of Offender Therapy and Comparative Criminology* 34, 105-114

Bremer JF (1992), Serious juvenile offenders: Treatment and long-term follow-up. *Psychiatric Annals* 22, 326-332

FBI: Crime in the United States 2002 – Forcible Rape. Available at: http://www.fbi.gov/ucr/cius_02/html/web/offreported/02-nforciblerape04.html

Greenfield L A (1997), Sex Offenses and Offenders: An Analysis of Data on Rape and Sexual Assault. US Department of Justice: Bureau of Justice Statistics. Washington, DC

Hanson R.K, Bussiere MT (1998), Predicting relapse: a meta-analysis of sexual offender recidivism studies. *J Consult Clin Psychol* 66, 348-62

Hunter J A (1999), Adolescent sex offenders. In Van Hasselt and Hersen (Eds.), *Handbook of Approaches with Violent Offenders: Contemporary Strategies and Issues*. New York: Kluwer Academic/Plenum Publishers

Hunter JA (2000), Understanding juvenile sex offenders: research findings & guidelines for effective management & treatment. *Juvenile Justice Fact Sheet*. Charlottesville, VA: Institute of Law, Psychiatry, & Public Policy, University of Virginia

Hunter, J Becker, J (1998), Motivators of adolescent sex offenders and treatment perspectives, in J. Shaw (Ed.), *Sexual Aggression*. American Psychiatric Press, Inc, Washington, DC

Kansas v. Hendricks, 117 S. Ct., 1997

Kaplan MS (Jan. 23,1999), Juvenile sex offenders. *Presented as part of the Conference entitled, "Sex, Psychiatry, and the Law."* New York, NY.

Rasmussen LA (1999), Factors related to recidivism among juvenile sexual offenders. *Sexual Abuse: A Journal of Research and Treatment* 11, 69-85

Rubinstein M, Yeager C A, Goodstein C. Lewis D O (1993), Sexually assaultive male juveniles: A follow-up. *American Journal of Psychiatry* 150, 262-265

Shaw J A (1999), Male adolescent sexual offenders. In J. A. Shaw (Ed.), *Sexual Aggression* 169-194

Sipe R, Jensen E L, Everett R S (1998), Adolescent sexual offenders grown up: Recidivism in young adulthood. *Criminal Justice and Behavior* 25, 109-124

Worling JR, Curwen T (2000), Adolescent sexual offender recidivism: success of specialized treatment and implications for risk prediction. *Child Abuse and Neglect* 24, 965-82

Author

Wade C. Myers, M.D.
Department of Psychiatry
University of Florida
8900 NW 39th Avenue
Gainesville, FL 32606

Chapter XIII

Juvenile Death Sentences

AACAP Policy Statement

Approved by AACAP Council, October 24, 2000

Prevalence of Mental Illness in the Juvenile Justice Population

The United States is one of the few countries in the world that executes juveniles, and, since 1990, it has executed 10 persons for crimes committed prior to age 18. Juveniles constitute approximately 2% of total death penalty sentences, and, as of June 1999, there were 70 persons on death row for crimes committed at age 16 or 17. With the increasing trend of waiving juvenile offenders to the adult court and imposing harsher sentences than in the past, these numbers can be expected to rise. In 1988, the U.S. Supreme Court in *Thomson v. Oklahoma* decided that the Eighth Amendment prohibited the execution of persons younger than 16 years of age at the time of their crimes. The United States remains the only country in the world that has not yet ratified the UN Convention, Article 37a, which states that "Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offenses committed by persons below eighteen years of age."

Our society recognizes that juveniles differ from adults in their decision-making capacities as reflected in laws regarding voting, driving, access to alcoholic beverages, consent to treatment, and contracting. For the following reasons, special consideration for crimes committed prior to age 18 should be made. Adolescents are cognitively and emotionally less mature than adults. They are less able than adults to consider the consequences of their behavior, they are easily swayed by peers, and they may show poor judgment. We also know that teens that have been victims of abuse or have witnessed violence may show increased levels of emotional arousal and a tendency to overreact to perceived threats. Victims of child abuse and neglect are overrepresented among incarcerated juveniles, including those on death row. Studies of this population consistently demonstrate a high incidence of mental disorders, serious brain injuries, substance abuse, and learning disabilities, which may predispose to aggressive or violent behaviors. In many instances, these juveniles have not received adequate diagnostic assessments or interventions. National statistics also indicate that African American and Hispanic youth are

disproportionately diverted into juvenile correctional facilities and waived to the adult criminal court system.

The pattern of the use of the death penalty indicates discrimination against the poor who do not have equal access to adequate legal representation. The death penalty is associated with an unavoidable risk of error, and its deterrent value has yet to be demonstrated. It is particularly unlikely to deter adolescents from crime, as they tend to live in the present, think of themselves as invincible, and have difficulty contemplating the long-term consequences of their behavior.

The philosophy of the juvenile court has always been rehabilitation. This goal is now made more attainable than ever by improved assessment tools, new effective community-intervention programs, and treatments for underlying psychiatric disorders. However, such efforts are often undermined by the diversion of scarce dollars into incarceration, long sentences, and the death penalty rather than into earlier intervention efforts and strengthening the juvenile justice system so that it can effectively respond to dangerous and/or repeat youth offenders to ensure public safety.

Therefore, the American Academy of Child and Adolescent Psychiatry strongly opposes the imposition of the death penalty for crimes committed as juveniles.

Addendum:

On March 1, 2005, the U.S. Supreme Court decided the case of *Roper v. Simmons* (543 U.S., 2005). Simmons, at age 17, committed a capital murder and a year later was tried in 2000 and sentenced to death. His crime was callous, yet he had no prior convictions or charges against him. In light of the subsequent Atkins decision (*Atkins v. Virginia* 536 U.S. 304 2002) forbidding execution of the mentally retarded, Simmons petitioned the Missouri Supreme Court and argued for postconviction relief. Simmons argued that the reasoning (regarding lessened culpability in certain classes of persons) used in Atkins prohibited the execution of juveniles. The Missouri Supreme Court agreed and set aside his death sentence, instead giving Simmons a sentence of life imprisonment without probation or parole. The Missouri Court noted “a national consensus has developed against the execution of juvenile offenders, as demonstrated by the fact that eighteen states now bar such executions of juvenile offenders, as demonstrated by states that bar executions altogether, that no state has lowered its age of execution below 18 since *Stanford*, that

five states have legislatively or by case law raised or established the minimum age at 18, and that the imposition of the juvenile death penalty has become truly unusual over the last decade.” (112 S. W. 3d at 399)

The U.S. Supreme Court sided with the Missouri Supreme Court, noting the national consensus against the death penalty for minors and the developmental immaturity of juveniles which renders them as a class less culpable than the average adult criminal. Three specific differences are cited in the Court’s decision including juvenile’s “underdeveloped sense of responsibility,” vulnerability to peer pressure and outside influences and the fact that their personality traits are more transitory and less fixed (pp. 15–16). The Court opined that the Eighth and Fourteenth Amendments forbid the imposition of the death penalty on offenders who were under the age of 18 when their crimes were committed. The Court further stated, “In concluding that neither retribution nor deterrence provides adequate justification for imposing the death penalty on juvenile offenders we cannot deny or overlook the brutal crimes too many juvenile offenders have committed.” (p. 18)

Chapter XIV

Alternatives to Adjudication: Drug Courts, Mental Health Courts, and Peer Courts

By Carol Kessler, M.D.

