

Chapter 18

Juvenile Corrections and Public Health Collaborations: Opportunities for Improved Health Outcomes

Michelle Staples-Horne, Kaiyti Duffy, and Michele T. Rorie

Most juveniles behind bars move in and out of facilities with short lengths of stay. Relatively few have longer sentences for more serious crimes; they all return to the community. In 2003, law enforcement agencies reported 2.2 million arrests of persons under age 18 (Snyder & Sickmund, 2006). The most serious charges in almost half of all juvenile arrests were for larceny-theft, simple assault, drugs, disorderly conduct, or liquor law violations (Snyder & Sickmund, 2006). The brevity and frequency of these contacts with correctional institutions create challenges and opportunities for health promotion and intervention during incarceration and in preparation for reentry. As the character of juvenile populations varies by region, the services must be customized to the developmental, cultural, and linguistic needs of the local inmate population. To do this, it is essential to understand the background of these young men and women, where they come from, and what circumstances contributed to their incarceration.

Antecedents of Juvenile Detention

In 2006, children under the age of 19 represented approximately 26% of the U.S. population; almost half of these were adolescents (U.S. Census Bureau, 2007). Though the percentage of the total population will remain stable, by 2050 the number of children in the United States will be approximately 36% larger than it was in 2000 (U.S. Census Bureau, 2004). As this population grows, successful transition from adolescence to adulthood becomes more important to the development of a healthy society. There are many forces that shape adolescents' development and treatment, not the least of which are race, ethnicity, socio-economic status, family structure, and sexual identity. Though incarcerated young men and women come from diverse backgrounds, the majority share the common experience of economic and social disadvantage.

The racial makeup of the juvenile justice population varies by region of the country. In 2002, of all incarcerated U.S. juveniles, 77.9% self-identified as white, 16.4% as black, 1.4% as American Indian, and 4.4% as Asian. Hispanic ethnicity, aside from race, was 18% overall. Ninety-two percent of Hispanic juveniles identified racially as white. These percentages varied significantly

by region, however. In the West, a much larger percent of juveniles identified as Hispanic, for example, 51% in New Mexico, 45% in California, 42% in Texas, 37% in Arizona, 30% in Nevada, and 24% in Colorado (Snyder & Sickmund, 2006).

Additionally, states with large native populations (Alaska, South Dakota, New Mexico, and Oklahoma) had juvenile populations with more than 10% American Indian or Alaska Natives. In the District of Columbia, a predominantly African-American city, 72% of the juvenile inmates were black. This is replicated in many southern states including: Mississippi (45%), Louisiana (40%), South Carolina (37%), Georgia (34%), Maryland (33%), and Alabama (32%) (Snyder & Sickmund, 2006).

As with adults, racial minorities have been overrepresented in juvenile justice systems across this country. Black youth, who accounted for 16% of the incarcerated juvenile population in 2003, were involved in a disproportionate number of juvenile arrests for robbery (63%), murder (48%), motor vehicle theft (40%), and aggravated assault (38%) (Snyder & Sickmund, 2006).

Though race and ethnicity are important factors affecting the development of a young person's identity and experiences of prejudice and discrimination, data suggest that socioeconomic status and family structure have a far greater influence on the risk of juvenile incarceration. In 2002, 17% of persons under 18 lived in poverty (based on the poverty threshold of income and family size, adjusted for inflation, using federal government standards), with many living in extreme poverty (U.S. Census Bureau, 2004). Lower socioeconomic status disproportionately affects young men and women of color. Almost one-third of black, 28.6% of Hispanic, and 11.7% of Asian juveniles live in poverty compared to 9.2% of whites.

Research indicates a link between poverty and juvenile delinquency (Snyder & Sickmund, 2006). Because of lack of resources, many lower income communities cannot provide the social supports needed for youth to reach their full potential, including adequate schools, community centers, and hospitals and clinics (Zigler, Taussig, & Black, 1992). Youth in these communities are much more likely to experience violent crime. A study by Lauritsen (2003) indicated that juveniles were more likely to be victims of violent crime if they lived in a disadvantaged community (i.e., high percentages of persons living in poverty, single-parent families with children, unemployment, and households receiving public assistance).

Family structure is also associated with a young person's likelihood of living in poverty and relying on public assistance for sustenance. More than half (52%) of all children living below the poverty level in 2002 were living in single-mother families. Although a greater proportion of children of color live in single-parent households, the proportion of incarcerated juveniles, regardless of race, living in single-parent households increased from 9% in 1960 to 27% in 2002. In 2002, 62% of all children receiving public assistance and 61% receiving food stamps lived in single-mother families (Fields, 2003).

McCurley and Snyder (2006) report that family structure is a better predictor of self-reported problem behaviors, such as running away from home, sexual activity, major theft, assault, and arrest, than race or ethnicity. One reason for this may be that children living in single-parent homes are often at greater risk of abuse and/or neglect. Research (Lauritsen, 2003) indicates that juveniles in single-parent families experienced a 50% greater risk of violence than those

in two-parent families. Additionally, young people in single parent families often lack supervision, making them susceptible to risk behaviors.

Though disadvantaged and lower income youth are at higher risk for incarceration, their social misfortune provides increased opportunities for intervention. A large number of juveniles in families receiving public assistance and food stamps will interact with public health facilities and providers by virtue of their Medicaid eligibility for health services. Health professionals should be better trained to assess physical, psychological, and behavioral risk during these encounters.

