

RECOMMENDATIONS FOR JUVENILE JUSTICE REFORM

American Academy of Child and Adolescent Psychiatry
Task Force on Juvenile Justice Reform
October 2001

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

**American Academy of Child and Adolescent Psychiatry
Task Force on Juvenile Justice Reform
October 1999 – October 2001**

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FOREWARD

The purpose of this monograph is to provide community leaders, policy-makers, 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 Task Force on Juvenile Justice Reform of the American Academy of Child and Adolescent Psychiatry (AACAP). Clarice Kestenbaum, MD, established this group in 1999. This effort is one facet of the mission of the Task Force.

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 Task Force 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 the Task Force membership: William Arroyo, MD; William Buzogany, MD; Dawn Dawson, MD; Theodore Fallon, MD; Pablo Goldberg, MD; Graeme Hanson, MD; Carol Kessler, MD; Diane Little, MD; William McMiller, MD; and Wade Myers, MD. In addition, the Task Force was assisted by a large and active corresponding membership group, some of whom directly contributed to this monograph.

This monograph would not be possible without the unrelenting support of AACAP staff, Mary Crosby, Nuala Moore and Catherine Nastro.

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

The Task Force on Juvenile Justice Reform (TFJJR) 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. This effort was identified as a primary initiative by Clarice Kestenbaum, AACAP President (1999 – 2001).

The mission of the TFJJR 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. The Task Force will pursue reform through professional, legislative, advocacy, community-based, and fiscal policy strategies.

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.

Forensic Evaluations

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

1. Courts should require an opinion by a child trained 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 child trained experts should determine a child's credibility of each potential child witness.
7. The court should solicit independent child trained 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.

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:

1. Establish national competency standards for juveniles that include a developmental framework.
2. All experts who conduct competency assessments should have specialized training relevant to working with children.
3. Require training for judges, defense attorneys, prosecuting attorneys and other court officials in the area of child development and other areas relevant to children.

Standards for Juvenile Detention and Confinement Facilities

Standards for juvenile detention and confinement facilities vary across jurisdictions; most State corrections agencies have issued standards. They may also vary according to duration of detention and confinement. A single set of national standards has yet to be 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 human services in juvenile facilities is also essential.

Recommendations

1. 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.

2. National standards for detention and confinement facilities should meet developmental needs of preteens.
3. National standards for detention facilities that primarily house adults should address the developmental needs of adolescents.

Healthcare 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 healthcare. Healthy individuals are more likely to undergo successful rehabilitation than are youth with medical problems.

Recommendations

1. Systematically monitor conditions of detention and confinement facilities; provide resources to improve adverse conditions.
2. Detention facilities should establish partnerships with pediatric 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 healthcare providers.
3. Fund research relevant to juvenile health and rehabilitation. Health risk behaviors, impulsive actions, and anti-social tendencies are not yet well understood by those who attempt to rehabilitate delinquents. The etiology of delinquent behavior including the role of child abuse, pre-natal 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. Detainees should have 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 counterpart. In 1997, 748,000 girls were arrested, representing 26% of all juvenile 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, 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 rates of mental illness among incarcerated female youth is another area that requires focused planning.

Recommendations

1. Fund 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 for female delinquents concerning sexually transmitted diseases, including HIV and birth control.
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 Delinquency and Prevention Act (JJDP), which mandates states to address the problem of DMC, encourages jurisdictions to maintain this tragic and harmful practice.

Recommendations for State/County:

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 competence in policy and program development.
8. Review and change laws that encourage the disparate racial impact providing for prosecution of juveniles in 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 non-violent and/or status offenses; these offenses undermine efforts to procure employment in young adulthood.

Recommendations for federal government:

1. Immediately reauthorize Juvenile Justice Delinquency and Protection Act (JJDP A) with inclusion of the 1992 four core mandatory requirements (which includes addressing DMC).
2. Provide intensive technical assistance to states/jurisdictions for compliance with DMC requirement
3. Support states' efforts to collect comprehensive data, to conduct analysis of data, and to develop research and data based state DMC intervention plans.
4. Strengthen the DMC protections in the JJDP A by enacting legislation to address DMC youth at all points in the justice system from first contact with police to incarceration

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 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:

1. National policies concerning the use of seclusion and restraint on our youths in correctional facilities should be established. Indications for the various types of restraints – shackles, soft restraints, handcuffs, blankets, etc. – should also be established. Safety must be a priority in these standards.
2. National policy regarding duration of restraints should also be established.
3. The role of physicians and mental health professionals should be clearly delineated in such policies.
4. Close monitoring of confinement facilities regarding compliance with national policies on restraints should be periodically conducted.
5. Therapeutic use of seclusion and restraints in confinement facilities should be consistent with the state mental health code at a minimum.

Meeting the Educational Needs of Youth in the Juvenile Justice Facilities

All children whether incarcerated in juvenile or adult facilities have the same right to an education. Unfortunately, the educational needs of youth are assigned a lower priority than correctional needs in some institutions; resources and

planning efforts may therefore be sub-optimal. 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 is much higher in urban communities. Such youth, whether in juvenile or adult facilities, are entitled to special educational 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

1. Meet the minimum standards set by federal and state laws of 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 possibility of learning disabilities, emotional behavioral disorders, or cognitive limitations that have an adverse effect upon learning to every youth entering the juvenile justice system.
4. Systematically identify all incarcerated youth who have special educational needs. Provide them with 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.

