National Center for Education in Maternal and Child Health
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Report from the 1991 ri-Regional Jorkshops

Executive Summary

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Health Care of Incarcerate Youth

Report From The 1991 Tri-Regional Workshops

Executive Summary

Edited by Paula M. Sheahan

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Foreword

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

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

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

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

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

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

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

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

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

Selected Papers

1 Workshop Overview

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

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

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

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

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

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

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

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

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

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

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

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

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

2 Historical Overview

The Forgotten Child in Health Care

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

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

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

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

Characteristics of Youth in the Juvenile Justice System

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

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

Health Issues for Incarcerated Youth

Predictably, delinquent youth suffer a higher incidence of health problems than their non-delinquent peers. The reasons for this higher rate of illness are predictable. Confined juveniles are more likely to smoke, or use illicit drugs or alcohol, behaviors that may compromise their health through increased risks of disease and shortened life expectancy (Kovar, 1979; Thompson, 1985). Their aggressive behavior is associated with an increased risk of injury, with subsequent disability or mortality (Johnson et al., 1972; Velcek, 1977). Confined youth offenders are also typically from

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

Maternal and Child Health Involvement in the Juvenile Justice System

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

involving all the agencies serving children, must be designed, to address their individual needs.

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

Where Do We Go From Here?

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

A Time For Change

The time is ripe for change. The depth and breadth of the change, however, will depend largely on the willingness and commitment of this group to advocate for youth. As leaders in your fields, you are in key positions to make necessary changes so that we will

not "forget" our children any longer. We can no longer close our eyes to the conditions of our incarcerated children.

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

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

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

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

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

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

3 Keynote Address

The Forgotten Child in Our Midst

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Financing of Health Services

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

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

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

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

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

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

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

Public Health and Community Resources

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

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

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

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

Future and Opportunity

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

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

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

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

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

4

Summary, Recommendations, and Conclusions

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

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

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

Summary The United States' juvenile and adult correctional systems process close to 1.3 million children each year. Many of these children come to correctional institutions from chaotic families, too often characterized by multiple divorces and separations, alcohol and drug abuse, and child abuse and neglect. Many lack a sense of roots or belonging. When, as often is the case, the families are poor, medical care can slip low on the list of family priorities.

Several studies have statistically characterized the health problems of incarcerated youth. We know they

have high rates of untreated chronic illness, respiratory infection, and respiratory disease, because they begin smoking early, suffer other environmental risk factors, are exposed to violence and trauma at greater rates, and have a variety of serious psychiatric disorders. The Maternal and Child Health Bureau (MCHB) has a long history of sponsoring programs to improve the health of high-risk children and youth. Children in the juvenile justice system, a particular subset of this vulnerable population, present significant health concerns and health-care delivery challenges.

In 1991, MCHB responded to the challenge by developing and sponsoring three tri-regional workshops on the health care of incarcerated youth. The workshops, held in San Diego, Philadelphia, and Birmingham, were designed to help agencies collaborate more effectively in addressing the health needs of incarcerated youth. Key professionals in maternal and child health and juvenile justice were brought together to share current information on health needs, resources and issues in health delivery, and to promote collaborative planning at the local, state and regional levels. Regional coordinators and planning committees conceived and implemented all three workshops, ensuring an appropriate regional focus. The three workshops shared a common focus, however, including a historical overview, a presentation of workshop goals, and a keynote speaker who focused on a unique aspect of the adolescent in custody. Following each keynote, members of a panel gave short

presentations on the topics of standards for health care, coalition building at the state level, financing health care for incarcerated youth, mental health and substance abuse issues, and academic and university involvement with adolescents in custody. Participants then split into focused discussion groups, moderated by facilitators, to talk about programs and problems related to the health care delivery system for incarcerated youth in their states. On the final day, participants met by state to develop action plans for collaborative efforts to improve their states' health care for incarcerated youth. Every state developed such an action plan.

The following illustrates the type of action recommendations proposed by states at the program, state and community levels.