Current Concerns

The traditional adjudication process is met with widespread difficulties, which has sparked creation of innovative alternative court structures targeting root causes of youth entry into and maintenance in the juvenile justice system. The causes include mental illness, substance dependence, family disruption, and negative peer influences.

Though studies are few, youth in the juvenile justice system have been shown to have a prevalence as high as 60% of mental disorders – i.e., posttraumatic stress disorder, depressive disorder, learning disorders, developmental disorders, and substance abuse/dependence. Those few mental health treatment resources available in the community have not engaged these youth. They may have been arrested for behaviors symptomatic of undiagnosed and untreated mental illness. Incarceration in overcrowded facilities with threats of violence may exacerbate an underlying mental disorder that is unlikely to be identified or treated due to lack of sufficient mental health professionals in detention facilities.

Those youth offenders who do receive mental health or substance abuse treatment while detained often fail to be linked to effective aftercare in communities with sparse treatment resources. They tend to be transitioned back to unchanged family structures and peer networks that may perpetuate those behaviors that lead to recidivism.

Creative Solutions

In response to correctional overcrowding, delay in processing cases, and frustration with ineffective case dispositions, the problem-solving court model was established to coordinate between justice, mental health consumers and providers, and community agencies. Adult drug courts have evolved nationwide since their inception in Miami in 1989, and their success has inspired the fashioning of adult mental health courts, juvenile and family drug courts, peer/youth/teen courts, domestic violence courts, and community courts. These holistic courts integrate efforts of justice and mental health

professionals to fashion treatment plans, whose implementation is supervised by judicial authority.

Juvenile drug courts have operated since April 1996, and they receive federal funding through Public Law 103-322. Youth entering the justice system charged with nonviolent drug-related offenses and/or exhibiting substance abuse or dependence are identified in a timely manner, preferably at arrest or through screening upon detention. A thorough, culturally competent, gender-sensitive clinical evaluation of the young person and his/her family is performed. In the courtroom, a team of judge, law enforcement official, prosecutor, defense attorney, detention liaison, and mental health professional devise a community-based treatment plan that addresses the young person's educational, family, and mental health needs. The drug court team coordinates with school, community mental health services, and other community agencies. Parents are engaged in parent groups and through periodic home visits. Periodic judicial monitoring and random urine drug screening ensures youth and family adherence, as well as community agency accountability to the treatment plan. The judge also motivates the youth, praising his/her progress and applying such sanctions as brief detention for nonadherence to treatment plans. Juvenile drug courts such as that of Escambia County in Pensacola, Florida, have demonstrated that their intense supervision and treatment/rehabilitation requirements support youth in a path toward sobriety, educational achievement, and positive peer relationships. Indeed, more than 80% of juvenile drug court participants return or remain in school full-time.

Family drug courts have been created to respond to the needs of families where substance-abusing parents face charges of child abuse or neglect and/or where guardianship is an issue. Since children of substance-abusing parents are at high risk, these courts engage youth in such preventive efforts as group therapy. Interventions aim to be culturally competent and community-based.

The drug court model has been adapted to address the needs of mentally ill individuals in the criminal justice system, many of whom also suffer from substance dependence. Broward County, Florida, paved the way in June 1997 and inspired King County, Washington, Anchorage, Alaska, and San Bernardino, California, to follow suit. Their effectiveness has led to the enactment of Public Law 106-515, which grants federal funding for the establishment of up to 125 mental health courts nationwide. Mental health courts aim to screen and thereby identify mentally ill offenders at arrest or upon confinement. Those offenders who are deemed competent and opt to

participate are diverted into residential or community-based integrated services, as determined by a team consisting of prosecutor, public defender, defense attorney, judge, jail liaison, probation officer, case manager, and mental health professional. Optimally, these professionals have received cross training so that they can proficiently function in both justice and mental health systems and discourse. A holistic treatment plan addressing vocational, educational, housing, health, and mental health needs of the offender is collectively fashioned. The consumer and his/her family are urged to be active in this process. Adherence to the plan by the client and the court-appointed service agencies is monitored by regular court appearances. Success leads to dismissal of charges and links to aftercare. Mental health courts have been deemed efficient and cost-effective, reducing jail time and recidivism rates, and in the words of Howard Finkelstein, Chief Assistant Public Defender, they have “brought humanity to people who have been abused by the criminal justice system for way too long” (Mental Health Court Progress Report, 7/97–6/98). In Santa Clara County, California, the mental health court model has been adapted to the juvenile justice population, with the hope of reversing a trend of “criminalization” of mentally ill youth. In February 2001, Supervising Judge Raymond Davila launched his efforts to create a model of “more humane, compassionate and effective strategies” that might address the needs of mentally ill youth offenders.

A unique alternative adjudication process functions in the 650 youth or peer courts, which have grown to become an integral part of the juvenile justice system nationwide. These courts are based in schools, probation departments, juvenile courts, or private, nonprofit agencies. They are supported by the National Youth Court Center (NYCC) in Lexington, Kentucky, which was established in 1999 as a clearinghouse, database, and resource for training, evaluation, and establishment of national guidelines. Peer courts aim to educate, motivate, and empower youth and to hold youth accountable for their actions through restorative, rather than punitive justice. Peer courts are staffed and managed by youth, with youth serving as defense attorneys, prosecutors, jury, court bailiff, and, in some instances, judge. Peers who do not condone delinquent behaviors thereby hold young offenders accountable. Offenders learn about the judicial and legal systems, and they learn to resolve conflict through listening and problem-solving skills. Young people learn of the impact of their behavior on themselves, their peers, and their community, and they learn of their potential to be agents of both self-improvement and community improvement. They are sentenced, not to incarceration, but to restorative action based in the community, that emphasizes the moral duty to

repair the harm that they have inflicted. Such restorative action might include writing a letter of apology or engaging in community service. Youth are also linked to educational, vocational, and/or mental health treatment resources to address those unmet needs that may have led to involvement with the justice system. Successful completion of the peer court's sentence leads to dismissal of charges. Peer courts have demonstrated themselves to be cost-effective and boast low recidivism rates. The South Bronx Community Justice Center's Youth Court in New York City claims 5% recidivism at a mere cost of \$300–\$500/youth/year. Youth courts also create the invaluable links of offenders to community agencies, where through mandated service, youth are empowered to positively influence their environs and communities are empowered to reclaim and nurture their young people's invaluable gifts (American Probation and Parole Association).