Medical Needs of Incarcerated Juveniles

Often, the public perceives juveniles as “well enough to get in trouble.” Ironically, it is often the behaviors that got them into trouble that increase their risk for morbidity and mortality. For instance, juvenile detainees are more likely to have experimented with smoking, alcohol, and drug use; engaged in risky sexual behaviors with multiple sex partners and lack of condom use; used weapons; and experienced violence and other risk taking behaviors (Crosby et al., 2003). These behaviors increase their likelihood of trauma, accidents, and disease.

A classic study conducted by Hein, Cohen, and Litt (1980) remains the largest study of health status of detainees. The study was conducted at the Spofford Juvenile Detention Center in New York between July 1968 and June 1979, during which 88,106 youth were admitted to the facility; 40,818 received a brief screening since they remained in the facility less than 24 hours. Of the 47,288 adolescents examined more fully, medical problems were diagnosed in 46%. The population demographics were 80% male, 60% African-American, and 25% Hispanic surnamed. The average age was 15 with an average length of stay of 14 days. In this study, the most commonly diagnosed conditions were upper respiratory infections (17%), minor dermatological problems (14%), minor trauma (21%), and psychosomatic states (18%).

Anderson and Farrow (1998) described health services provided for incarcerated adolescents in Washington State. For short-term detention centers with a mean daily population of 47.2, the most common reasons for sick call visits were for substance use (36.6%), trauma (30.8%), psychiatric (21.8%), dermatological (19.2%), respiratory (15.5%), and sexually transmitted diseases (15.3%). For long-term facilities with a mean daily population of 161.7, the most common complaints were for dental care (65.9%), psychiatric (44.9%), dermatological (44.1%), respiratory (35.6%), trauma (35.4%), and substance use (33.7%).

Feinstein et al. reported (1998) the medical status and history of health care utilization of juvenile offenders on admission to an 80-bed detention center in Birmingham, Alabama. African Americans made up 74.5%, while white non-Hispanic males made up 15.4% of the population. Only 7.3% of the juveniles were African-American females and 2.8% white non-Hispanic females. The most common condition was asthma. Other common conditions included: orthopedic problems, mental illness, hearing-related problems, and pregnancy. Almost one-fifth (16.5%) reported a history of hospitalization, the majority of these resulting from trauma-related injuries. Despite these findings, only

a third of these youth reported a source of regular medical care, and only 20% reported having a private physician.

The provision of health care to adolescents in an incarcerated environment presents a challenge to health care providers, as well as administration and security staff. The health care model is often perceived as contradictory in a correctional setting. Custody staff, medical providers, and public health agencies have different goals. Fulfilling security requirements and protecting the public safety are the correctional facility's primary goals. In contrast, assuring that the juveniles receive unimpeded access to appropriate medical care is the primary goal of the facility medical provider. The public health agency's goal is to provide disease surveillance and protect the health of the free-world community through risk reduction, disease identification, and treatment. On the surface, it may seem that these goals conflict, but they need not, especially if the mission of the agency includes access to appropriate medical care and continuity of care with community practitioners.

Collaboration is the key to success. A 1997 NIH/CDC study (Hammett, 1998) analyzed data from a prison and jail survey to identify elements of successful collaboration in the prevention and treatment of HIV/AIDS, STDs, and TB. The key recommendations of the study were:

- Public health agencies should collect and disseminate data on the burden of infectious disease in inmate populations.
- Correctional agencies should be represented on all HIV Prevention Planning groups
- Public health agencies should initiate or expand funding for services and staff in correctional facilities
- Public health and correctional agencies should recognize the importance and potential benefits of interventions in correctional settings to the health of the larger community

Oral Health

Oral health is an important part of overall health and self-esteem. In a review by Treadwell and Formicola (2005), no data were found on the oral health needs of incarcerated juveniles. However, in the general population, 80% of tooth decay occurs among 25% of children 5–17 years of age, primarily in minority and low-income families and in children with low educational levels. These are the children who are disproportionately represented in juvenile justice facilities. For incarcerated adolescents, there are few preventive services and often failure to access dental services, even when covered by Medicaid.

Immunizations

The federally funded Vaccine for Children Program may be used to provide free vaccine to incarcerated juveniles. Public health agencies should be aggressive in enrolling all juvenile correctional facilities in this program and assist them in meeting program requirements.

Routine vaccine for hepatitis B has been recommended for high-risk groups since 1982 and for adolescents generally since 1996. Since risk behaviors

for the spread of hepatitis B are highly prevalent in the juvenile population, this vaccine in particular should be strongly promoted. As hepatitis B can be a sexually transmitted infection, juveniles can receive the vaccine without a parent or guardian's consent.

Between November 2001 and March 2004, the Georgia Department of Juvenile Justice, in collaboration with the Georgia Department of Human Resources, Division of Public Health, immunized 16,182 juvenile offenders across 30 detention and long-term secure facilities with hepatitis B vaccine. The Department has continued this aggressive immunization program. The long-term implications of this initiative with regards to decreased morbidity and mortality, reduced medical costs for adult corrections and community health care, increased productivity, and overall reduction in infection rates will likely be significant.

Many states have implemented systems to electronically track immunizations. These systems allow for immunization data to be both retrieved and entered by all registered health providers. Public health agencies have taken the lead in this effort, working with community health care providers. Juvenile justice agencies should gain access to these databases, review immunization status on intake to facilities, and assure that patients are fully immunized prior to release. Where full immunization is not possible because of length of stay, public health agencies can follow up on any remaining dosages required on release.