Waiver 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 1980's 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 following the enactment of such laws despite the premise that stiffer sentences would discourage law breaking on which such efforts are based.

Recommendations

1. Waiver 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 waiver does not achieve the desired goals and may be potentially harmful to the community and the involved youth.
2. Any waiver to adult 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. Further study must be devoted to explore other alternatives to waiver to adult court in order to develop a more effective juvenile justice system.

Juvenile Sexual 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 are common among 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

1. Fund research in two key areas in order to: (a) better define subtypes of juvenile sexual offenders that will allow clearer predictions of treatment amenability and recidivism, and (b) continue further development and assessment of treatment programs and their effectiveness.
2. Placements of sexually offending youth should meet their developmental needs. Placements with sexually offending adults should be avoided.
3. Identify those youth who are most likely to benefit from therapeutic interventions.

Capital Punishment for Adolescents

The American Academy of Child and Adolescent Psychiatry adopted a position statement 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.

Recommendations:

1. All relevant agencies and organizations should adopt a similar statement.
2. Advocate changing laws that allow for capital punishment for individuals whose offense occurred prior to the age of 18.

Alternatives to Adjudication: Drug Courts, Mental Health Courts, 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 non-violent 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 non-violent offending peer is "judged and sentenced" by the offender's peers.

Recommendations:

1. 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 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.

Model Program

Island Youth Programs is a unique and innovative project to reduce youth violence in Galveston. During a period of five years it was able to produce a decrease of all youth arrests by 65%, 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 was key to this project's success.

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

Recommendations:

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.

October 2001

Chapter I

Juvenile Justice: Yesterday and Today

By Theodore Fallon, Jr., MD, MPH and Dawn Dawson, MD

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 for which to care, many of whom have “graduated” from other child-caring systems.

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. These two forces have created a set of checks and balances with conflicts and inefficiencies that sometimes lead to responses that are ineffective in assisting young people, their families and the community.

Although it may seem otherwise, 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 continues to act in the best interest of the youth. This is true even at the first point of contact where 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 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 are filed seeking court action. Juveniles are not found guilty; the petition is sustained or dismissed. Juveniles are not sentenced as a punishment; their case disposition reflects the court’s view of the best treatment to meet their needs. Juvenile court judges typically have much wider discretion than adult criminal court judges in disposition. This

variation in dispositions remains a major concern for juvenile justice reform. These judges (unlike their adult counterparts) usually have no rigid guidelines, although they are constrained by constitutional considerations, Supreme Court decisions (re: Gault), and judicial council rules.

Originally, this system was created to be a swift, confidential mechanism for obtaining treatment and services for youths; however, because of changes in laws, court rulings and public attitudes, the juvenile courts in most jurisdictions operate today 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.

Current Concerns

Each year, over 2.7 million youths under the age of 18 are arrested. Over one million of them have formal contact with the juvenile justice system, and 500,000 annually are admitted to local juvenile detention facilities. Over 65,000 are admitted to long-term juvenile correctional facilities.

Approximately 7,500 youth are prosecuted as adults. Most of these decisions to prosecute youth in the adult criminal court are made by prosecutors or legislatures (85%), and not by judges (15%). Almost 67 % of these youth who are detained pretrial were 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 emotional and behavioral development, and the vast majority of them have diagnosable mental disorders, many are not screened for mental health problems – either pre-adjudication 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 on disproportionate minority confinement (DMC).

Females in the juvenile justice system have often been overlooked. Female adolescent offenders have higher rates of depression, suicide attempts, drug, 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.

These statistics highlight the inadequacies in our juvenile justice systems and create motivation for change. Although the motivation for change has been gaining momentum, 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 youths 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 firing 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. This staff usually depends on their own personal experiences 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 common words 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 that 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 have eluded them up to now. For many within the juvenile justice system, the complexities are a fact of life that often cast a shadow of 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.

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Chapter II

Forensic Evaluations of Children and Adolescents

By Diane H. Schetky, MD

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 are treated lightly in the American Academy of Psychiatry and The Law (AAPL) Ethical Guidelines, of which the latter are in the process of revision. Members of AAPL are required to belong to the APA or AACAP 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 loathe to testify against colleagues on issues surrounding the standard of care.

Testimony by Children or Adolescents

Several US Supreme Court cases have addressed issues concerning child witnesses. *Maryland v. Craig* 497 US 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 US 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 helping to determine 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 youths 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 exams, 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).

In as much as the forensic examiner needs 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 undeserved 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 due to 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 of causing harm to the patient by way of the therapist’s testimony. A patient may discontinue treatment on own accord or by parents’ wish after a therapist provides testimony as in the case of custody disputes.

Similar conflicts may exist in the area of corrections. Clinical therapists are ethically bound to provide competent treatment; this is very different from acting as a worker on behalf of the court as an expert witness, of a plaintiff or law enforcement agency. An individual should not simultaneously assume a role of a therapist and expert witness. Similarly, there should be no conflicts of interest that might taint an expert's opinions e.g., being on staff at an institution he is defending in a lawsuit or ties with any of the parties in a lawsuit.

The minor to be examined (forensic child and adolescent clients) should be informed at the outset in regard to whom has retained the examiner, the purpose of the evaluation and with whom the results will be shared. Informed consent from parents or guardians for evaluation of the minor and/or for sharing of information is also required.