Recommendations

Program

1. Identify how health care services are currently being provided in the state including assessment, treatment and preventive activities.
2. Develop an evaluation mechanism for monitoring the effectiveness and efficiency of programs providing services to youth in custody.
3. Recruit to increase the number of qualified health care professionals providing services to youth offenders.

4. Develop a referral and follow-up mechanism for youth discharged from the criminal or juvenile justice system. Include in this mechanism a way to monitor identified health status concerns within the community. The development of individualized health care plans is one way to monitor and track youth.
5. Develop a training curriculum that specifically addresses the health and social needs of youth in the juvenile justice system.
6. Provide training, education and technical assistance to staff working in juvenile facilities. Staff should be trained to assess the common health problems of youth and sources of referral.
7. Establish a statewide network to review local, state and national regulations and to make recommendations for change. Representatives should include not only health, social services, education, court and correctional officials, but also child advocates.
8. Devise strategies for improving working conditions and training programs for health care and juvenile justice personnel.
9. Continue to use local health department staff to provide relevant health education programs, technical assistance, consultation and evaluation of health services to clients in juvenile justice facilities. Expand this relationship by incorporating it in systematic planning.

10. Use "interagency consortium" approaches to identify a flexible pool of human and financial resources for juvenile justice programs.
11. Provide cuturally specific programming to various ethnic and minority groups.
12. Recruit and train individuals from various ethnic and minority groups to provide care and treatment, and to serve as role models for youth.

State

1. Health care professionals should become more actively involved in the state Advisory Committee on Juvenile Justice and Corrections.
2. Encourage state Advisory Committee on Juvenile Justice to include health care issues on its agenda, and to design policies to improve the health status of youth offenders.
3. Establish interagency councils to focus on the needs of children and adolescents. These groups should include juvenile justice providers.
4. States should explore the possibility of securing accreditation of state juvenile justice facilities.
5. States should explore alternative methods of funding programs for youth. Existing funded programs should be identified and evaluated for potential linkage and interface with the justice system.

6. Establish standards for health care staffing within juvenile correctional facilities, including: nursing, medicine, mental health, nutrition and health education.
7. Assess the adequacy of state-allocated funds for incarcerated youth health services *versus* other youth services throughout the state.
8. Apply epidemiological methods to juvenile justice and correctional data.
9. Convene problem-solving conferences at the state and regional levels to address the multiple problems of youth offenders. These conferences should design policy initiatives to improve the health status of children and youth.
10. Complete a comprehensive self study to determine the need for prevention, intervention and follow-up of adjudicated youth.
11. Ensure that health care initiatives for incarcerated youth meet the Healthy People 2000: National Health Promotion and Disease Prevention Objectives.

Community

1. Establish a coalition of state and private advocacy groups to address the health and social-environmental needs of incarcerated youth. These groups should lobby policymakers for adequate resources

and legislation to improve the status of youth in custody.

2. Raise the issues of health care of children and youth in the juvenile justice system to various coalitions that advocate or deliver health care services to adolescents.

3. Establish policies and procedures to secure funding and programs for screening, diagnostic and immunizations services for youth in custody.

4. Increase community awareness of the health and social needs of incarcerated youth. Establish linkages and resources to address delinquency as a public health problem affecting the community and family.

5. Establish ways to involve parents in policy decisions and programming for children and youth in the justice system.

6. Establish community-based health care services for youth after release from state custody.

7. Design research and demonstration programs to investigate the home environment of high-risk children and youth.

8. Link clients in the juvenile justice system to community-based services including: school-based youth services, public health clinics, community health centers, and community mental health clinics.

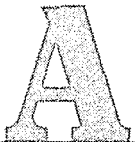
9. Develop health education and awareness programs to prevent problem behaviors in adolescents including substance abuse, violent and aggressive behavior and risky sexual behavior.
10. Consider efforts at implementing the OBRA '89 EPSDT expanded service provision as a way to maximize federal dollars to support needed specialized services for the population of youth in the juvenile justice system.
11. Develop reciprocal working relationship between local universities and institutions to provide and expand medical, nursing, social, and mental health services to incarcerated youth.
12. Develop a network with other state and local agencies, and with private providers, to complement present services and provide a comprehensive system of care.