Providing Comprehensive, Adolescent-Friendly Health Care to Incarcerated Juveniles

Health care and prevention efforts within the juvenile justice system should address the extant risks and conditions of incarcerated youth, focusing on treatment and guidance on healthier living on release. As adolescents are different from children and adults, emotionally, physically, and mentally, their health care services should reflect these differences. Services should be developmentally appropriate and adolescent specific, paying particular attention to the many factors affecting health decisions and behaviors.

Juvenile justice facilities detain youth of varying ages. The needs of these youth differ by stage of development and mental ability. The early adolescent (usually ranging from 10 to 13 years old) is mostly very concrete in his/her thought process. Therefore, counseling and behavioral interventions must reflect this concrete thinking. For instance, a tobacco prevention/cessation program for a young person in this age group should focus on the physical unpleasantness associated with smoking, i.e., bad breath and yellowing teeth, instead of the later health complications that may resound with an older teenager. At this age, the majority of young people will begin the process of physical sexual maturation but this does not mean that the individual has not already initiated sexual activity.

In middle adolescence (ranging from age 14 to 16), the physical changes of puberty are complete and thought processes become more abstract. In this stage, the individual develops a stronger sense of identity and is more susceptible to the influences of peer groups. Counseling and interventions for these teens should incorporate the role of friends and peers in risk-taking behaviors.

Late adolescence encompasses 17 years old and above. In this stage, the body continues to take on adult form and the process of identity development continues. These young men and women, on the verge of becoming legal adults, are of particular concern for juvenile justice authorities and the public health community. Though they might look and often act like adults, these young men and women are still in need of counseling, care, and intervention.

The major causes of morbidity and mortality in these adolescents are unintentional injuries, many of which are related to alcohol and drug use. Other causes of morbidity include unintended pregnancy, sexually transmitted diseases, eating disorders, and depression (Eaton et al., 2006). These factors are not easily discernable from the traditional patient provider model of health interviewing. An alternative model, the HEADSS Model, was developed in 1972 by Dr. Harvey Berman of Seattle and refined by Dr. Eric Cohen and Dr. John M. Goldenring. An acronym for Home, Education/Employment, Activities, Drugs, Depression, Safety, and Sexuality, this model can be particularly useful in the juvenile justice system as health care practitioners explore the complex forces affecting an adolescent's behavior and health outcomes (Goldenring & Cohen, 1988).

In addition to being adolescent specific, services provided to juvenile justice detainees should be culturally and linguistically competent. This includes sensitivity to the ways that culture and health interact. An individual's culture can have profound impact on how pain and illness manifest and when and how individuals seek care. Youth from cultures with stoic attitudes toward illness, may not present for treatment. Also, the acknowledgment and treatment of mental illness may not be acceptable in some cultures which could prevent those youth from seeking treatment for symptoms. As the juvenile justice system is so diverse, professionals need to be trained to assess the effect of culture (including acculturation and cultural isolation) on a detainee's health and risk behavior. Youth may be the first generation in their family to be born in the United States, or may have immigrated recently. These youth may be trapped between the health perceptions of two cultures during the already difficult period of adolescence. Additionally, care must be taken when communicating with youth who do not speak English proficiently. Efforts to address this can include the use of translators and hiring health professionals who are fluent in different languages.

Medical professionals in the juvenile justice system should be aware that insensitive attitudes on the part of practitioners, lack of knowledge and skills regarding reproductive and sexual health, insufficient or inadequate communication, and clinician discomfort with different cultures or the discussion of risk behaviors with adolescents can prevent a young person from disclosing vital health information (Huppert & Adams Hillard, 2003). The final important factor in providing adolescent-friendly health services involves discussing and assuring confidentiality wherever possible. Concerns regarding confidentiality keep many young people from disclosing crucial health information and from seeking care. For instance, a recent study of girls younger than 18 attending family planning clinics found that 47% would no longer attend if their parents had to be notified that they were seeking prescription birth control pills or devices, and another 10% would delay or discontinue STI testing or treatment (Reddy, Fleming, & Swain, 2002).

In the juvenile justice system, parents and/or guardians are not present but concerns about confidentiality still exist and detainees should be assured that their disclosures will be kept confidential. There are times when the provider may need to contact a parent and times when the law allows such contact, but the bias should be toward confidentiality. If a patient appears to be a danger to him/herself or to another person, state laws mandate that a provider inform parents or authorities. Laws governing minors' access and confidentiality to services differ state by state, and many health care providers are unaware of minors' ability to consent to certain confidential health services. Title X dictates that family planning services must be confidential. In many states, confidentiality is decided by the provider but because Title X is federal, it preempts state statutes. Medicaid provides for confidential services to minors, along with Title X.

Federal Medical Privacy Regulations also apply. There is variation across the country among juvenile correctional facilities regarding federal HIPAA compliance. There is a general HIPAA exclusion for correctional facilities; however, if any part of a juvenile justice system is billing electronically for medical services such as Medicaid, they should be HIPAA compliant. It is also advisable that public health and juvenile justice both be HIPAA compliant, so that medical information can pass freely between agencies for improved continuity of care, allowing for appropriate consents from youth and parents/guardians to be utilized. Memoranda of Understanding (MOUs) between agencies can address any HIPAA concerns regarding sharing of confidential medical information.