Recommendations

1. Courts should require an opinion by a child trained 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 that may overwhelm a child who may be testifying (AACAP, 1986).
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 repetitive examinations.
6. The court should solicit independent experts with training in child mental health 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.
7. The determination of the understanding of Miranda rights by a child should be conducted in a developmental context.

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Chapter III

Competency to Stand Trial

By Dawn Dawson, MD

The roots of competency can be traced at least to the seventeenth century. The English courts were faced with defendants who stood mute rather than make the required plea. The court would then have to decide if 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 sixty years of the juvenile justice system’s history. It was not thought to be necessary since the proceedings were not adversarial. In the 1960’s, 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 1980’s, one-third of states had recognized, by statute or state law, the legal concept of competence 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 their 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 United States 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 one’s accusers and present evidence. Competence is fundamental to our justice system, which is a trial between evenly matched adversaries, and through this discourse, facts relevant to the case emerge.

Although competency for adults seems to be somewhat well understood, this is not the case for children. There is tremendous variation in regards to how judges in different districts and different states view competency of children. There are many judges who believe if a child simply knows who the judge is, they are competent to stand trial. Other judges and courts will 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 probation.

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 United States 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 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 that may vary from among cases and necessary abilities or demands on an individual 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. In general, competence to stand trial focuses on ability to understand information and to reason with it, for example, plea-bargaining.

The United States 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 question of a defendant's competency may be raised by the defense, the prosecution, or the judge 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, often a psychologist or psychiatrist (legal expert) is appointed to do the examination. Judges do not use 'experts' in all competency evaluation. Sometimes, brief screening procedures are used, the defendant is put into an inpatient setting for the evaluation or it can be done as an outpatient.

It has been argued that 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. Competency is a legal opinion rendered by the judge. 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.

Competence 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 incompetence. These may be circumstances under which competence 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.

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

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.

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Chapter IV

Standards for Juvenile Detention and Confinement Facilities

By Louis J. Kraus, MD

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 only have the occasional youth, to massive pre-adjudication facilities as seen in the major cities. These facilities can hold hundreds of children. Their focus is typically short-term detainment until adjudication and then the children 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 AMA to support model legislation addressing the physical and mental health care needs of detained and incarcerated youths 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 of 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.

The ACA, several years ago, came out with a competency program which involves a number of video tapes and reading materials to help assist security in

understanding some the developmental and mental health needs of teens. This is a useful competency tool but in some respects minimizing the need for qualified mental health staff. At present the majority of healthcare professionals and security in detention have a relative paucity of knowledge and typically feel unprepared to handle adolescence issues and concerns.

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, with a second printing in June of 2000.

Current Status

There are a variety of other accrediting agencies, including ACA, JACHO and others. Most major medical organizations, including the AMA, AACP, APA and the 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 facilities' requirement to have clear policies and procedures, medical autonomy, responsible health authority, access to care, emergency plans, and examples of communications concerning special need patients.

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, minimal competencies, including continuing education and minimal requirements for staff who would work with juveniles.

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 youths 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, dental screenings, as well as focusing on specialty issues, such as juveniles who were placed in seclusion and a variety of other important issues such as patient transport, assessment of protocols, continuity of care, etc.

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

Section G focuses on children with special needs and services, including infirmary care, perinatal care for female offenders, issues focusing on intoxication and withdrawal, suicide assessment and prevention, sexual assault, alcohol and substance abuse treatment, family interventions, prosthetics, glasses, hearing aids and other aids for impairment.

Section H focuses on health records, the format, the content, confidentiality and specific information that is inclusive.

Section I focuses on medical legal issues, including such topics as right to treatment, right to refuse treatment, therapeutic restraints, informed consent for psychotropic medication and how corrections health information can be used in the court, and issues concerning research.

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 is 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, 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. Concern at the present time has to do with states' decreased interest in rehabilitating, educating and generally helping delinquent children and their specialized needs. 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, if not more stringent, than hospital affiliation.

Recommendations for Reform:

1. There needs to be requirements for standardized credentialing. 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 that 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.

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Chapter V

Healthcare in the Juvenile Justice System

By Robert Morris, MD

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 voluntarily seek care 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. Lastly, rehabilitation of delinquent youths 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 while others, for example, acne, while not medically serious substantially affects 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 healthcare 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 youths 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, non-judgmental care that allows youths 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. Healthcare services can be provided by university affiliated healthcare providers. This expansion of potential healthcare providers may also serve to develop new advocates for detained youth in the form of health professionals. Lastly, these physicians and other healthcare 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. Lastly, 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 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 Base Standards are being developed also by A.C.A. 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 USA 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 which result in momentary interest rarely create sustained concern and hardly ever enough on-going 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 politicians to address the welfare of incarcerated youth through state legislation.

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. Detention facilities should establish partnerships with pediatric academic centers in order to enhance quality improvement activities, to entice medical trainees to pursue juvenile corrections medicine and to expand pool of potential healthcare providers.
3. Fund research relevant to juvenile health and rehabilitation. Health risk behaviors, impulsive actions, and anti-social tendencies are not yet well understood by those who attempt to rehabilitate delinquents. The etiology of delinquent behavior including the role of child abuse, pre-natal 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. Detainees should have 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, which have a primary focus on sexually transmitted diseases, HIV, and birth control.

