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U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention
State Relations and Assistance Division

Challenge Activities Program Areas

OJJDP

Challenge to the States

The 1992 reauthorization of the Juvenile Justice and Delinquency Prevention (JJDP) Act of 1974 added Part E, State Challenge Activities, to the programs funded by OJJDP. The purpose of Part E is to provide initiatives for States participating in the Formula Grants Program to develop, adopt, and improve policies and programs in 1 or more of 10 specified Challenge areas.

Challenge Activity A:

Developing and adopting policies and programs to provide basic health, mental health, and appropriate education services, including special education, for youth in the juvenile justice system as specified in standards developed by the National Advisory Committee for Juvenile Justice and Delinquency Prevention prior to October 12, 1984.

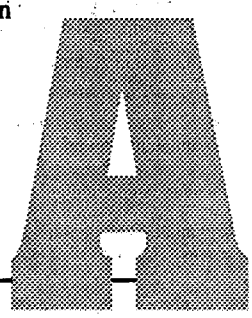
Background

Across the country, class action litigation, damage suits, and judicial orders in individual cases have drawn attention to the problems of providing adequate medical, mental health, and educational services in juvenile correctional facilities. Overcrowding and understaffing are major obstacles to successful "habilitative" services that enable youth to stop their delinquent behavior.

To address this problem, the National Advisory Committee for Juvenile Justice and Delinquency Prevention, prior to October 12, 1984, established the *Standards for Administration of Juvenile Justice*. The standards served as a baseline for provision of services to juveniles. The primary standards relevant to Challenge Activity A are listed in the appendix of this document. Further background information and commentary on the standards are available in the *Standards for the Administration of Juvenile Justice*.

Experts agree that there is no model juvenile correctional facility in the country.[1] Training schools have had difficulty maintaining excellence in any component of their programs. An outstanding medical, mental health, or educational program may exist in a juvenile correctional facility for a few years, only to suffer the loss of talented staff or funding cutbacks that reduce "unnecessary" expenditures. The program may decline when the target population is changed, without the program being altered accordingly, or if overcrowding compromises the individualized approach that is so important in innovative services. Nevertheless, evidence shows that effective interventions can help delinquent youth change their lives, provided that youth needs are matched with services.[2]

Adequate medical, mental health, and educational services in a juvenile correctional facility must be defined by the needs of the young people housed in it. Traditional delinquent assessment protocols tend to be deficit driven and typically lead to similar treatment plans for all youth.[3] Incarcerated youth are sometimes presented with proposed treatment goals, but they do not want what social workers, teachers, and other staff believe they need. The institutional treatment plan, for example, may send the young person to work in the laundry, attend history class, and participate in a social skills group, all of which he or she might find insulting or irrelevant. Traditional treatment plans for delinquents fail because a conflict arises between professional judgments and undisclosed client goals. Assessments that include the input of clients can help delinquent youth examine their strengths and identify what they need to stop their delinquent behavior. All people feel better when their strengths are appreciated. Services



based on strengths are more effective than those driven by deficits. Youth who go to a job, class, or group because they believe that it will meet their needs are more likely to change positively during incarceration.[4]

Although standards and case law have clarified what is unacceptable, it is difficult to describe adequate medical, mental health, and educational care in a juvenile facility without reference to the needs of the young people being served. Instead of encouraging replication of model institutional programs, this challenge grant offers the opportunity to develop needs-driven institutional medical, mental health, and educational services for the particular delinquent population in the State requesting funds.

Health Needs of Youth in the Juvenile Justice System

While youth in the juvenile justice system have many of the same health problems as other adolescents, they are particularly at risk for having sexually transmitted diseases (STD's), unexpected pregnancies, and drug or alcohol dependencies.