Reproductive Health Needs of Incarcerated Juveniles

Adolescents in correctional facilities report becoming sexually active at earlier ages and partaking in risky sexual behaviors more frequently than their nonincarcerated peers (Strack & Alexander, 2000). In one study of juvenile offenders aged 14–18, 87% of the sample reported being sexually active. Over one-third reported having sex *before* they were 12 years old and 57% before they were 13 years old. The median age for first sex was 12 for males and 13 for females. Of those who reported having sexual intercourse, half (49%) had had 6 or more partners in their lifetimes, including 22% with 6–10 partners and 16% with more than 20 partners. Of all the sexually active youth, over half had had sex in the past month and 42% reported having *multiple* partners in the past 3 months (Strack & Alexander, 2000). In another study of sexual debut among female juvenile offenders, results showed that the mean age of sexual debut was 13. The mean number of sex partners (lifetime) was 8.8 (Crosby et al., 2004).

Though incarcerated juveniles report greater sexual risk-taking behavior, many do not use condoms consistently (Morrison, Baker, & Gillmore, 1994). Strack and Alexander (2000) found that 44% of the youth reported using condoms only about half the time or less and nearly one fifth of the youth indicating that they *never use* a condom. Among those youth who have had anal intercourse, 70% have had anal sex at least once without a condom. Another study of incarcerated juveniles found that although 96% of female and male respondents were sexually active, only 4% used a condom consistently (Crosby et al., 2004).

Although sexual activity is prohibited within juvenile correctional facilities, it may be occurring either consensually or by sexual assault. The Prison Rape Elimination Act (PREA) was enacted by Congress and will require all correctional facilities, including those serving juveniles, to implement policies and procedures to eliminate prison rape.

Because the majority of detainees have had sex, the discussion of sexual behaviors, including risk and protection, should be included in every preventive medical encounter. Providers should include questions about age at first vaginal, oral, and anal intercourse, current sexual practices, number of partners within the last 3 months, and gender(s) of partners. Though same-sex sexual relations between juvenile detainees are officially prohibited, many detainees may have had same-sex sexual experiences in the past. Additionally, same-sex sexual contact may be occurring within the facility. (See section on Special Populations: GLBTQ Youth.) When questioning all youth about sexual behaviors, it is important to use the word *partner* and not *boyfriend* or *girlfriend* so as not to assume heterosexuality and behaviors. Many youth may be having sex with casual partners or sex work clients who they would not consider as a “boyfriend” or “girlfriend.” They may use these terms in reference to a regular partner with whom there may be an emotional attachment.

Additionally, all reproductive health clinical interviews should include discussions on condoms. Though juvenile justice systems often have restrictions on displaying and dispensing condoms within the facility, medical providers and health educators can educate inmates regarding correct and consistent use of condoms so they will be better equipped to protect themselves after incarceration. On release, detainees should either be given (depending on institutional policy) or told where condoms can be purchased or are given out for free.

Due to the high rates of sexual risk behaviors and low rates of condom use, it is not surprising that juvenile detainees experience higher rates of sexually transmitted infections (STIs), including HIV. In one study, 20% of juvenile detainees tested positive for an STI (Crosby et al., 2004). Rates of chlamydia among juvenile detainees range between 2.4, and 27% in females and 1 and 8% in males (Lofy, Hofmann, Mosure, Fine, & Marrazzo, 2006; Kahn et al., 2005; Robertson & Thomas, 2005). Because these rates are so much higher than in the general population, chlamydia screening is recommended for *both* males and females. Gonorrhea rates are also disproportionately high for juvenile detainees—from 0 to 17% in females and 0 to 18% in males (Kahn et al., 2005; Robertson & Thomas, 2005).

In addition to chlamydia and gonorrhea, other STIs affect incarcerated youth, although these are the most common. A 1996 study assessed the prevalence of genital herpes in a sample of detained juveniles and found that 15% of the males and 20% of the females tested positive (Huerta et al., 1996). HPV prevalence has not been defined in this population, but can be extrapolated as being high, based on the other STI data available, low condom use, early sexual debut, and abnormal Pap smears among female juvenile offenders.

The public health implications of these data are overwhelming. Though statistics demonstrate that incarcerated young men and women are at high risk for STIs, many are still not tested. Recent data are limited, but in 1994, 53% of incarcerated juveniles were screened for STIs. In 33% of the surveyed facilities, nonmedical personnel did the screening (Parent et al., 1994). The detention and confinement period for juveniles is a golden opportunity for

screening and treatment of STIs by juvenile justice and public health agencies, which should develop the resources to implement effective screening and treatment programs.

New urine-based tests can improve compliance for testing and may be easily incorporated into the intake process of the juvenile correctional facility. The urine-based nucleic acid amplification tests (NAATs) are highly sensitive and specific. Self-collected genital specimens can be used to accurately diagnose chlamydia and gonorrhea infections. In many cases, use of urine specimens can reduce the necessity for a pelvic examination on females and urethral swabs for males, thus extending the diagnostic capability for detecting these infections in nonclinic screening venues (CDC, 2006).

Public health agencies must consider partnering with juvenile justice agencies to promote and facilitate STI screening and treatment of juvenile offenders prior to their return to the community. Partnerships may be informal with staff communicating regarding treatment and follow up and partner notification or may become formalized with the development of an agreement such as a Memorandum of Understanding (MOU). An MOU can allow sharing of information across agencies and define all parties' responsibilities whether in kind or with some fiscal responsibility.

HIV infection rates are growing among this population based on risk behaviors. Adult correctional populations have at least six times the prevalence of HIV than the general population (CDC, 1996). The prevalence of HIV within juvenile correctional facilities is not documented well, as many juvenile systems do not have universal or mandatory testing. Also, adults may be presenting medically with AIDS while infected juveniles may not be symptomatic yet. Juvenile justice facilities should be encouraged to implement the latest CDC recommendations of opt-out testing for HIV incorporated into the routine health care admission process. However, the agency should be prepared for positive HIV test results and develop a mechanism to provide treatment while the youth is still incarcerated and appropriate follow-up on release into the community.