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Chapter VI

Females in the Juvenile Justice System

By Louis J. Kraus, MD

Introduction

In prior decades, concerns about female delinquents were minimized. For example, in Illinois there is no maximum-security facility for female delinquents, even if they are transferred to adult court and convicted of murder. A female delinquent would still be placed in a medium security facility.

The number of delinquent females is increasing at a faster rate than the number of males. Between 1989 and 1993, the number of delinquent females increased at twice the rate than for males. Females are an increasingly large proportion of delinquent youth (24% of juvenile arrests and 20% of juvenile court cases). Moreover, females are increasingly arrested for crimes against persons (29% in 1993 compared to 16% in 1989¹).

In 1997, there were 748,000 female delinquents arrested, representing 26% of all juvenile arrests. There has been increased concern about the seriousness of crimes females are committing. The relative greatest increase for cause for arrest is related to drug and curfew violations.

Current Status

Recent studies show that female delinquents may have more psychiatric morbidity and worse outcomes than their male counterparts. Dr. Linda Teplin's recent trials report that incarcerated females have higher rates of substance abuse, alcohol abuse, mental health disorders and co-morbidity with behavioral problems than their male counterparts. At present, there are no long-term, longitudinal studies that have assessed outcomes for females in corrections. Dr. Dorothy Lewis followed twenty-one delinquent females and found that they are unlikely to become violent criminals. However, she reported that they were at a much higher risk for suicidality, alcohol and substance abuse, and continuing self-destructing relationships.

Many have looked at early intervention programs for girls who are at risk, including girls with early behavioral problems, history of victimization, including physical and sexual assault, as well as emotional abuse and/or neglect. There are a variety of other risk factors that have been described, including family fragmentation, academic failure, behavior difficulties at school, health and mental health concerns. There continues to be a paucity of services for female juvenile offenders, which seems to be perpetuating the difficulties. At present there are few community-based programs for girls who have been adjudicated.

An example of such a program is the Baltimore Female Intervention Team, started in 1992. The focus is on gender specific programming that assists with evaluation and assessment of girls in detention and follows up with community-based programming.

Funding for gender specific programming has only been minimally supported. Specific areas of concern that need to be addressed are girls' increased risk for mental health issues, sexually transmitted diseases, including HIV/AIDS, and drug abuse.

Once delinquent females are released from incarceration, there are often few services for them in the community. This results in increased risk for recidivistic behavior, substance abuse and other mental health difficulties, including associating with other offenders and taking part in relationships that are abusive. Teplin has found that many adult female detainees had a history of adolescent difficulties.

Summary

In summary, there continues to be a paucity of gender specific interventions for female detainees, yet they continue at higher risk than their male counterparts for co-morbid mental health, alcohol, and substance abuse disorders. Female delinquents continue to be at extremely high risk for drug use, HIV and violent abuse. Often females' needs go undetected, and there continues to be many barriers to treatment. These continued difficulties will continue to minimize the likelihood of female delinquents participating as active members of society and being helped. Longitudinal understanding of this problem continues to need investigation.

Recommendations for Reform:

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

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Chapter VII

Disproportionate Minority Confinement

By William Arroyo, MD and William McMiller, MD

Disproportionate minority confinement (DMC) is a pattern of detaining or confining a proportion of youths in secure detention facilities, secure correctional facilities, jails and lockups that are members of minority groups that exceeds their groups' proportions in the general population. Minority populations as per the Juvenile Justice and Delinquency Act (JJDP) 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 asked States to address DMC. In 1992, DMC was elevated to a core requirement of the Juvenile Justice and Delinquency Act (JJDP) along with three others, namely, de-institutionalization of status offenders, removal of juveniles from adult jails and lockups, and separation (elimination all visual and auditory exposure) of juvenile offenders from adults in secure institutions. The DMC core requirement of the amended law mandated states receiving funding via U.S. Department of Justice had 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. Non-compliance with this core requirement or any other of the three core requirements could jeopardize their funding allocated through JJDP.

Current Status

Secure confinement

Minority youth in many states are over represented and receive disparate treatment in several stages of the juvenile justice system at various major decision points in the juvenile justice process including arrest, prosecution, adjudication, transfer to adult court, and especially in secure confinement. According to recent national data released (1999), minority youth constituted about 32% of the youth population in the country yet represented 68% of the juvenile population in secure detention and 68% of those in secure institutional environments such as training schools. 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 ages 10-17 account for 15% of their age group of the U.S. population and yet constitute 46% of youths in correctional institutions making them seven times more likely to be placed in a detention facility. Latino youth were held in custody in state public facilities on average 112 days more than white youth. New Mexico, California, Texas and Arizona, the states with the

largest proportions of Latino populations, all report disproportionate confinement of Latino youth in secure detention, corrections, or both.

Arrests

African-Americans are twice as likely to be arrested as white (Caucasian) youth accounting for nearly 26% of all juvenile arrests and 41% detained in juvenile delinquency cases. Latino youth arrest data are generally combined with white youth data by federal agencies.

Transfers to adult court

African Americans account for 46% of juveniles transferred to adult criminal court after judicial hearings. In California, youth of color are 2.5 times more likely than white youth to be tried as adults. In Los Angeles County, African American youth are 12 times more likely, Latino youth 6 times more likely, and Asian/other youth 3 times more likely to be transferred to adult court than white youth.