Youth in the juvenile justice system engage in sexual activity more often and at younger ages than do other adolescents.[5] Many have histories of childhood sexual abuse, and many have been victimized sexually during their adolescent years.[6] With limited exposure to pregnancy and STD prevention programs, these youth often hold unrealistic views about sexuality and childbearing.[7]

Juvenile offenders are also more likely to jeopardize their health by smoking, drinking, and using drugs.[8] They appear to be more susceptible to, and often more dependent on, controlled substances to help maintain peer relationships and cope with stress and depression.[9]

Many adolescents engage in alcohol- and drug-involved delinquent behavior, for which they are then arrested. When they are subsequently admitted to secure facilities (police stations, jails, juvenile detention facilities), they are under the influence of intoxicants.[10] In such facilities, intoxicated juveniles must be identified upon admission to guard against severe toxic or withdrawal reactions, depression, and suicide.[11]

The Office of Juvenile Justice and Delinquency Prevention's (OJJDP) 1992 study on confinement conditions in juvenile correctional facilities found significant gaps in health care available to youth. Less than one-half of youth in institutions are given health screenings within 1 hour of admission as required by nationally recognized standards, such as the American Correctional Association Standards for Accrediting Juvenile Facilities, as amended in 1991; the National Commission on Correctional Health Care Standards, 1984; and the American Bar Association/Institute for Judicial Administration Standards, 1980. One-fifth of youth in juvenile detention facilities do not have full health examinations within a week of admission, and one-third are screened by staff who have no professional medical training. More than 30 percent are in facilities where no tests are given for tuberculosis, and more than 40 percent are in facilities where no tests are given for STD's.[13]

Full health examinations of juveniles in detention and corrections facilities soon after admission are important. These examinations uncover unknown health problems and prevent the spread of disease among confined youth and facility staff. They are also an opportunity for staff to provide youth with needed health education and referral to community health resources.[12]

A juvenile correctional facility's medical services must also meet youth's acute and chronic health needs. Acute needs include injuries, infections, dental emergencies, and pregnancy. The ability to implement an effective prevention strategy against epidemics is also essential. Chronic needs include, but are not limited to, substance abuse, asthma, juvenile diabetes, sickle cell, and HIV. Routine dental care must also be provided. Furthermore, juvenile correctional medical services must dispense a wide variety of medications, including psychotropics that require close monitoring of side effects and dosage, as well as regular blood tests. For youth with chronic health needs, an important function of the medical unit is to arrange continuing care when young people are released from the institution.

Although nonmedical staff may be trained to perform some of these acute and chronic care functions, many health services must be provided by medical professionals: technicians, nurses, physician assistants, dentists, and physicians (including psychiatrists). The responsibilities of the medical and nonmedical staff must be clearly defined.

The Echo Glen Children's Center, a State-operated facility in Smoqualmie, Washington, has a strong medical unit that provides acute and chronic services for 200 incarcerated delinquents. The clinic logs approximately 1,200 visits each month and has a nurse on duty 24 hours a day. A physician is on the center's grounds every weekday and a dentist is there 4 days a week. Three part-time psychiatrists carefully follow youth on psychotropic medications. Postdoctoral students from the University of Washington Medical School rotate shifts at the facility; one of these students works with a physician's assistant to provide special services to the program's female delinquents.

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Other juvenile facilities have strengthened their medical units by contracting with a hospital to operate them.

Mental Health Needs of Youth in the Juvenile Justice System

Severe Symptoms. The prevalence of mental disorders for youth in the juvenile justice system is considerably higher than in the general population.[14] Common diagnoses of juvenile

offenders include conduct disorders, attention deficit disorders, and affective disorders.[15] The occurrence of psychotic disorders among juvenile offenders ranges from 1 to 6 percent. Although this is a relatively small number, psychotic youth need immediate and intensive services.[16] Many youth have substance abuse disorders that co-occur with significant mental disorders.[17]

Confined youth do not fit neatly into a single diagnostic category.[18] Their multiple mental health needs often result from, or have been intensified by, a history of physical abuse, sexual abuse, or severe emotional neglect.[19] Depression is probably their most common mental health problem. It is often expressed through angry, hostile feelings and aggressive, belligerent, or suicidal behavior; withdrawal from others; and weight and sleep problems. Depressed youth are often mistakenly judged to have low intelligence.[20]