Young men and women confined in the juvenile justice system are also more likely to have been pregnant or involved in a pregnancy. A 2004 study indicated that 32.2% of juveniles had ever been pregnant (Crosby et al., 2004). Another study found that more half (52.3%) of the sexually active youth in out-of-home care reported that they thought they or their partners were pregnant at one time, but found out that they were not. Twenty-five percent indicated two or more such instances (Strack & Alexander, 2004).

A substantial number of young women are pregnant upon their confinement in the juvenile justice system. A 1995 study of 261 juvenile detention facilities found that 68% of the respondents estimated that they were holding one to five pregnant adolescents on a given day, with a reported yearly census of 2000 pregnant teenagers and 1200 teenaged mothers. Nearly half of the facilities (45%) continue to incarcerate after it is determined that a youth is pregnant. Of those institutions that incarcerate pregnant adolescents, 31% provide no prenatal services and 70% provide no parenting classes. Of these facilities, 60% reported at least one obstetric complication in their pregnant population (Breuner & Farrow, 1995).

Pregnancy testing should be a routine part of medical intake for all females entering juvenile correctional facilities. As more than half of all rapes (54%) of women occur before age 18, juvenile justice health professionals should

assess for sexual trauma on diagnosis of pregnancy (Tjaden & Thoennes, 2000). Additionally, detainees should be provided with unbiased and comprehensive options counseling regarding their choices, including parenthood, adoption, and pregnancy termination. Juvenile corrections, public health, and other child serving agencies should partner to provide the best outcome for the young offender whatever her choice. If the pregnancy is continued, prenatal care can be provided through coordination with public health agencies. Many females will be discharged from the facility prior to delivery, so follow up into the community for obstetric care is essential. If the young woman decides to terminate the pregnancy, the detention center, while acting within the confines of state law, should see to it that the termination is obtained at the earliest gestation possible.

Although the juvenile justice system is predominately male, pregnancy prevention interventions are needed in this population. Information on pregnancy prevention, particularly contraception, should be provided to males as well as females in the clinical setting. For instance, many young men and women are unaware of emergency contraception. In the event of forced intercourse or contraceptive failure, emergency contraception provides a second chance to prevent pregnancy. Though commonly referred to as “the morning-after pill,” the drug regimen has reasonable effectiveness up to 120 hours after unprotected intercourse. Discussion of emergency contraception should be incorporated into the medical intake process. If the young woman has had unprotected intercourse in the last 5 days, juvenile justice medical personnel should be prepared to administer emergency contraception. Young women and men should be educated regarding emergency contraception before release to prevent future pregnancies.

As noted, young men and women run significant reproductive health risks before incarceration. These risks persist and even increase after release. In a 2003 study of the sexual behaviors of young men on release from incarceration, results indicated that 36% men reported having had risky sex (\geq two female sex partners and unprotected vaginal sex) in the months following reentry (MacGowan et al. 2003). Therefore, the period of incarceration is an excellent time to initiate pregnancy and STI prevention interventions for both young women and men. In addition to clinical counseling, these can include programs that focus on the antecedents of risky sexual behavior: knowledge of reproductive physiology, condoms, and contraception; and programs that focus on the nonsexual antecedents such as self-efficacy and communication skills.

One final step in public health efforts to reduce pregnancy on release is to partner with juvenile justice agencies in the provision of family planning services during incarceration. Contraception should be provided on release or initiated while the youth is still incarcerated. There are many advantages to the latter. Even though detained young women are not sexually active, initiating a method of contraception will allow for adjustment to the medication and resolution of any related problems while the individual has full access to a medical provider.

Mental Health and Substance Abuse

Nearly one-third of teens report episodes of sadness, depression, and hopelessness (Eaton, 2006). Depression is defined as an illness when the feelings of sadness, hopelessness, and despair persist and interfere with a teen’s ability to

function. It is more than the normal, everyday ups and downs or the “blues,” as some may refer to them. It also is not just situational, relating solely to the fact that the youth is incarcerated. The term *clinical depression* is used when this mood persists for more than a couple of weeks. Clinical depression is a serious health problem that can change behavior, physical health and appearance, academic performance, social activity, and the ability to handle everyday decisions and pressures (DSM-IV, 1994). These feelings may prevent youth from seeking preventive health care and complying with health regimens which can affect behavioral problems and eventual incarceration.

Between two-thirds and three-quarters of detained youths have one or more psychiatric disorders (Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). Federal courts have affirmed that under the U.S. Constitution’s Eighth and Fourteenth Amendments, which bar cruel and unusual punishment and assure the right to substantive due process for youth in the juvenile justice system, detainees with serious mental disorders have a right to receive needed treatment as part of the state’s obligation to provide needed medical care (*Estelle v. Gamble*, 1976; *Ruiz v. Estelle*, 1980; *Madrid v. Gomez*, 1995; *Bowring v. Godwin*, 1977). In addition to this argument that all children with mental illness are deserving of care, to ignore this major affliction may contribute to public health and legal problems such as continuation of antisocial behavior, higher health care use, and criminal recidivism.