Secure state detention facilities

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 to white youths accused 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).

Attempts to Resolve DMC

Approximately forty-eight states, six territories, and District of Columbia have made attempts to gather data relevant to DMC and to develop implementation plans, an effort of limited success. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) has provided technical assistance to various states. A five state (Arizona, Florida, Iowa, North Carolina, and Oregon) pilot project to address DMC was conducted in the mid-90's. The pervasiveness of DMC and the significance and variability of local factors was evident in this project. The primary factors (or domains) contributing to DMC were found to be the juvenile justice system, the educational system, family, and socioeconomic conditions. The influence of each of these factors was noted on an individual basis and in combination with the others. Distrust of the justice system by minority groups was not uncommon and sometimes appeared to result in a vicious cycle of distrust and incarceration. A myriad of juvenile justice decision-making, prior to confinement, clearly influenced patterns of confinements in these states. These serious state efforts to address DMC required numerous resources, including funding, time, technical assistance, and commitment.

Some municipal jurisdictions have partially succeeded. Cook County, for example, the largest local jurisdiction in the country, has tried for nearly ten years to establish various alternatives to secure detention and incarceration including community service and mentoring programs for lesser offenses. These efforts have reduced the total number of youth in the system and duration of detention; DMC, however, still exists. Santa Cruz County in California has had remarkable success in this area where the DMC of Latinos decreased from 64% in 1998 to 46% in early 2000 in a span of 18 months with technical assistance from the Youth Law Center in San Francisco.

The JJDP law directs states to identify the extent to which DMC exists, to determine why it exists and to develop intervention strategies to reverse the trend. It does not require states to release youths from custody based on race nor does it require them to establish numerical quotas for arrests. Furthermore, not a single state has had their funding reduced as a result of their non-compliance with this mandate.

The reauthorization of JJDPA lapsed in 1995; funds, however, were still allocated to states. Efforts to reauthorize JJDPA have subsequently failed. The reauthorization effort in 2000 was in part hamstrung by gun control amendments, which received mixed support during that election year. The DMC requirement was actually deleted from one of the amended versions of the reauthorization bill being considered by Congress in 2000. The failure to pass JJDPA undermines efforts by states to address and resolve this pattern of confinement of minority youth whose families have historically had limited access to general community services. These youth must be given another opportunity to become productive citizens.

The increasing pattern of harsher consequences for youth who violate the law will likely result in higher numbers of minority youth being prosecuted as adults. One recent study indicated that one third of all African-American males ages 20 to 29 in the U.S. are under the jurisdiction of the criminal justice system; higher percentages exist in cities such as Baltimore and Washington, D.C. Drug enforcement policies and prior criminal records of minority defendants are key in this pattern.

The impact on minority families is extremely alarming. Adult felony convictions in most states result in the loss of voting rights for a period of time, if not for life. Thus 1.4 million African-American males, which represents 14% of African-American males of voting age, are now either currently or permanently banned from voting, which also translates into a loss of the voting power of their community. High rates of incarceration of minority adult males also diminishes the parenting effectiveness, reduces wage earning potential, employability, a disruption of family relationships, and increasing alienation of minority males from the larger society.

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 competence in policy and program development.
8. Review and change laws that encourage the disparate racial impact providing for prosecution of juveniles in 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 non-violent and/or status offenses; these offenses undermine efforts to procure employment in young adulthood.

Recommendations for Federal Reform:

1. Immediately reauthorize Juvenile Justice Delinquency and Prevention Act (JJDP A) with inclusion of the 1992 four core mandatory requirements.
2. Provide intensive technical assistance to States/jurisdictions for compliance with DMC requirement.
3. Support states' efforts to collect comprehensive data, to conduct analysis of data, and to develop research and data based state DMC intervention plans.
4. Strengthen the DMC protection in the JJDP A by enacting legislation to address DMC of youth at all points in the justice system from first contact with police to incarceration.

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 public.
2. Meet with legislators to provide input on how to reform the juvenile justice system.

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Chapter VIII

Seclusion and Restraint Standards in Juvenile Corrections

BY Louis Kraus, MD and Robert Morris, MD

Protocols for seclusion and restraint within departments of corrections are hazy. They are complicated by an overlap of rules for both seclusion and restraint covering general medical security and mental health 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. The use of medical seclusion. This is almost always an isolation process for infectious disease, but may also be used for a transition when a child is returned from the hospital secondary to illness or injury.
2. The use of 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. The use of mental health seclusion. The use of isolation versus simply removal from their 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, a risk of harm to others.

Types of mental health diagnoses may include depression, bipolar disorder, ADHD, 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

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. 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.

There are a variety of examples of security's use of restraints that for the most part go unquestioned. For example, youths that 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 that when youths are transferred out of a facility that they are placed in shackles. The point here is that shackles are clearly a form of restraint. This greatly limits a person's movement. The level of restraint and the type of shackles used determines limitations of movement.

Therapeutic restraints should only be used by qualified mental health professionals, where there is no less restrictive alternative. There are associated morbidity's associated with restraints including, fractures, nerve compression, soft tissue contusions and associated mortality's which primarily occur when a youth is being placed prone. There will be occasions where a decision must be made to place a child in restraints where a mental health professional may not be present. A physician, preferably a psychiatrist, must be contacted in as timely a manner as possible as per the state's mental health code. 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, a level of delirium or psychosis which is of such a significant nature that the teen is at acute risk of harm. There are times where this decision may be debatable, depending on a specific facility or individual. This needs to be further explored. 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, which institutions must minimally comply with.