Approximately 15 to 20 percent of confined juveniles experience hallucinations. Many of the hallucinations are anxiety related: the youth feel scared, threatened, or punished. Others have command hallucinations in which they hear voices directing them to engage in antisocial behaviors.[21]

The most serious consequences of untreated or inadequately treated mental disorders are suicidal thoughts and attempts. An assessment of suicidal indicators should be conducted with each youth upon admission into custody to alert mental health staff to the need for intervention and to provide each youth with an opportunity to request assistance.[22] OJJDP's 1992 juvenile confinement study found, however, that only half of all confined juveniles are held in facilities that monitor suicidal youth every 4 minutes, the length of time after which permanent brain damage can occur in an attempted hanging—the most common method of suicide attempt in juvenile facilities. About 25 percent are in facilities that do not screen juveniles for indicators of suicide risk at admission, and approximately 25 percent are in facilities that do not train staff in suicide prevention.[23]

Young people sometimes become severely depressed, suicidal, or psychotic because of their confinement. Staff may have little prior indication that a young person will deteriorate rapidly, sometimes because of homesickness, fears, and sensory deprivation or overload. Youth placed in isolation are particularly at risk of depression. A recent study found that youth in a locked unit became significantly more angry, depressed, and paranoid than they had been before they were admitted.[24]

Chronic, Widespread Symptoms. Whereas severe depression or psychosis may affect less than one-fifth of the youth in a juvenile correctional facility, many incarcerated youth need help because they experience chronic hopelessness and anger.[25] These feelings contribute to a lack of empathy for their victims, including other residents or staff against whom they may lash out over apparently trivial disagreements. Past victimization may lead these youth to "thinking errors" that allow them to continue to justify their antisocial behavior. The use of drugs and alcohol not only requires immediate medical treatment in institutions but also requires mental health services that teach delinquents less self-destructive ways to manage their hopelessness and anger.

The Tom Ray Center, a secure mental health program for violent young people in Charlotte, North Carolina, uses techniques applicable in a juvenile correctional facility. The treatment program in this 24-bed, county-run center revolves around social skills training through several daily groups, intensive supervision, one-to-one staff work with youth, and small special education classrooms applying the same principles of supporting youth to succeed.

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Many delinquents, to make peace with their pasts, need mental health services. Although peer acceptance is important in adolescence, delinquents often look to their families when they make decisions, especially regarding criminal involvement. When juvenile correctional programs ignore or criticize delinquents' parents, young people typically defend their families by not engaging in treatment. Delinquents may wonder, "If what I come from is so bad, how can I be any good?" Youth protect their parents' pride by not aspiring to higher levels of school achievement than that of other family members. A young person whose father has been in jail most of his life may simply be following in his father's footsteps when he sells drugs. Although they may express anger at their mothers, female delinquents also reject services that make them feel disloyal to their families and require caregivers that are sensitive to their family relationships. Building on the strengths of the family to support the young person's success is a critical mental health service, even for youth who are not returning home. As youth begin to understand how their families have influenced their development, they will learn how to cope with family problems that are unlikely to change.

The Family Services Research Center in Charleston, South Carolina, operating in conjunction with the Medical University of South Carolina, has demonstrated an effective family- and school-focused intervention for delinquents who live in the community. Families are supported to encourage positive behavior in youth and to guide them away from poor judgment calls or self-destructive choices. This technique could be used with incarcerated delinquents.

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Educational Needs of Youth in the Juvenile Justice System

Most delinquents have failed in school, and their lack of success in this important part of their lives has contributed greatly to their antisocial behavior. Some, barely able to read, have felt since grade school that they have been shut out of opportunities requiring basic skills. Others, bored in school, have found only illegal applications for their intelligence. Building on their individual strengths, the educational component of the program must enable young people to apply their cognitive abilities to nondelinquent pursuits. Making this component work requires using high-interest subject matter, creating a nonthreatening environment, using creative and motivational activities in the classroom, and providing time each day for students to practice reading and writing.