Problem-solving courts – mental health courts, drug courts, and peer courts – all rely on diversion from juvenile court. Success requires coordination with community-based treatment programs. Where available, community-based programs have proved to offer safe, successful, and cost-effective alternatives to institutional care for many youth in the juvenile justice system. Over the past 25 years, successful programs have been developed to serve a wide variety of children with differing degrees of mental illness and legal involvement. These programs operate throughout the country and serve youth of diverse backgrounds in their neighborhoods with staff of similar backgrounds. Positive outcome data have been reported in urban, suburban, and rural programs.

Two approaches with demonstrated efficacy are multisystemic therapy (MST) and wraparound (WA). MST research on youth with serious antisocial behavior demonstrates improvements in severity of psychiatric symptoms, recidivism, and substance abuse. WA outcome data from diverse and unrelated programs have demonstrated similar improvement. Wraparound Milwaukee is a large-scale collaborative program supported by pooled funds from its system partners. Wraparound Milwaukee reports positive data on clinical outcomes, recidivism rates, psychiatric admissions, and rates of overall placement. Youth Advocate Programs is a multistate nonprofit organization that contracts directly with local juvenile justice and child welfare authorities. Youth Advocate Programs reports positive data from different programs in New Jersey, Pennsylvania, and Texas on recidivism, felonious recidivism, overall placement rates, and successful completion of probation. Community-based programs with demonstrated success have been

very willing to aid underserved areas to develop their own programs tailored to the individual needs of the children they serve. Integration of community-based programs with centralized judicial monitoring in problem-solving courts is a promising alternative to traditional adjudication processes that have been failing youth, families, and communities.

Recommendations for Reform

1. Federal law (Public Law 106-515) should be expanded to provide grants to develop youth mental health courts adapted from established mental health courts for adults, yet addressing the developmental, educational, and family needs of youth.
2. Availability of funds through federal law (Public Law 103-322) should be publicized so that the successful juvenile and family drug court model can be replicated.
3. A central database, resource center, and informational clearinghouse of juvenile and family drug courts should be established to facilitate exchange of resources and to provide training and support to newly developing programs.
4. Federal funding should be granted to establish a broader network of community-based treatment programs that have proven effective – i.e., Multisystemic Therapy and Wraparound.
5. Timely, culturally competent, gender-sensitive screening for mental illness, including substance abuse, should be provided upon arrest or upon confinement.
6. Mental health treatment should be supervised and continually monitored by the judge of a problem-solving court, to ensure service provision and client participation.

References

American Probation and Parole Association. Peer Justice and Youth Empowerment: An Implementation Guide for Teen Court Programs. Cayce, James D. and Burrell, Kari. (June 1999). King County's Mental Health Court – An Innovative Approach for Coordinating Justice Services. *Washington State Bar News*

Bureau of Justice Assistance. (April 2000), Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts. Monograph available at www.ncjrs.org/txtfiles1/bja/182504.txt.

Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project at American University. Juvenile and Family Drug Courts: An Overview. Monograph available at www.ojp.usdoj.gov/dcpo/.

Roberts, M, Brophy, J, and Cooper, C (March 1997), The Juvenile Drug Court Movement. Monograph available at www.ncjrs.org/txtfiles/fs-9759.txt.

Vickers, M (May 2000), National Youth Court Center. Fact sheet available at: <http://www.ncjrs.org/txtfiles1/ojjdp/fs20000t.txt>.

Author

Carol Kessler, M.D.
15 Gates Avenue
Ossining, NY 10562

Chapter XV

A Model Program: The Island Youth Programs

By Christopher R. Thomas, M.D.

The rapid increase in youth violence in America in the late 1980s prompted the development of new community approaches in dealing with this problem. Experts described this sudden increase in youth homicide and its contribution to youth morbidity and mortality as an epidemic and a public health problem (Moore and Tonry, 1999). The identification of specific risk factors and course of development for youth violence made a public health perspective feasible. Specific individual, family, school, peer, and community factors predictive of youth violence and delinquency have been extensively studied (Hawkins et al., 1998). The influence of these factors also appears to vary depending on the age of the individual youth (Lipsey and Derzon, 1998). Violent and aggressive behavior also develops in a predictable course (Kelley et al., 1997). These characteristics permit a community health approach to reducing youth violence with programs that address specific risk factors and work with target populations defined by age or exposure to risk factors. The problems created by youth violence and the factors contributing to it involve a wide range of public agencies and community services, including law enforcement, education, family services, mental health, and juvenile justice. Any public health initiative should therefore consider the other involved systems in developing effective interventions. A specific project, the Island Youth Programs, illustrates the development, implementation, and results of a collaborative, community-based initiative.

Island Youth Programs is a unique and innovative project to reduce youth violence in the City of Galveston. In November 1993, community leaders representing city government, law enforcement, juvenile justice, public recreation, public schools, the University of Texas Medical Branch, and local families concerned about youth violence formed the Island Youth Advisory Board. This group identified poor individual social skills, lack of positive relationships and activities, and dysfunctional families as important risk factors contributing to violent behavior in our youth. Discussions and review of other efforts resulted in 1994 with the creation of the Island Youth Programs. The five interrelated programs are community-based and emphasize collaboration between agencies. The design is a comprehensive approach integrating prevention and intervention efforts to target the

identified risk factors at critical stages of development. Youth Activities provides supervised recreation with trained leaders for all ages focused in neighborhoods of highest need. Second Step, a violence prevention curriculum, provides critical social and problem-solving skills in elementary schools. Peer Court works with youth convicted of misdemeanor offenses, involving them and other youth in a creative approach to community restitution and education. The Truancy Abatement and Burglary Suppression Program, or TABS, brings together local schools, community agencies, and police in working with truants. Second Chance is an intensive, home-based counseling service using a family preservation approach to work with serious delinquents. Programs are evaluated to determine their impact, identify problems requiring correction, and justify continued support. This evaluation also provides critical information on the development of youth violence and factors such as families and gangs that influence it. The University of Texas Medical Branch coordinates the project on behalf of the involved programs and the Island Youth Advisory Board, providing administrative support, training, and evaluation.

Arrests for all juvenile crime in Galveston have decreased since the initiation of the Island Youth Programs. The juvenile arrests for 1999 were the lowest in over a decade, and these decreases are greater than national and regional trends.

Juvenile Arrests for the City of Galveston

	1994	1999	%Decrease
All Arrests	1674	592	65%
Violent Offenses	161	35	78%
Other Offenses	1513	557	63%
Murder	6	0	100%
Attempted Murder	22	0	100%

Programs

Supervised group activities offer opportunities for practicing desirable behaviors and contact with prosocial peers. They are an important resource for other youth programs, reinforcing those efforts with positive alternatives. Adult leaders provide constructive role models in addition to supervision of activities. Research shows that the level of training of adult leaders is a critical factor in developing positive behaviors for youth group participants.