Summary

In summary, there continues to be much debate and at times conflict, concerning the use of seclusion and restraint. In fact, many differ in regards to 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 youths, and on 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 youths in correctional facilities should be established. Indications for the various types of restraints – shackles, soft restraints, handcuffs, blankets, etc. – should also be established. Safety must be a priority in these standards.
2. National policy regarding duration of restraints should also be established.
3. The role of physicians and mental health professionals should be clearly delineated in such policies.
4. Close monitoring of confinement facilities regarding compliance with national policies on restraints should be periodically conducted.
5. Therapeutic use of seclusion and restraints in confinement facilities should be consistent with state mental health code at a minimum.

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Chapter IX

Meeting the Educational Needs of Incarcerated Youth

By Graeme Hansen, MD

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 re-entry into the community. An excellent set of rationales for the provision of educational programs in juvenile detention facilities is provided in *A Desktop Guide To Good Juvenile Detention Practice*, developed by the Office of Juvenile Justice and Delinquency Prevention (OJJDP):

- Most youth admitted to detention have a history of poor academic performance.
- 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 all youth up to a minimum age to attend school.
- It provides youth enrolled in school with an opportunity to keep current with their studies, and it facilitates 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, 1996).

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 conditions in many juvenile facilities, including woefully inadequate educational opportunities. "Many youth advocates, such as Mark Solar of the Youth Law Center, point out 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). A promising avenue for maintaining good quality of educational programs is seeking accreditation from professional educational associations and colleges.

Success in academic achievement, provided through a good school program in a juvenile facility, enhances the student's self-esteem, and provides capacities and

tools for more successful re-entry into the community. Many youth in the juvenile justice system have special educational needs or come into the system inadequately educated, and 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 liaison be designated to oversee the collaboration between the two authorities.

It is strongly recommended that an inter-agency agreement between the local school district and the agency that operates the juvenile detention facility be developed, and 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 inter-agency agreement, including how the program would be funded, what role correctional staff has in providing the discipline and disciplinary actions, 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 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.

Some educational programs in detention facilities are consolidated administratively and fiscally with correctional programs. Such arrangements discourage planning and decision-making with an exclusive focus on education for detained youth. Decision-making and planning for education should not be strongly influenced by correctional goals.

Youth With Special Educational Needs

There is considerable literature on the special educational needs of youth confined to juvenile justice facilities and to adult jails. Among the juvenile justice population, the prevalence rate for disabilities that affect learning is remarkably high, in contrast to the general population. 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 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, T.R., Rapport, J.K., 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; these services need to be individualized for each student, taking into account the environmental context, family culture, and the student's particular strengths and weaknesses.

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

1. Screening, identification and referral.
2. A comprehensive evaluation to determine the extent of the disability, and to evaluate what educational services would be necessary for that student.
3. An individualized education plan (IEP) that is developed by a special team that evaluates the student's particular needs and devises specific interventions to address those needs.
4. Individually tailored services and the educational services need to be provided in the least restrictive environment.
5. "Related services," which assist the student with disability to benefit from special education.
6. Procedural protections that ensure that the special education process is fair and proceeds according to statute.
7. A transition plan put in place and services provided when a student transitions from one level of care to another.

Although epidemiological studies of prevalence rates of disabilities in incarcerated youth show wide ranges (depending on the study), a conservative estimate is that 11% of the juvenile justice population show some type of learning disability (LD). Several significant studies show a connection between learning disabilities and juvenile delinquency.

Estimates for prevalence rates of at least one mental disorder, including substance abuse, vary widely, ranging from 40% to 70%. 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, a strikingly high and discrepant figure in proportion to the general population.

There are several studies that show a connection between these disabilities and juvenile delinquency. Several hypotheses have been developed to understand

this correlation, including the School Failure Hypothesis, which proposes that because of school failure, children drop out or feel disenfranchised, and this leads to delinquent behavior. The Differential Treatment Hypothesis proposes that children with these disabilities are treated differently, not only by the educational system, but are handled differently in society, which also leads to a sense of failure and to delinquent behavior. The Susceptibility Hypothesis proposes that the underlying disability or set of disabilities makes the youth more susceptible to a misunderstanding of the social system, inability to read social cues, and ultimately leads to delinquent behavior. The true picture is most likely a combination of factors from all of these hypotheses. 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 educational services in detention centers, including basic issues such as poor physical facilities, lack of trained and certified special education teachers, 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 incomplete and do not provide sufficient data to lead to an understanding of the child's particular difficulties.

It is estimated that somewhere between 20% and 30% of adult correctional inmates are youth, and this number is rising. Access to special education services is even less 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 are few formalized mechanisms to provide preparation and 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 a matter of days or weeks only; other youth are incarcerated either in juvenile or adult facilities for extensive periods.

Recommendations need to address both of these circumstances.

1. Meet the minimum standards set by federal and state laws of 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 possibility of learning disabilities, emotional behavioral

- disorders, or cognitive limitations that have an adverse effect upon learning to every youth entering the juvenile justice system.
4. Systematically identify all incarcerated youth who have special educational needs. Provide them with 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.