Academic Needs of Youth With Disabilities. About 40 percent of incarcerated delinquents have disabilities that make them eligible for special education.[26] These youth have learning disabilities, emotional problems that interfere with learning, and/or low intelligence. At least half of these youth, however, are likely never identified during their incarceration. As a result, they may not have individual educational plans (IEP's) or may not have been provided with special education services prior to their incarceration. To address this neglect, the educational program in juvenile correctional facilities must include disabilities assessment, eligibility determination, IEP development, and services specified in the IEP.[27] For those youth whose disabilities were identified in their home schools, arrangements must be made to ensure prompt receipt of their IEP's at the institution. The required student-teacher ratios, special instructional methods, and support services to implement IEP's for all incarcerated youth with disabilities are clearly defined in the Individuals with Disabilities Education Act. The Act, which mandates a free and appropriate education to all handicapped persons under the age of 22, applies to correctional education programs. The law requires that each disabled child receive special education reasonably designed to meet his or her unique needs.[28]

The provision of special educational services for youth in the juvenile justice system should begin with a system to diagnose youth's educational disabilities and to identify their particular needs.[29] An individualized education program should be developed for each identified child, with specific educational goals and timelines for reaching those goals.[30] Related services necessary for the child to benefit from special education should also be provided, including such services as psychological treatment, speech pathology, and audiology.[31]

Academic Needs of Youth Who Are Ineligible for Special Education. Many incarcerated youth do not have disabilities, but they are illiterate or years behind in their skill levels. Many nondisabled delinquents, age 14 or older, who have reading and/or math skills at the fourth-grade level or below require significant remedial education. Incarcerated youth with skills above the seventh-grade level need instruction to prepare for the high school equivalency examination (GED). Programs have demonstrated that delinquents can gain one grade in skill levels every 2 months through individualized education.[32] Youth needing remedial and GED education benefit from a combination of individual instruction and instructional computer programs that allow them to go at their own pace. Although they need to strengthen their compensatory skills through instruction in reading and listening more effectively, many delinquents learn best by doing. An effective juvenile facility educational program cannot rely primarily on auditory or visual instruction.[33]

Law-related education (LRE) for delinquents is an example of instruction that can provide an avenue for success for youth who have failed in school.[34] Teaching the simple concepts of how to purchase cars, obtain insurance, and rent apartments helps youth understand the practical applications of the law. By discussing these real-life examples, an LRE class engages youth by capitalizing on their verbal skills.

Many youth who have failed in school have trouble asking questions. By not telling students what to think and by helping them inquire into what is behind a problem, LRE encourages them to question, to express their own ideas, and to draw their own conclusions. Critical-thinking and decisionmaking skills are developed in the process as young people recognize their own intelligence and how they can apply it to problem solving and future success.

Catalina Mountain in Tucson, Arizona, is an example of a State-run juvenile facility with an educational program designed to meet individual needs. The facility has been accredited by an independent association. Lookout Mountain in Golden, Colorado, is a State-run juvenile facility that recently contracted with a local university, Metropolitan State College in Denver, to operate its educational program. The program uses certified teachers and student teachers receiving supervision by and conducting research with faculty from the university's education department. In Los Angeles, the county board of education's approach to providing educational services to delinquent youth is unusual because, through its Courts and Community Schools branch, it operates the schools in juvenile facilities as well as a day treatment program for delinquents living in the community. At the Florida Environmental Institute, a remote program for serious juvenile offenders in Venus, Florida, more than half of its youth pass their high school equivalency exams and the remainder make at least a three-grade increase in reading and math skills during their stay. The Associated Marine Institutes operate the facility.

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Education Through Vocational Instruction

Educational services can address the hopelessness among delinquents described in the mental health section. Delinquents often have no image of future success for themselves other than criminality. Hustling is familiar—they do not have to leave their families, neighborhood, or culture to work. Most incarcerated youth do not have the life experience needed to seek employment and they need preparation if, when released, they are to find legal jobs that build on their personal strengths and interests.