Collaboration in training provides a consistent approach across agencies and activities, reinforcing their effect on youth. Providing transportation for activities increases participation and access to other programs. Youth crime in Galveston is highest in areas lacking youth programs and facilities. The City Department of Parks and Recreation, Galveston Independent School District, and the Boys and Girls Club have developed a cooperative plan, sharing resources in order to serve youth and families in those districts. Youth Activities currently supports four youth group leaders working in neighborhood centers with the Parks and Recreation Department and the Boys and Girls Club. The program provided over 500 hours of training for these and other youth activity leaders over the past 3 years. Project funding repaired two existing community youth centers and purchased equipment and program materials, including four 15-passenger vans. In two neighborhoods lacking community centers, programs utilize elementary school gyms. Developing new programs with the community, Youth Activities supports a Rites of Passage group created by the Family Support Group to Stop the Violence. The project more than doubled program activity and youth participation for the Boys and Girls Club and the City Parks and Recreation Department.

Extensive research shows violent individuals lack specific skills including empathy, problem-solving, and anger management. A school-based program provides the most efficient means to teach children these skills. The project established Second Step, a violence prevention curriculum in five of the nine Galveston Independent School District elementary schools, kindergarten through fifth grade. Second Step is a sequential, developmentally graded social competency program designed by the Committee for Children, a Seattle-based nonprofit organization. It teaches recognition of the feelings of others, strategies for solving social problems, and anger management skills in a year-long curriculum of 30 lessons. Classroom activities aimed at illustrating and rehearsing skills incorporate techniques of cognitive-behavior modification and interpersonal problem-solving. The curriculum uses existing teaching staff and school counselors, providing them with training and well-prepared instruction materials. This expands the impact of the program as skills are modeled by teachers solving problems in other lessons and reinforced by discipline with students. Parents are provided information on the curriculum and suggestions on how to practice skills at home.

Peer Court provides early intervention with juvenile offenders, a creative alternative involving youth who have committed offenses and their peers.

Local teenagers trained by volunteer professionals conduct the punishment phase of class C misdemeanors. A prepared list of community services assists in the sentencing and focuses on restitution to the community and involvement in positive activities. Teenagers cannot easily discount the feedback of their peers. Sentences also include the expectation that offenders will then play a future role participating in the Peer Court. In this way, youth are given a constructive role in the community. Seminars are included to provide guidance and instruction in relevant areas for participating youth. Youth and families referred to Peer Court are screened for other risk factors and offered other services and resources. Since it began in 1995, more than 300 youth have been through Peer Court; 208 cases have been tried and 138 have completed their sentences; 184 local teenagers have served as trained volunteers. Of the more than 80 cases completing their sentence in 1995, none of the participants have become repeat offenders.

Truants are another group identified as needing early intervention. These youth are at increased risk for engaging in delinquent acts and dropping out of school. The Island Youth Advisory Board supported and the Galveston City Council passed a daytime curfew for youth during the school year. It is not enough to pick up youth and return them to home or school. Island Youth Programs established the Truancy Abatement and Burglary Suppression Program, or TABS. This program provides identification and follow-up for truants. Under this program, a youth picked up by the police for violation of the curfew will not be arrested. If the youth does not have a valid reason to be out of school, he/she will be taken to the TABS center. A coordinator provides screening and counseling. Parents are then contacted to pick up their child and return him/her to school or home. Reasons contributing to the truancy are identified and services offered in coordination with school liaison. The youth and family will also be referred to other resources, including youth activities. The TABS program has worked with 550 truancy cases since it started. Improvement with reduced truancy is indicated by the number of truants processed dropping from 94 for April and May of 1995 to 29 for April and May of 1997. The overall monthly average of truancy cases has fallen from 50 to 20. In 1998, the TABS program was in operation for all four years of high school for the graduating class of students. The overall dropout rate fell from almost 6% in 1994 to just under 3%. Even more dramatic were the sharp decreases in dropout rates among African American and Hispanic students. These reductions surpassed the Galveston Independent School District dropout goals set for academic year 1999–2000.

The project established Second Chance to work with youth on probation for violent or repeated offenses and their families. This effort is modeled on the Family Preservation Using Multisystemic Therapy developed by Charles Borduin, Ph.D., and Scott Henggeler, Ph.D. Evaluation has demonstrated this to be a cost-effective alternative for delinquents. An administrator and four counselors work in coordination with juvenile probation officers. Counselors go into the homes to work with youth and families intensively for 3 months. Individualized plans with specific goals are developed with the family. A crucial aspect of the program is its emphasis on promoting behavior change in the youth's natural environment – family, peers, friends, and school. Identified problems throughout the family are explicitly targeted for change. Family interventions attempt to provide parents with the resources needed for effective parenting and for developing increased family structure and cohesion. A related goal is to decrease the youth's involvement with deviant peers and increase his or her association with prosocial peers through organized athletics, church youth groups, and other activities. Under the guidance of the counselor, the parents develop strategies to monitor and promote the youth's school performance and vocational functioning. Interventions also focus on modifying the youth's social perspective-taking skills, belief system, and motivational system, and on encouraging the youth to deal assertively with negative peer pressures. An overriding goal of Second Chance is to empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems. Seventy-six families, about 75% of those eligible, agreed to participate in the program. For the purpose of evaluation, families were randomly assigned to receive usual probation services with or without Second Chance.

Administration

The Island Youth Advisory Board meets every other month to review the progress of programs, facilitate coordination with other efforts, and continue to develop and improve community programs to reduce youth violence. Support for specific programs is arranged through subcontracts between the University and the involved agencies. Expenditures are documented and accounts prepared as needed for funding agencies and the Island Youth Advisory Board.

Summary

The Galveston Island Youth Programs demonstrate the efficacy of strategic community planning in dealing with the problem of youth violence. Critical to the project's success was the involvement of community leaders willing to collaborate and share resources between agencies to create new programs. It was difficult but necessary to design the project from the ground up in a group involving a wide variety of professions and different perspectives. This approach ensured the support of all involved agencies and the community. It reduced the overall cost of programs as well as the duplication of effort.

Another critical factor was the use of several programs that addressed different risk factors and age groups. As observed by Elliott (1998), no single program prevents violence for all youth. An important element of using multiple programs was selecting those that dealt with identified risk factors at each stage of development. While gaps in services or special target groups of youth might identify specific program needs in a community, it is important to provide intervention for every age group. A strategic plan helped the community in selecting from the various promising programs and ensured that the project would have the widest impact possible on the city. The programs created by the project were intended to fill gaps in existing services rather than replace them. The new programs also provided screening and referral for participants that sought to improve utilization of existing services, including mental health. The Department of Justice developed the Comprehensive Strategy for Serious, Violent and Chronic Juvenile Offenders to assist communities in planning prevention and intervention efforts involving all relevant groups and agencies, including mental health (Howell, 1995).

The Galveston Island Youth Programs is an example of how mental health professionals can contribute to community efforts to reduce youth violence. Working together with other agencies and communities, mental health professionals can create effective efforts to deal with the threat of violence to maintain the health and safety of youth.