Conclusions

The depth and breadth of the proposed recommendations suggest a commitment on the part of participants to investigate new solutions to the problems facing incarcerated youth. How far these recommendations will go as measured by changes in health status, however, is unclear. Professionals in health, education, behavioral science and juvenile justice must forge ahead to establish new policies to prevent and treat the problems plaguing our youth.

Our future depends on professionals working together in advocacy, training and research, and development. By working together, we can jointly identify new solutions to improve the conditions of incarcerated and troubled youth. The 1991 tri-regional workshops' report represents an initial step in achieving this goal.

Appendices



Appendix

Western Regional Workshop Program

February 22–24, 1991 • San Diego, California

Friday, February 22, 1991

8:30–8:45 **Welcome and Introductions**

James Farrow, M.D.
University of Washington

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

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

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

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

9:15–10:00 **Model Programs**

STATE MODEL

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

COUNTY MODEL

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

10:00–10:30 **Keynote Address**

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

Friday, February 22, 1991 (Continued)

11:00–11:30 Health Status

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

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

11:30–12:00 Legal Issues

Elizabeth Jameson
Youth Law Center, San Francisco

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

1:30–3:15 Panel

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

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

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

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

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

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

Friday, February 22, 1991 (Continued)

3:45–5:30 **Focused Discussion Groups A**

STANDARDS IMPLEMENTATION

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

ACADEMIC/UNIVERSITY INVOLVEMENT

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

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

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES

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

CREATIVE FINANCING

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

INTERAGENCY PROGRAMMING

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

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

Saturday, February 23, 1991

8:00–9:00 **Breakfast Buffet**

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

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

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

3:30–4:30 **Preliminary Reporting—Plenary**

4:30–5:00 **Recorders/Facilitators Meeting**

Sunday, February 24, 1991

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

B Appendix

Eastern Regional Workshop Program

March 8–10, 1991 • Philadelphia, Pennsylvania

Friday, March 8, 1991

11:00–12:45 **Opening Session**

Greetings and Overview

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

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

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

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

Friday, March 8, 1991 (Continued)

Keynote Session

Moderators:

Richard W. Friedman
Director,
Maryland Juvenile Justice Advisory Council

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

CRITICAL ISSUES IN HEALTH CARE OF INCARCERATED YOUTH: TWO PERSPECTIVES

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

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

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

Saturday, March 9, 1991

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

Moderator:

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

STANDARDS FOR HEALTH CARE

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

COALITION BUILDING AT THE STATE LEVEL

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

FINANCING HEALTH CARE FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM

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

Saturday, March 9, 1991 (Continued)

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

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

10:30–12:00 Topic Discussion Groups

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

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

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

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

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

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

Sunday, March 10, 1991

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

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

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

WRAP-UP

12:30 **Adjourment**

C Appendix

South/Central Regional Workshop Program

April 7–9, 1991 • Birmingham, Alabama

Sunday, April 7, 1991

1:30–3:00 **MCH Facilitator/Recorder Training**

3:30–3:40 **Opening Remarks and Introduction**

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

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

3:40–4:00 **The Health Care Needs of the Forgotten Child**

Linda Thompson, M.S.N., Dr.P.H.
Director, Office of Occupational Medicine and Safety, Baltimore, MD

4:00–4:45 **Keynote Presentation—Advocacy Issues**

Sandra Ross
Judge, Family Court of Jefferson County, Alabama

4:45–5:00 Break

Sunday, April 7, 1991 (Continued)

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

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

Monday, April 8, 1991

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

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

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

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

FINANCING
Carol Herrmann
Commissioner, Medicaid Agency of Alabama

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

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

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

Monday, April 8, 1991 (Continued)

10:45–11:00 **Break**

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

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

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

For topics, see Focus Discussion Group A above.

3:45–5:00 **Regional Workshops**

Regions IV, V, and VI

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

Tuesday, April 9, 1991

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

8:30–10:30 **Regional Workshops**

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

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

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

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

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

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