Vocational educational must build on delinquents' interests and how they fit into the job market. Youth are cynical about "make work" in the facility's kitchen or maintenance services because it is not tied to skills promising employability in the future.

Youth with entrepreneurial interests can learn how to set up their own businesses. For example, a youth-run enterprise such as making T-shirts could include not only developing the needed artistic skills, but also teaching product development, loan and grant applications, marketing, and accounting. A vocational program in fitting staff and youth customers with eyeglasses and then making those glasses at cost could be offered in facilities to develop youth's skills for the job market.

YouthBuild U.S.A. is an example of educational/vocational services originally developed for school dropouts that would be applicable in a juvenile correctional facility. For 12 to 18 months, youth in this program are trained in construction skills that they use to rehabilitate abandoned buildings or construct new housing for homeless or low-income families. For half of their instruction time, they attend academic classes to prepare for the high school equivalency diploma. Leadership training is an important element of the program. Trainees are included in apprenticeships so they can gain entry into construction unions.

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Conclusion

The problems of providing high-quality services to delinquents are well known. Adequate medical, mental health, and educational services in a juvenile correctional facility must be defined by the needs of its residents. A facility's medical services must meet the acute and chronic health needs of youth in its custody; its mental health services must meet the needs of a few severely depressed, suicidal, or psychotic youth, as well as the larger number of angry and hopeless residents. Educational services must be designed to interest youth who have failed in school and must include: (1) eligibility determination, IEP development, and special education services for the 40 percent of incarcerated youth with disabilities; (2) remedial and GED preparation for nondisabled youth; and (3) vocational instruction that builds on the youth's interests, and preparation for the job market. Rather than simply replicating model programs, States are challenged to design services based on the individual needs of youth incarcerated in a target facility.

The Office of Juvenile Justice and Delinquency Prevention acknowledges the outstanding contribution made by Marty Beyer, Ph.D., Youth Advocate; Stephanie Morris, law clerk to the Honorable Steffen Graae, District of Columbia Superior Court; and Mark Soler, president, Youth Law Center, Washington, D.C., in the development of this paper.

This document was prepared under contract number OJP–94–C–004 from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), U.S. Department of Justice.

Points of view or opinions expressed in this document are those of the authors and do not necessarily represent the officials position or policies of OJJDP or the U.S. Department of Justice.

The Office of Juvenile Justice and Delinquency Prevention is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, the Bureau of Justice Statistics, the National Institute of Justice, and the Office for Victims of Crime.

Additional Resources

Programs

Alaska Youth Initiative, Department of Health and Human Services, P.O. Box 110602, Juneau, AK 99811–0620; Robert Gamble; 907–465–3370.

Boysville of Michigan, Clinton, MI 49236; Joseph Tillman; 517–781–2780.

DeWitt Nelson Training Center, 7650 South Newcastle Road, Stockton, CA 95213–9003; Celia Cruz-Reed; 209–944–6168.

Dozier School for Boys, 4111 South Street, Mariana, FL 32448; William Baxter; 904–526–4135.

East Baltimore Mental Health Partnership, 1235 East Monument Street, Baltimore, MD 21202; Dr. Raymond Crowel; 410–614–4050.

Hennepin County Home School, Sex Offender Program, 14300 County Road 62, Minnetonka, MN 55345; Paul Gerber; 612–949–4500.

Los Angeles County Court and Community School, 16703 South Clark Avenue, Bellflower, CA 90706, Bellflower Annex; Sharon Roberts; 310–867–1783.

Los Angeles County Juvenile Court Health Services, 1925 Daly Street, First Floor, Los Angeles, CA 90031–3399; Charles Baker, M.D., Medical Director; 213–226–8723.

Medical Services for the Circuit Court for Baltimore City, Room 126, Clarence Mitchell Courthouse, 100 North Calvert Street, Baltimore, MD 21202; Nicholas Conti; 410–396–5078.

Orange County Court and Alternative Schools Program, 200 Kalmus Drive, Costa Mesa, CA 92628; Mary Lou Vachet; 714–966–4485.