Other very promising models include the Midwestern Prevention Project, a community-based, multifaceted program for adolescent drug abuse prevention; Functional Family Therapy, an outcome-driven prevention and intervention program for youth who exhibit a broad range of maladaptive behaviors; PATHS (Promoting Alternative Thinking Strategies), a program for reducing aggression and behavior problems through enhancement of emotional and social competencies; and the Prenatal and Infancy Home

Visitation by Nurses, a program consisting of intensive home visitation by nurses during a women's pregnancy and the first 2 years after birth.

Recommendations for Reform

1. A public health approach should be used in developing community efforts dealing with youth crime and violence.
2. Community planning should occur at the local level and involve all agencies dealing with youth crime, including mental health.
3. Community programs must address the developmental and mental health needs of the youth they serve.

References

Elliot, D (Ed.) (1998), *Blueprints for Violence Prevention* (Vols. 1-10). Denver, CO: C&M Press

Hawkins D, Herrenkohl T, Farrington D, Brewer D, Catalano R and Harachi T (1998), A review of predictors of youth violence. In: *Serious & Violent Juvenile Offenders*, eds. R. Loeber and D. Farrington. Thousand Oaks, CA: Sage Publications, pp. 106-146

Howell, J (1995), *Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders*, Washington, DC: Office of Juvenile Justice and Delinquency Prevention

Kelley B, Loeber R, Keenan K & DeLamatre M (1997), Developmental pathways in boys' disruptive and delinquent behavior. *Juvenile Justice Bulletin* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention

Lipsey M and Derzon J (1998), Predictors of violent or serious delinquency in adolescence and early adulthood. In: *Serious & Violent Juvenile Offenders*, eds. R. Loeber and D. Farrington. Thousand Oaks, CA: Sage Publications, pp. 86-105

Moore M & Tonry M (1999), Youth Violence in America. *Youth Violence, Crime and Justice*, vol. 24, Washington, D.C. National Institute of Justice

Author

Christopher R. Thomas, M.D.
UTMB/Department of Psychiatry
301 University Boulevard
Galveston, TX 77555

Chapter XVI

Post-Adjudicatory Assessment

By Louis J. Kraus, M.D.

Introduction

The most complex and common assessments within juvenile court are post-adjudicatory evaluations. These evaluations must take into account a developmental framework, dependent on the age, cognition, and associated mental health issues of the youth being evaluated. In association with this, key issues such as recidivism, seriousness of offense, responsiveness to treatment, the family system the child is from, and the age of the child all need to be taken into consideration. Post-adjudicatory assessments must also consider the balance of police power with a *parens patriae* model.

Current Status

At the present time there is concern over a shift from a more rehabilitative model to the criminalization of juvenile court. Intensifying youth violence and a decrease of public support for youth offenders have resulted in a more punitive concept. However, jurisdictions are variable, with some juvenile court jurisdictions continuing to focus heavily on a rehabilitative model.

There continues to be a dichotomy within the U.S. criminal justice system, with courts basically designed for the adult system and those courts attempting to address juvenile offenders with case law, and U.S. Supreme Court decisions primarily focused on the adult system. Even though juveniles have the same constitutional rights as adults (Re: Gault), the structure of juvenile court and its civil focus on custodial care make it very different from the adult system. However, this has also resulted in tremendous variation in juvenile courts from state to state, from county to county, and sometimes even from courtroom to courtroom.

Assessment of violent offenses, in association with better research documenting the complex and significant mental health needs of youthful offenders, has resulted in further interest in post-adjudicatory interventions. Although much has been done regarding community-based treatment techniques and community-based programs, there is a paucity of long-term research in this area. Research has generally revealed advantages to participation in community-based services, although recidivism continues to

be problematic. Ryan et al., in 2001, reported that youth who received services while within a residential treatment facility, as well as community reentry services, had a decreased likelihood of incarceration as adults. However, the reality is that many communities cannot afford the treatment interventions necessary to help these wayward youth. In many communities there is an assumption (without basis) that if these youth are not incarcerated, they will be at significantly higher risk for reoffense.

The post-adjudication evaluation request may come from the court, the prosecuting attorney, or the defense attorney. The evaluator should attempt to remain consistent in the evaluation, specific questions and concerns should be identified in writing, appropriate releases of confidentiality should be provided, and if possible the child's parent or guardian should participate in the evaluation process. Collateral information, including delinquency history, school records, mental health records, and pediatric records, should all be made available prior to the evaluation. A well-structured assimilation of the collateral information is crucial in producing key recommendations. Ideally, one should meet with the youth on at least two occasions, one of those preferably with the parent or guardian.

The role of a post-adjudicatory assessment by a qualified mental health professional is to help determine developmental, mental health, and educational needs of the child, taking into account the potential risk for recidivism and dangerousness; the assessment should be explained to the court in a way that is helpful to the judge and should assist in meeting the needs of the child. Delinquent youth are at a significantly higher risk for learning disabilities and mental health diagnoses compared with their community-based counterparts. Yet they will likely have a paucity of services available to them in comparison with their community counterparts. The majority of children and adolescents being assessed within juvenile court can be helped with appropriate mental health and educational assistance. This group of children is likely the highest-risk population we have. Yet the services available to them typically cannot meet their needs.

At times, an evaluator will have to address whether or not a child should be incarcerated. At other times, it has already been determined that a youth will be incarcerated. However, even with incarceration, questions regarding specific needs of the youth within the placement may be requested. The evaluator will need to have an understanding of the services of a given facility, including educational interventions, mental health interventions, and

other specialized interventions such as speech and language therapy, occupational therapy, etc.

At the present time, nationally, all youth do not have consistent evaluations. Most youth going through juvenile court in the United States do not have mental health evaluations. There are other countries, such as the Netherlands, that have consistent mental health evaluations on all youth going through the juvenile justice system. Before we are able to help our youth, we need to understand better what their needs are. This can be assisted with comprehensive assessments on all youth going through juvenile court.

Recommendations for Reform

1. The needs of delinquent children must be better understood. There is a need for continued longitudinal research.
2. Uniform mental health evaluations are needed, including educational assessments of all youth who are adjudicated within juvenile court. These assessments will assist the court in understanding the needs of the youth and to make appropriate recommendations, which will likely result in decreased recidivism.
3. Services within correctional facilities must be consistent with community norms.
4. Parameters for post-adjudicatory evaluations should be consistent.
5. Obtaining educational, social work, psychological, and child and adolescent psychiatric services for delinquent youth within the community should be consistent with community norms for delinquent youth.