Despite these known risks, this population remains largely underserved. According to a study done by Teplin, Abram, McClellan, Washburn, and Pikus (2005), there are two reasons juvenile justice youth may receive even fewer services than youth in the general population. The first is that juvenile justice youth (as previously discussed) are disproportionately poor, as well as undereducated; these characteristics limit the type and scope of mental health services that are sought and provided. Second, as many as 75% of detainees with mental disorders also have substance use disorders, which is a higher rate than found in the community. Capitated mental health care also affects service utilization by youth in the juvenile justice and child welfare systems. The Teplin et al. (2005) research suggested that as many as 13,000 detained youths with major mental disorders do not receive treatment every day. It was also noted that the juvenile courts may process more than 139,000 youths per year whose major mental disorders go untreated.

Many factors may influence service utilization, such as family pressure, environmental stress, having a primary care doctor, health insurance, and experiences with past services. These factors may be seen as hindrances or can conversely aid in recovery. The RWJ report found a greater distance from traditional support systems for teens who experience symptoms of depression (Bethell, Lansky, & Fiorillo, 2001). These juveniles were 12 to 21% less likely to report feeling connected to people in their school and are significantly less likely to report involvement in community activities. Forty-eight percent of adolescents with depressive symptoms said they could talk openly with providers compared to 65% without depressive symptoms.

A range of mental health and substance abuse treatment services are needed in criminal justice settings, as the problem of substance use is more pronounced within the detained population. Survey results among juvenile arrestees provide evidence of illegal drug use with more than half of the males testing positive for at least one drug; marijuana was the most frequently detected

drug (National Institute of Justice, 1999). Another study concluded that 60 to 87% of female offenders need substance abuse treatment (Prescott, 1998). Substance abuse treatment services are often among the first to be cut during budget reductions. Security and supervision measures are seen as more important obligations than treatment plans when it comes to allocating funds.

Substance abuse treatment is not legally mandated in most correctional settings although it has been proven to have a tremendous effect on reducing the rate of recidivism among inmates. Treatment partnerships within the criminal justice system are time-consuming, and those involving mental health and substance abuse services require additional work. The decision to cut those services without regard to long-term outcomes usually has a detrimental effect (Chandler, Peters, Field, & Juliano-Bult, 2004).

Mental health and substance abuse were perceived as such a major problem among incarcerated juveniles that in 1997, the New York State Office of Children and Family Services (OCFS) implemented a statewide diversion initiative. The Mental Health Juvenile Justice (MH/JJ) Diversion Project has 10 county sites involving county probation and a mental health provider. While each site has its own structured program tailored to the needs of the youth in their community, there are some areas that are common to all 10. Each site is required to provide, at a minimum, the following: screening; assessment; direct services, including individual, group, and family counseling; and referral to mental health, substance abuse, and other community-based services. The variability is seen when it comes to the type of services available, when the youth is diverted, voluntary or mandatory participation, and treatment models. It has also been noted that youth in community-based treatment fared better than youth whose treatment was provided in institutions (Lipsey, 1992).

Special Populations: Gay, Lesbian, Bisexual, and Transgender Youth

It is difficult to ascertain the actual percentage of youth who are grappling with questions regarding their sexuality and gender identity. The majority of the states do not include questions regarding these issues on their Youth Risk Behavior Surveys. The limited data that we do have regarding sexual orientation indicate that between 2 and 4.5% of high school students self-identify as gay, lesbian, or bisexual (Garofalo, Wolf, Kessel, Palfrey, & Durant, 1999; Ries & Saewyc, 1999). These data are definitely underestimates, as many youth have difficulty understanding complexity of sexual attractions or fear disclosure. There are virtually no data on transgenderism in the adolescent population. *Transgender* is an umbrella term that refers to the range of individuals whose gender identity does not match anatomic or chromosomal sex. Transgendered individuals can live as full- or part-time members of another gender and can be heterosexual, homosexual, or bisexual (ACOG, 2005).

What is known, however, is that sexual minority youth face disproportionate risk of family, school, and community violence. After coming out to their families or being discovered, many gay, lesbian, bisexual, transgender, and questioning (GLBTQ) youth can be thrown out of their homes or mistreated. Service providers estimate that 25 to 40% of homeless youth may be GLBTQ (Savin-Williams, 1994). Additionally, these young people often experience

greater rates of school violence. In one nationwide survey, over 84% of GLBTQ students reported verbal harassment at school. Over 39% of all gay, lesbian, and bisexual youth reported being punched, kicked, or injured with a weapon at school because of their sexual orientation while 55% of transgender youth reported physical attacks because of their gender identity or gender expression. The consequences of physical and verbal abuse directed at GLBTQ students include truancy, dropping out of school, poor grades, and having to repeat a grade. In one study, 28% of gay and bisexual youth dropped out of school due to peer harassment (Savin-Williams, 1994). Juvenile correctional facilities must consider the potential for violence against these youth and make appropriate security considerations.

Most likely a result of isolation caused by societal homophobia, a disproportionate number of GLBTQ youth turn to drugs or alcohol, suffer from depression, and engage in risky sexual behavior, including survival sex (Garofalo et al., 1998). These factors can increase the risk of juvenile incarceration. Though very little data exist regarding the actual number of GLBTQ youth in the system, it is estimated these youth make up between 4 and 10% of detainees (Feintein et al., 2001). Few juvenile justice facilities have policies prohibiting discrimination on the basis of sexual orientation or gender identity or provide training for staff on how to create safe environments for these youth (Feintein et al., 2001).

Juvenile justice centers can maintain a ban on same-sex sexual contact while maintaining policies that are affirming to all sexual minority youth. This includes implementing training for staff on sensitivity issues and respecting differences. Additionally, if sexual minority youth are experiencing harassment within the facility, appropriate action must be taken to assure their safety. Juvenile justice authorities can also partner with the public health community to secure successful reentry for GLBTQ youth. This includes addressing family counseling needs, locating proper shelter and interventions to limit risk behavior including survival sex.