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Chapter X

Waiver of Juvenile Cases to Criminal Court

By Christopher Thomas, MD

One of the more important changes in juvenile justice over the past decade is 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, the majority are now required. The mandatory transfer of cases undermines a principle tenet of juvenile justice, that an individualized approach is the best way to handle youth offenses.

Background

Beginning in the 1980's, 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 criterion usually includes 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 if the case meets criteria set by law for waiver.

Concurrent jurisdiction (also referred to as prosecutor discretion or direct file) is another means where the prosecutor is allowed the decision as 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.). There is limited research on the impact of these changes, but initial reports indicate that they have not improved the handling of delinquents. One extensive review of long term outcome for youth tried in criminal courts compared to those in juvenile court found that waiver resulted in extensive delay of case processing without necessarily providing longer sentences (Fagan). A study on the impact of new waiver laws in Pennsylvania found that it referred many cases that would have been previously handled in juvenile 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 the change achieved little (Snyder and 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.). Waiver to adult criminal court can also result in youth being exposed to adult criminals with 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, Jensen & Metsger, Risler 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 as to 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 will result in additional delays.

Summary

The boundary between juvenile justice and criminal courts has changed for youth in the past decade. There is no evidence that automatic or mandatory waiver to criminal court improves community safety or reduces recidivism. Nor does it provide the individualized approach and services of juvenile justice. Waiver 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 waiver 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. Waiver 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 waiver does not achieve the desired goals and may be potentially harmful to the community and the involved youth.
2. Any waiver to adult 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. Further study must be devoted to explore other alternatives to waiver to adult court in order to develop a more effective juvenile justice system.

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Chapter XI

Juvenile Sex Offenders

By Wade C. Myers, MD

Background

Juvenile sex offenders are a heterogeneous group—more so than their adult counterparts—with widely varying etiologies, acts, and outcomes (Kaplan, 1999). According to U.S. Department of Justice statistics (Greenfield, 1997), youth under the age of 18 account for 16% of forcible rapes and 17% of other sex crimes. The typical juvenile sexual offender is an adolescent male with a history of nonsexual offenses as well. In about one-half to three-quarters of cases he himself will have been sexually abused. A history of impaired family functioning, child physical and sexual abuse, deficits in self-esteem and social skills, poor impulse control, mental disorders, lack of empathy, and deviant sexual interests are also common findings (Becker and Hunter, 1993; Shaw, 1999). Victims are usually younger females that are relatives or acquaintances of the perpetrator.

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 backwards, 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). Rubenstein, Yeager, Goodstein, and Lewis (1993) carried out a follow-up study of 19 sexually assaultive male juveniles who had been incarcerated for their offenses without treatment. At a mean follow-up period of eight years, 37% had reoffended sexually, and some had committed multiple sexual offenses. Moreover, 89% had been rearrested for other kinds of violent offenses and had committed twice as many violent offenses as the violent juveniles who had served as a control group. In contrast, Sipe, Jensen, and Everett (1998) followed up a group of 124 nonviolent juvenile sexual offenders after a mean of six years, and found a recidivism rate of 9.7%. These authors concluded that we should expect differing recidivism rates by type of presenting sexual offense. Thus, it appears that the violent adolescent sexual offender is at greater risk for becoming a serial sex offender.

Treatment Issues

Rasmussen (1999) examined factors related to recidivism in juvenile sexual offenders. Molestation of multiple victims, parental divorce or separation, and a history of sexual abuse increased the odds of the youth reoffending sexually. The recommendation was made to address all factors in treatment that may contribute to any type of criminal behavior—not just those that appear directly related to the sexual offending. This recommendation comports with the

successful use of multisystemic therapy in a small sample of adolescent sex offenders (N = 8). In this study, those treated with multisystemic therapy had a lower recidivism rate at three years (12.5%) when compared to a control group treated with individual counseling (75%) (Borduin, Henggeler, Blaske, & Stein, 1990).

The U.S. Supreme Court has upheld the constitutionality of violent sexual predator commitment proceedings for prison inmates who have completed their sentences, *Kansas v. Hendricks* 117 S. Ct. (1997). This proceeding results in some offenders being placed in state hospitals 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. The application of this legal procedure to juvenile sexual offenders raises significant concern. At a minimum, the youth's appropriateness for such an intervention 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 not uncommonly still developing their psychosexual identity, and may therefore be more amenable to community treatment. Less restrictive alternatives that would better facilitate their reentry into the community, and not place them around older, more sophisticated adult sexual offenders in forensic institutions, should be strongly considered whenever possible.

In general, treatment of the juvenile sexual offender can range from community-based services to psychopharmacology to intensive residential treatment, the latter sometimes requiring two or more years of treatment in certain instances (Hunter, 1999). Treatment programs typically employ some combination of individual, group, family, social skills, behavioral, and educational therapies. Cognitive-behavioral therapy is felt to be the most useful of psychotherapies for this population. It is also helpful in treating this population to have the court system involved so that there is added motivation to consistently participate in therapeutic endeavors.