References

Abram, KM, Teplin, LA, McClelland, GM, & Dulcan, MK (2003), Comorbid Psychiatric Disorders in Youth in Juvenile Detention. *Archives of General Psychiatry* 60(11),1097-1108

Carney, M M and Bartell, F (September 2003), Reducing Juvenile Recidivism: Evaluating the Wraparound Services Model Research on Social Work Practice. *Research on Social Work Practice*. 13(5):551-568

DePrato, DK, Hammer, JH (2002), Principles and Practices of Forensic Psychiatry. Assessment and Treatment of Juvenile Offenders. Edited by Schetky DH and Benedek EP. Am Psychiatric Publishing Inc.267-278

Quinn, K (October 2002), Juveniles on Trial. Child and Adolescent Psychiatric Clinics of North America. 11(4):719-730

Ryan, JP, Davis, RK and Yang, H (2001), Reintegration Services and the Likelihood of Adult Imprisonment: A Longitudinal Study of Adjudicated Delinquents. Research on Social Work Practice. 11(3), 321-337

Teplin LA, Abram KM, McClelland GM (1996), Prevalence of Psychiatric Disorders Among Incarcerated Women; 1. Pretrial Jail and Detainees. *Archives of General Psychiatry* 53;505-512

Vermeren, R, Schwab-Stone, M., Rushkin, V, DeClippele, A, and Deboutte, D (2002), Predicting Recidivism in Delinquent Adolescents from Psychological and Psychiatric Assessments. *Comprehensive Psychiatry* 43(2),142-149

Author

Louis J Kraus, M.D.
Chief, Section of Child and Adolescent Psychiatry
Rush University Medical Center
1720 W. Polk Street
Chicago, IL 60612

Chapter XVII

Advocacy in Juvenile Justice

By William Arroyo, M.D.

Advocacy refers to the group of actions that support, plead, or argue for a cause or a proposal. Advocacy on behalf of children and youth is, in large part, common sense. Their immaturity in various lines of development, especially in the psychological and cognitive areas, often compromises their capacity to advocate on their own behalf in contrast to adults. In addition, many children and youth in the juvenile justice system generally have very limited understanding of the consequences of their behavior, the impact of their behavior on others and on their future, statutes pertinent to their offense, court proceedings, judicial decisions, their rights as individuals, and the complex setting of correctional institutions. Children and youth with mental illness who are incarcerated are, in general, a more vulnerable population than the group without mental illness. Some mental disorders may compromise a youth's ability to behave and deliberate relevant issues in a manner similar to adults. Unfortunately, advocacy on behalf of youth in juvenile justice is often misinterpreted as the politically polarizing phrase, "soft on crime." This moniker discourages some individuals, including potential elected officials, from pursuing advocacy in this arena, despite their convictions. This chapter will primarily address advocacy as it pertains to the general juvenile justice population as opposed to the advocacy that one may pursue on behalf of one's individual patients.

The ethics principles of both the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA) broaden the ethical responsibility of their members beyond the treatment issues relevant to a single patient and family. They strongly promulgate the idea that members should become active advocates on behalf of all individuals in society. Principle IV of the AACAP Code of Ethics states:

The child and adolescent psychiatrist recognizes a larger responsibility to children, adolescents, and families, and when possible will seek to reduce, by all appropriate means, the deleterious influence or actions of other individuals or society at large on the well-being of children, adolescents, and families.
(AACAP, 1980)

Section 7 of the APA's code of ethics, which is adopted verbatim from that of the American Medical Association, reads:

A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

The annotation by APA that elaborates on Section 7 states:

Psychiatrists should foster the cooperation of those legitimately concerned with the medical, psychological, social, and legal aspects of mental health and illness. Psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judiciary branches of the government.... (American Psychiatric Association, 2001)

The ethical obligation to advocate on behalf of children with mental illness is clearly stated in both of these codes of ethics. Both codes of ethics provide the ethical framework by which to provide treatment. However, neither provides many details as to how to advocate for the general population of children and youth in the juvenile justice system.

Methods of Advocacy

A child and adolescent psychiatrist can effectively advocate as an individual. In the juvenile justice arena, advocacy may entail solo visits, telephone calls, correspondence, and other means of communication with "decision makers" whose decisions affect children or youth in the community or in an institution. At times it may involve raising public awareness about a certain relevant issue, e.g., deplorable conditions in detention facilities. The decision makers may include the judiciary of the juvenile court; local, state, and federal officials (elected and nonelected); probation officers; managers of correctional institutions; education personnel; and other managers of other child and youth service agencies. The focus of advocacy might range broadly from current policies, regulations, pending legislation, specialized programs, and new resources to community concerns. This method of individual advocacy may seem like a daunting task to many, but it can be effective. A thoughtful strategy should be developed and the rationale of the potential opposition should be well understood. It can involve repeated attempts with the same or a combination of decision makers. This method can be very

labor-intensive and, therefore, not ideal for the practitioner with a full schedule. A novice advocate may want to serve as an observer while accompanying a veteran advocate. An individual advocate often does better in a group of individuals, especially individuals who are familiar with the issues for which one is advocating. Advocating as an individual has the advantage of focusing on an issue from the single advocate's point of view, which may be different from that of a formal position of, for example, an organization that does advocacy.

Advocating as a member of an organization often has the advantage of the appearance of representing many individuals, which, in general, is viewed as a more powerful effort. Professional organizations often become the sole voice for the type of professional that the organization represents; this perception exists despite the fact that not all members of that profession are members of the organization. For example, AACAP often becomes the sole voice concerning certain policies or pending legislation of all child and adolescent psychiatrists in the country despite the fact that a large number of child and adolescent psychiatrists may not be members. At times organizations are sought out to assist the legislature or some other decision-making body to develop policies or legislation prior to their introduction to the legislative process. Generally, the larger the membership of an organization, the more influential the organization's advocacy may be. The adoption of a position statement by an organization is often a great challenge; many organizations have cumbersome mechanisms through which the initial proposed position must be funneled. The first draft of a position statement may undergo various changes as it is circulated among key members or components of an organization before being considered by the board of directors of the particular organization; large organizations may also have review processes of substantial duration. Coalitions of organizations which may advocate on a single issue can be even more influential than a single organization. A recent example of this was the coalition of organizations that during a few years coalesced to advocate for the elimination of the juvenile death penalty. Coalitions of "like-minded" organizations, for example, mental health organizations, are generally much easier to establish than coalitions of organizations representing disparate sectors. However, broader coalitions, which include organizations that represent different sectors, can be even more influential. For example, a broad-based coalition might include a child and adolescent psychiatric organization, a law enforcement association, a teachers' association, a child welfare association, and a family advocate organization.

The Regional Organizations of Child and Adolescent Psychiatrists (ROCAPs) of AACAP can advocate on a more local or statewide basis, where a lot of policy development and legislation can affect the practice of child and adolescent psychiatry and the well-being of children in general. Forming coalitions with other organizations may be advantageous. Some examples include a statewide ROCAP collaborating with another medical organization such as a district branch of the APA or the statewide medical society. Oftentimes, ROCAPs may share the same position or vision as other organizations that focus on children and youth and which are not medical organizations. In general, the more strategic the advocacy, the better the outcome.

Current Advocacy Organizations

Many organizations advocate on behalf of children in the juvenile justice system. The focus can be broad or narrow; some may advocate for alternatives to incarceration, for reduction of disproportionate minority contact, for adequate and appropriate mental health services, for special education, among many other issues, or for several related issues.