Incarcerated Juveniles: An Opportunity for Public Health

The period of incarceration for a juvenile presents an opportunity for public health to access a population they may not routinely serve. The catalogue of services available through public health can augment the health care provided by the juvenile facility whether in the form of direct services or through support services for the health program. A strong collaboration with juvenile justice agencies can support the primary goal of public health to prevent the spread of communicable diseases and benefit the overall health of the youth when they return to the greater community. The Georgia Department of Juvenile Justice has just such a collaborative agreement between the Georgia Department of Human Resources Division of Public Health, Division of Family and Children's Services and the Division of Mental Retardation, Developmental Disabilities and Addictive Diseases, and the Juvenile Courts. This interagency program has a formalized MOU. It allows sharing of relevant health information between agencies for the continued medical and mental health care of juveniles on release from a detention center into the community. Youth with health needs are referred to the appropriate agency; tracking of appointments and

follow-up is shared among the agencies, so youth will not fall between the cracks. It is hoped that this safety net will assure greater continuity of care in the community and ultimately reduce recidivism of these youth. The I CAN Program is a model program between juvenile corrections and public health that will have a positive impact on the outcome of the lives of many young people.

References

- American College of Obstetricians and Gynecologists. (2005). Health care for transgendered individuals. In *Special issues in women's health* (pp. 75–88). Washington, DC: Author.
- Anderson, B., & Farrow, J.A. (1998). Incarcerated adolescents in Washington State, health services and utilization. *Journal of Adolescent Health, 22*, 363–367.
- Bethell, C., Lansky, D., & Fiorillo, J. (2001). *A portrait of adolescents in America, 2001*. FACCT—Foundation for Accountability. Princeton, NJ: Robert Wood Johnson Foundation.
- Bowring v Godwin*, 551 F2d 44, 47 (4th Circuit 1977).
- Breuner, C.C., & Farrow, J.A. (1995). Pregnant teens in prison: Prevalence, management, and consequences. *Western Journal of Medicine, 162*, 328–330.
- Centers for Disease Control and Prevention. (1996). HIV/AIDS education and prevention programs for adults in prisons and jails and juveniles in confinement facilities—United States, 1994. *MMWR, 45*, 268–271.
- Centers for Disease Control and Prevention. (2006). Sexually transmitted diseases treatment guidelines, 2006. *MMWR Recommendations and Reports, 55*, 1–94.
- Chandler, R., Peters, R., Field, G., & Juliano-Bult, D. (2004). Challenges in implementing evidence-based treatment practices for co-occurring disorders in the criminal justice system. *Behavioral Sciences and the Law, 22*, 431–448.
- Crosby, R., Salazar, L.F., Diclemante, R.J., Yarber, W.L., Caliendo, A.M., & Staples-Horne, M. (2004). Health risk factors among detained adolescent females. *American Journal of Preventive Medicine, 27*, 404–410.
- Crosby R., DiClemente R.J., Staples-Horne M. (2003). *Health issues of juvenile offenders*. In Moore J. (Ed.). Management and Administration of Correctional Health Care: Policy, Practice, and Administration, Kingston, New Jersey: CRI, Inc; 11.1–11.15.
- Diagnostic and statistical manual of mental disorders, 4th ed.* (1994) Washington, DC: American Psychiatric Association.
- Eaton D.K., Kann, L., Kinchen, S., Ross, J., Hawkins, J., Harris, W.A., Lowry, R., McManus, T., Chyen, D., Shanklin, S., Lim, C., Grunbaum, J.A., & Wechsler, H. (2006). Youth risk behavior surveillance—United States 2005. *MMWR Surveillance Summaries, 55*, 1–108.
- Estelle v Gamble*, 429 US 97 (1976).
- Feinstein, R., Greenblatt, A., Hass, L., Kohn, S., & Rana, J. (2001). *Justice for all? A report on lesbian, gay, bisexual, and transgendered youth in the New York juvenile justice system*. New York: Lesbian and Gay Project of the Urban Justice Center.
- Feinstein, R.A., Lampkin, A., Lorish, C.D., Klerman, L.V., Maisiak, R., & Oh, M.K. (1998). Medical status of adolescents at time of admission to a juvenile detention center. *Journal of Adolescent Health, 22*, 190–196.
- Fields, J. (2003). Children's living arrangements and characteristics: March 2002. *Current Population Reports*. Washington, DC: Census Bureau.
- Garofalo, R., Wolf, R.C., Kessel, S., Palfrey, J., & Durant, R.H. (1998). The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics, 5*, 895–902.
- Gavdos, C. (2005). Nucleic acid amplification tests for gonorrhea and chlamydia: Practice and applications. *Infectious Diseases Clinics of North America, 19*, 367–386.