Treatment results for juvenile sexual offenders have been variable, with some cautiously optimistic recidivism rates in the range of 10% at roughly one to two or more years follow-up (Becker, 1990; Bremer, 1992; Hunter, 1999). In all fairness, these same outcomes can be just as easily viewed from a pessimistic perspective based on the relatively short periods of time after treatment used to assess recidivism rates. One of the difficulties in assessing treatment outcomes is accurately determining rates of recidivism. Rearrest rates are spuriously low indicators of recidivism rates, as most offenders are not arrested for any given offense. Moreover, self-report measures are dependent on the reporter answering honestly, and thus can be unreliable. This is particularly true in a population that has some members with antisocial character traits, who may not be convinced of reassurances of confidentiality when asked to self-report, and who stand to lose their liberty if they are caught for their sex offenses.

In summary, society will be best served if we can improve our ability to identify and provide treatment for those youth most likely to benefit from therapeutic interventions.

Recommendations for Reform:

1. Fund research in two key areas in order to: (a) better define subtypes of juvenile sexual offenders that will allow clearer predictions of treatment amenability and recidivism, and (b) continue further development and assessment of treatment programs and their effectiveness.
2. Placements of sexually offending youth should meet their developmental needs.
3. Placements with sexually offending adults should be avoided.
4. Identify those youth who are most likely to benefit from therapeutic interventions.

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Chapter XII
Juvenile Death Sentences
AACAP Policy Statement

Approved by Council, October 24, 2000

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 judgement. 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 over represented 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.

Recommendations for Reform:

1. All relevant agencies and organizations should adopt a similar statement.
2. Advocate changing laws that allow for capital punishment for individuals whose offense occurred prior to the age of 18.

Chapter XIII

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

By Carol Kessler, MD

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, 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 receive federal funding through public law 103-322. Youth, entering the justice system charged with non-violent 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

is performed of the young person and his/her family. 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, assures youth and family adherence, as well as community agency accountability to the treatment plan. The judge also motivates the youth, praising their progress, and applying such sanctions as brief detention for non-adherence to treatment plans. Juvenile drug courts such as that of Escambia County in Pensacola, Fla. 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 in the criminal justice system, many of whom also suffer from substance dependence. Broward County, Fla. paved the way in June '97, and inspired King County, WA. 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, they have "brought humanity to people who have been abused by the criminal justice system for way to 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, KY, 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, as judge. Peers who don’t condone delinquent behaviors thereby hold young offenders accountable. Offenders learn about the judicial and legal systems, and learn to resolve conflict through listening and problem-solving skills. Young people learn of the impact of their behavior on themselves, their peers, and on their community, and they learn of their potential to be agents of both self 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’ve 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 NYC 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 re-claim and nurture their young peoples’ 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 youths in the juvenile justice system. Over the last 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 has been reported in urban, suburban and rural programs.

Two approaches with demonstrated efficacy are multi-systemic 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 has 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 multi-state 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 (P.L. 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 (P.L. 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., Multi Systemic Therapy and Wraparound.
5. Timely cultural 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.

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Chapter XIV

A Model Program – The Island Youth Programs

By Christopher R. Thomas, MD

The rapid increase in youth violence in America in the late 1980's 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 inter-related 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 will also provide critical information on the development of youth violence and factors like 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 4 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 three years. Project funding repaired two existing community youth centers and purchased equipment and program materials, including 4 fifteen-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 competence 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 yearlong 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 that 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 youths have been through Peer Court with 208 cases 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 just 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, youth picked up by the police for violation of the curfew will not be arrested. If they do not have a valid reason to be out of school then they will be

taken to the TABS center. A coordinator provides screening and counseling. Parents are then contacted to pick up their child and return them 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 the program 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 amongst 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 4 counselors work in coordination with juvenile probation officers. Counselors go into the homes to work with youth and families intensively for three 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, motivational system, and 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 youths to cope with family, peer, school, and neighborhood problems. 76 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 assured 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 assured 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, multi-faceted 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 two years after birth; among others.

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.

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Epilogue

The Task Force on Juvenile Justice Reform was established 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.

There continues to be a variety of deficits in the juvenile justice system on all levels, both pre- and post-adjudicatory. There continues to be much concern over the court process and the need for appropriate assessment of youths who are in the process of adjudication within juvenile court. There have been a variety of areas of concern, including the disproportionately large number of mentally ill children within the juvenile court population, the disproportionately high number of minorities within the court system and juvenile corrections and the increasingly large number of females within the court system.

Recent studies have shown that there continues to be significant unmet mental health, developmental, and educational needs for youth within corrections. Important issues that need to be addressed include the high association of alcohol and substance abuse with teens in corrections in association with other high risk behaviors that place these children at high risk for sexually transmitted diseases, including HIV and of increased risk for unwanted pregnancy. There are few programs set up to attempt to educate these children.

Much of our future is dependent on juvenile justice reform. Many of these children can be helped if their difficulties/deficits are identified and appropriate interventions put into place. The focus must cover the life span of the child, including mothers having appropriate prenatal care, not abusing drugs and alcohol during pregnancy, appropriate early intervention programs for children at risk, having community-based wraparound services for children in need, and making sure that a child's basic educational needs are being met. There is a need to better assess our nation's pre- and post-adjudicatory correctional institutions. There is still state-by-state variation in accreditation and focus with some facilities more punitive and some rehabilitative.

It is time to look at the patterns of incarceration of our youth and what can be accomplished to set up new models, including correctional, residential and community-based programs. Although the cost of improving our juvenile justice system seems high, it is insignificant compared to what we will pay by ignoring the mental health needs of juveniles in the system.

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