National

Many national organizations have been in the forefront of advocacy in juvenile justice. They include the Child Welfare League of America, Physicians for Human Rights, Free Child Project, National Mental Health Organization, Families and Advocates Partnership for Education, Coleman Advocates for Children and Youth, United Indians for All Tribes Foundation, Human Rights Watch Southern California, American Civil Liberties Union (ACLU), American Bar Association, Children's Defense Fund, Center on Juvenile and Criminal Justice, Building Blocks for Youth, Juvenile Law Center, The Sentencing Project, Girls Justice Initiative, Society for Adolescent Medicine, Bazelon Center, JEHT Foundation, MacArthur Foundation, Youth Law Center, H. Burns Institute, and many others.

State

Many state coalitions and organizations have been established that advocate for youth in the juvenile justice system. These include the Juvenile Justice Project of Louisiana, Juvenile Justice Initiative (Illinois), Juvenile Rights Advocacy Project: Representing Girls in Context (Massachusetts), Fight

Crime: Invest in Kids (California), Sweetser (Maine), North Carolina Child Advocacy Institute, South Dakota Voices of America, United Advocates for Children of California, and many others.

Youth Organizations

Several advocacy organizations have launched efforts to organize youth advocates; oftentimes they may be graduates of the juvenile justice system. These include such organizations as Building Blocks for Youth, W. Haywood Burns Institute, and Louisiana Youth Net.

Advocacy Tools

Many advocacy organizations have developed tools, tip sheets, and pamphlets related to advocating for children in the juvenile justice system. These include *Making Your Voice Heard – Family Advocacy Handbook* by the Juvenile Justice Project of Louisiana; *Youth with Disabilities in the Education System* by U.S. Department of Education, Office of Special Education Programs; *Take Action Now!* by Coles Advocates for Children and Youth; *The South Dakota Juvenile Justice System Guidebook for Youth and Parents* by the South Dakota Coalition for Children; and *Advocacy Guide to Rights Protection for Youths in the Juvenile Justice System* by the National Mental Health Association. These can be found at each organization's website, listed below.

Summary

Advocacy for children and youth is clearly an ethical obligation for child and adolescent psychiatrists. Both individual advocacy and organized advocacy are effective. A multitude of advocacy organizations exist on national and state levels. Working in collaboration with any number of these organizations likely strengthens the effort. Tools for advocacy are available from various websites.

Resources

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Bar Association
<http://www.abanet.org/crimjust/juvjus/home.html>

Bazelon Center for Mental Health Law

<http://www.bazelon.org/issues/children/7-7-04jjsignonltr.htm>

Building Blocks for Youth

<http://www.buildingblocksforyouth.org/>

Center on Juvenile and Criminal Justice

www.cjcj.org

Children's Defense Fund

<http://www.childrensdefense.org/safe-start.htm>

Child Welfare League of America

<http://www.cwla.org/programs/juvenilejustice/jjabout.htm>

Coleman Advocates for Children and Youth

www.colemanadvocates.org/take_action/advocacy.html

Families and Advocates Partnership for Education

<http://www.fape.org/index.htm>

http://www.cec.sped.org/law_res/doc/resources/detail.php?id=2099 (special education)

Federation of Families for Children's Mental Health

www.ffcmh.org

Free Child Project

www.freechild.org/juvenile_injustice.htm

Georgia Public Defender Standards Council

<http://www.gidc.com/resources-juvenile-main.htm>

Girls Justice Initiative

<http://www.girlsjusticeinitiative.org/index.shtml>

Human Rights Watch – Southern California

<http://www.hrwcalifornia.org/south/advocacy.htm>

JEHT Foundation

<http://www.jehtfoundation.org/interests.html>

Juvenile Law Center
<http://www.jlc.org>

Juvenile Justice Initiative (Illinois)
(www.jjustice.org)

Juvenile Justice Project of Louisiana
(www.jipl.org/FamilyAndCommunityResources/AdvocacyHandbook/handbook.html),

Juvenile Rights Advocacy Project: Representing Girls in Context
<http://www.ncjrs.org/html/ojjdp/jjjournal1099/brief1.html>

Louisiana Youth Net
www.layouthnet.org

MacArthur Foundation
<http://www.macfound.org/>

National ACLU
<http://www.aclu.org/CriminalJustice/CriminalJusticelist.cfm?c=46>

National Mental Health Association
<http://www.nmha.org/children/justjuv/execsum.cfm>

North Caroline Child Advocacy Institute
<http://www.ncchild.org/jjdp.htm>

Physicians for Human Rights
<http://www.phrusa.org/students/jj.html>

Society for Adolescent Medicine
http://www.adolescenthealth.org/incarcerated_youth.htm

South Dakota – Voices for America's Children
<http://www.voicesforamericaschildren.org/>

State

Fight Crime: Invest in Kids (California)

<http://www.fightcrime.org>

Sweetser (Maine)

<http://www.sweetser.org/help/advocacy.html>

The Sentencing Project

<http://www.sentencingproject.org/>

United Advocates for Children of California

www.uacc4children.org

United Indians for All Tribes Foundation

<http://www.unitedindians.com/juvenilejustice/>

W. Haywood Burns Institute

www.burnsinstiute.org

Youth Law Center

http://www.ylc.org/ylc_jcon.htm

References

American Academy of Child and Adolescent Psychiatry (AACAP), (1980). *Code of Ethics*. Washington, DC.

American Psychiatric Association (2001). The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. Washington, DC.

Author

William Arroyo, M.D.

Child and Family Services Bureau

Department of Mental Health, 3rd Fl.

550 S. Vermont Avenue

Los Angeles, CA 90020

Chapter XVIII

Juvenile Aftercare

By Kenneth M. Rogers, M.D., MSHS

The detention of youth in the juvenile justice system is a source of serious concern. Although the number of youth committing violent offenses has decreased dramatically over the past decade, there has not been an equally dramatic decrease in the number of youth detained in juvenile detention facilities. Even more disturbing is the fact that the majority of youth detained in detention centers have some type of diagnosable psychiatric illness (Otto et al., 1992). When only severe disorders are taken into account, approximately 20% of youth suffer from psychiatric disorders. Youth detained in juvenile detention facilities are at increased risk for emotional disturbances due to their increased levels of witnessing trauma or being victims of trauma themselves, having family histories that are more likely to show mental illness or substance abuse, and having grown up in more impoverished neighborhoods. The rate of mental health need among these youth is significantly higher than for youth in the general population (Teplin, 2002; Atkins et al., 1999). Additionally, because many of these youth are from communities with inadequate health care, their illnesses are less likely to be identified prior to their detention.

For many youth, the first time that any mental health problems are identified is in the juvenile justice system. Because many detention centers have screening measures in place to identify both physical and mental health issues in recently detained youth, many youth with significant mental health problems are identified and referred for services. However, most juvenile detention facilities lack appropriate mental health resources to address the identified mental health needs of these youth (Anno, 1984), and so only the most severely affected youth receive services. Youth with less severe problems often are not identified or are not referred for further services. Because many detention facilities use contract psychiatrists who are there for only a few hours a week, they have relatively little contact with the general population of youth at the facility and must rely on detention staff who have little training in mental health issues to determine who will receive further treatment. These contract providers are also at a disadvantage because they are often unaware of when youth will be discharged from a detention facility;

therefore, setting up follow-up mental health appointments or providing medications upon discharge does not occur.