- Goldenring, J., & Cohen, E. (1988). Getting into adolescents heads. *Community Pediatrics*, 5, 75–90.
- Hammett, T.M. (1998). *Public health/corrections collaborations: Prevention and treatment of HIV/AIDS, STDs and TB*. National Institute of Justice Centers for Disease Control and Prevention. Research in Brief.
- Hein, K., Cohen, M.I., & Litt, I.F. (1980). Juvenile detention: Another boundary issue for physicians. *Pediatrics*, 66, 239–245.
- Huerta, K., Berkelhamer, S., Klein, J., Ammerman, S., Chang, J., & Prober, C.G. (1996). Epidemiology of herpes simplex virus type 2 infections in a high-risk adolescent population. *Journal of Adolescent Health*, 18, 384–386.
- Huppert, J.S., & Adams Hillard, P.K. (2003). Sexually transmitted disease screening in teens. *Current Women's Health Report*, 2, 451–458.
- Kahn, R.H., Mosure, D.J., Blank, S., Kent, C.K., Chow, J.M., Boudov, M.R., Brock, J., Tulloch, S., & Jail STD Prevalence Monitoring Project. (2005). Chlamydia trachomatis and Neisseria gonorrhoeae prevalence and coinfection in adolescents entering selected US juvenile detention centers, 1997–2002. *Sexually Transmitted Diseases*, 32, 55–59.
- Lauritsen, J. (2003). *How families and communities influence youth victimization*. OJJDP Juvenile Justice Bulletin. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Lipsey, M.W. (1992). *Juvenile delinquency treatment: A meta-analytic inquiry into the variability of effects*. In T. Cook et al. (Eds.), *Meta-analysis for explanation: A casebook* (pp. 83–127). New York: Sage.
- Lofy, K.H., Hofmann, J., Mosure, D.J., Fine, D.N., & Marrazzo, J.M. (2006). Chlamydial infections among female adolescents screened in juvenile detention centers in Washington State, 1998–2002. *Sexually Transmitted Diseases*, 33, 63–67.
- MacGowan, R.J., Margolis, A.D., Gaiter, J., Morrow, K., Zack, B., Askew, J., McAuliffe, T., Sosman, J.M., Eldridge, G., & the Project START Study Group. (2003). Predictors of risky sex of young men after release from prison. *International Journal of STDs and AIDs*, 14, 519–523.
- Madrid v Gomez*, 889 F Supp 1146, 9617277v2. US 9th Circuit Court of Appeals (ND CA 1995).
- McCurley, C., & Snyder, H. (2006). *Risk, protection, and family structure*. OJJDP Juvenile Justice Bulletin. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Morrison, D.M., Baker, S.A., & Gillmore, M.R. (1994). Sexual risk behavior, knowledge, and condom use among adolescents in juvenile detention. *Journal of Youth and Adolescence*, 23, 271–288.
- National Center for Health Statistics. (2003). Estimates of the July 1, 2000 and July 1, 2001, United States resident population from the Vintage 2001 postcensal series by year, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau.
- National Institute of Justice. (1999). *Arrestee Drug Abuse Monitoring Program: 1998 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, Washington, DC: Author.
- Parent, D., Leiter, V., Kennedy, S., Livens, I., Wentworth, D., & Wilcox, S. (1994). *Conditions of confinement: Detention and corrections facilities*. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.
- Prescott, L. (1998). *Improving policy and practice for adolescent girls with co-occurring disorders in the juvenile justice system*. Delmar, NY: National GAINS Center.
- Reddy, D.M., Fleming, R., & Swain, C. (2002). Effect of mandatory parental notification on adolescent girls' use of sexual health care services. *Journal of the American Medical Association*, 288, 710–714.
- Ries, B., & Saewyc, E. (1999). Selected finding of eight population-based studies as they pertain to anti-gay harassment and the safety and well-being of sexual minority students. Safe Schools Coalition of Washington, 1–29.

- Robertson, A.A., & Thomas, C.B. (2005). Predictors of infection with chlamydia or gonorrhea in incarcerated adolescents. *Sexually Transmitted Diseases, 32*, 15–22.
- Ruiz v Estelle*, 503 F Supp 1265 (SD Tex 1980).
- Savin-Williams, R.C. (1994). Verbal and physical abuse as stressors in the lives of lesbian, gay male and bisexual youths: Associations with school problems, running away, substance abuse, prostitution, and suicide. *Journal of Consulting and Clinical Psychology, 62*, 261–269.
- Snyder, H., & Sickmund, M. (2006). *Juvenile offenders and victims: 2006 National Report*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Strack, R., & Alexander, C. (2000). *Report of the Monitoring of Adolescents in Risky Situations (MARS) Project: Findings from the 1999 Out-of-Home Youth Survey*. Baltimore: Department of Health and Mental Hygiene.
- Teplin, L., Abram, K., McClellan, G., Washburn, J., & Pikus, A. (2005). Detecting mental disorders in juvenile detainees who receive services. *American Journal of Public Health, 95*, 1773–1780.
- Tjaden, P., & Thoennes, N. (2000). Full report of the prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey. Washington, DC: National Institute of Justice Report NCJ 183781.
- Treadwell, H., & Formicola, A. (2005). Improving the oral health of prisoners to improve overall health and well-being. *American Journal of Public Health, 95*, 1677–1678.
- U.S. Census Bureau. (2004). *Annual demographic survey, March supplement, 2004. POV01, age and sex of all people, family members and unrelated individuals iterated by income-to-poverty ratio and race*.
- U.S. Census Bureau. (2004). *U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin*. <http://www.census.gov/ipc/www/usinterim> Internet Release Date: March 18, 2004.
- U.S. Census Bureau. (2007). *Annual Estimates of the Population by Five-Year Age Groups and Sex for the United States: April 1, 2000 to July 1, 2006*. (NC-EST2006-01)
- Wasserman, G.A., McReynolds, L.S., Lucas, C.P., Fisher, P., & Santos, L. (2002). The voice DISC-IV with incarcerated male youths: Prevalence of disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 314–321.
- Zigler, E., Taussig, C., & Black, K. (1992) Early childhood intervention. A promising preventative for juvenile delinquency. *American Psychologist, 47*, 997–1006.