One of the great challenges in moving youth from secure detention settings is determining how to transition them from a highly structured detention setting into a community setting with much less structure and the temptations that initially got them into trouble (Altshuler and Armstrong, 2001). Moving youth with mental illness from a juvenile justice placement to the community, where mental health may be the primary agency, can be complex. The difference in philosophy and practice between these two fields is often dramatic and difficult to integrate. Unfortunately, aftercare is in reality often focused only on placing youth back in the community, rather than on developing a plan for integration into the community with a focus on providing appropriate services before, during, and after release from a facility (Altshuler, 2001).

The problems related to developing aftercare plans for these youth are numerous. Some of the differences include the following:

1. Detention facilities are often unable to coordinate care as youth move between detention settings; therefore, medical records, medications (or prescriptions), and prior recommendations do not go with the youth. Many youth are transferred between multiple facilities prior to discharge, and so a great deal of clinical information is lost in the process.
2. Many of the youth are going back into neighborhoods where there is a relative lack of mental health services. Therefore, getting the family and the youth an appointment to see a clinician is often difficult.
3. In many areas of the country, the wait for a youth to see a child and adolescent psychiatrist can exceed 3 months. Trying to keep a family and youth engaged during multiple periods of crisis while not having an available clinician can be daunting for a family.
4. Youth who are stabilized on medications in a detention facility and who may be motivated to continue the medications often are unable to do so because of lack of availability of the medications. Youth are often discharged with a 30-day supply of medications.

Those unable to get an appointment during the 30 days will often discontinue the medications and will be less likely to follow up.

5. Many of the services that are provided are inadequate for these youth. Many of the services provided in traditional mental health settings have been shown to provide little benefit to youth, and some are potentially harmful.
6. Youth discharged from detention centers are often seen as “bad” youth; therefore, many clinicians are less motivated to accept them into their practices.
7. The youth in this population have many special needs that may not be addressed by traditional mental health programs. For example, many have a history of academic difficulties, poverty, family difficulties, comorbid psychiatric and medical conditions, substance abuse issues, and ongoing impulsivity and delinquency. Addressing these issues requires a coordinated approach and a continuum of services.
8. Funding is often inadequate to provide services. Juvenile detention facilities are often better funded than outside mental health service agencies, and so providing treatment for youth in detention facilities is often easier than providing similar services to youth once they are discharged from the facility.
9. Youth and families are often not motivated to receive services upon discharge because of perceived lack of importance or barriers to care, including transportation to appointments, missed time from work/school for parents and youth to attend sessions, or being perceived as “crazy” because the youth is receiving mental health care.

Despite the challenges presented by the attempt to integrate youth into the community, there is sufficient evidence that this goal is within reach. The goal of the intensive aftercare program funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) was to assess the current knowledge in the field and to develop promising model programs. Four goals were identified which must be met if reintegration into the community is to be successfully achieved:

1. Define the overall aftercare function in a way that guarantees the inclusion of interlocking staff across the entire continuum from the point of judicial commitment and residential placement to the point of community placement.
2. Design a network of community-based service provision that can respond comprehensively to the needs of multiproblem, chronically delinquent youth.
3. Devise a framework for case management that ensures the continuity of supervision and service delivery which matches the clients with appropriate interventions and brings the most objective procedure for making an informed decision.
4. Focus on more collaborative, interagency approaches and solutions to the challenges of supervision and service provision for a high-risk, high-need population.

This model continues to be empirically tested to determine whether these approaches continue to be beneficial when disseminated to the larger population rather than the pilot sites where the models were developed and initially tested. However, the approach looks promising, as it has identified several areas that must be addressed with youth if reintegration is to be successfully achieved. These include (1) special needs and special population, (2) education and school, (3) vocational training and job readiness, (4) living arrangements, (5) social skills, (6) leisure and recreation, (7) client-centered counseling (individual and group), (8) family work and intervention, (9) health, and (10) surveillance and monitoring technology. Although it is impossible to integrate all of these items into a single program, this model argues for an integrative approach that will be essential for successfully integrating youth into a community setting.

Recommendations for Reform

1. Mental health clinicians should be better integrated into juvenile justice settings. Even if clinicians are contract providers, additional resources should be made available for integrating them into the detention setting, including attending court and probation settings where the decisions about aftercare service are made.

2. Youth should be provided with a continuum of services, including mental health services, upon discharge from a detention facility so that they can receive more or less intense services dependent upon the severity of problems or level of need.
3. Mental health and substance abuse treatment, education, job training, and social services should be better integrated before, during, and after release from detention facilities. All appointments for treatment and follow-up should be coordinated; dates and times should be provided to youth and families prior to discharge from the detention facility.

References

Altshuler, DM, and Armstrong, TL (1994), Intensive Aftercare for High-Risk Juveniles: A Community Case Model. Program Summary. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. NCJ 147575

Altshuler, DM, and Armstrong, TL (2001), Reintegrating high risk juveniles into the community: Experiences and prospects. *Corrections Management Quarterly* 5(3)

Anno B (1984), The availability of health services for juvenile offenders: Preliminary results of a national survey. *Journal of Prison and Jail Health*, 4: 77-90

Armistead L, Wierson M, Forehand R, Frame C (1992), Psychopathology in incarcerated juvenile delinquents: Does it extend beyond externalizing problems? *Adolescence*, 27: 309-314

Armstrong, TL (2003), Having positive results with serious juvenile offenders in a reintegrative framework: Strategies essential for rehabilitative effectiveness with the intensive aftercare (IAP) model. Presented at Youthful Law Violators, Human Rights, and Development of New Juvenile Justice Systems, Spain

Atkins D, Pumariega A, Rogers K, Montgomery L, Nybro C, Jeffers G, Sease F (1999), Mental health and incarcerated youth I: Prevalence and nature of psychopathology. *J Child Fam Studies*, 8: 193-204

Otto R, Greenstein J, Johnson M, Friedman, R (1992), Prevalence of mental disorders among youth in the juvenile justice system. Responding to the

Mental Health Needs of Youth in the Juvenile Justice System. Seattle: The National Coalition for the Mentally Ill in the Criminal Justice System

Teplin, LA, Abram, KM, McClelland, GM, Dulcan, MK, and Mericle, AA
2002, Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry* 59:1133–1143

Author

Kenneth M. Rogers, M.D., MSHS
University of Maryland School of Medicine
701 West Pratt Street, Rm 424
Baltimore, Maryland 21201

**American Academy of
Child & Adolescent
Psychiatry**

**3615 Wisconsin Avenue, NW ◆ Washington, DC ◆ 20016-3007 ◆
202.966.7300**