Ventura School, 3100 Wright Road, Camarillo, CA 93010; Gary Collins; 805–485–7951.

Young Women's Transition Project, Children's Services Project, 2630 North Pacific Highway, Woodburn, OR 97071; Jonnie Zimmermann; 503–986–4478.

Organizations

Abraxis Erie Mental Health, RFT, 429 West Sixth Street, Erie, PA 16507; David Tamilin; 814–459–0618.

American Bar Association, Criminal Justice Section, Juvenile Justice Center, 1800 M Street NW., Washington, DC 20036; Patricia Puritz, 202–662–1515; Fax 202–331–2226.

Juvenile Justice Clearinghouse, P.O. Box 6000, Rockville, MD 20849–6000; 800–638–8736.

Juvenile Law Center, 801 Arch Street, Sixth Floor, Suite 610, Philadelphia, PA 19107; 215–625–0551.

National Center for Education in Maternal and Child Health, 2000 Fifteenth Street North, Suite 701, Arlington, VA 22201–2617; 703–524–7802.

National Center for Youth Law, 114 Sansome Street, Suite 900, San Francisco, CA 94104; 415–543–3307.

National Commission on Correctional Health Care, 2105 North Southport, Chicago, IL 60614–4017; 312–528–0818.

National Maternal and Child Health Clearinghouse (NMCHC), 8201 Greensboro Drive, Suite 600, McLean, VA 22102; 703–821–8955, ext. 254.

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20. "Mental Health," *supra*, at 127; "Challenging Perceptions of Youth: 'Bad' or 'Disturbed'?" *supra*, at 101–102.

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34. National Street Law Institute, Washington, D.C.; Juvenile Justice Center, American Bar Association, Washington, D.C.

Appendix: Standards for the Administration of Juvenile Justice

National Advisory Committee for Juvenile Justice and Delinquency Prevention

4.213 Services

At a minimum, juveniles placed in training schools should have access to the services described in Standards 4.214–4.218. When location and security permit, arrangements should be made for appropriate residents to receive these services in the community.

4.214 Development and Implementation of an Individual Program Plan

Within 15 days of a juvenile's admission to a training school, a comprehensive assessment report should be completed. This report should provide an evaluation of the juvenile's specific problems, deficiencies, and resources, and contain the individual's program plan.

An assessment team, composed of a caseworker, a youth-care worker, an educational diagnostician, a psychiatrist, and a psychologist, should perform the assessment.

The assessment should include: family history, developmental history, physical examinations, psychological testing, psychiatric interviews, community evaluation, language and educational analyses, and information concerning the nature and circumstances of the conduct on which the adjudication is based. It should be the responsibility of the family court to ensure that any of the above material in its possession is forwarded to the training school.

After all assessment team members have completed their respective tasks, they should meet together to discuss the findings and finalize their recommendation for the juvenile's program plan. At such meetings, and throughout the assessment process, the juvenile should be given full opportunity to participate in the formulation of the program plan and to have a voice in determining his/her program goals.

The juvenile should be given a copy of the program plan; a copy should be maintained in the juvenile's institutional file; and a copy should be forwarded to the placing family court.

The plan should be reviewed monthly by appropriate staff including members of the assessment team and other members of the treatment staff with knowledge of the juvenile's progress under the plan. Any change in the plan should be noted in the juvenile's file and notification of the significant modifications forwarded to the placing family court.

4.215 Individual and Group Counseling Programs

Training schools should provide a broad range of individual and group counseling programs with emphasis upon positive reinforcement and strict limits on negative reinforcement.

4.2151 Group Therapy

Group therapy should be conducted in groups no larger than 10 and should meet at least once per week. Such therapy should be conducted by group leaders whose experience and training are commensurate with the type of therapy being provided and the responsibilities that they have for supervising the group.

4.216 Educational Services

Training school education programs should provide for the diverse educational needs of the juveniles placed therein, and should include academic, vocational, and special education components.

4.2161 Academic Education

A curriculum substantially equivalent to that required under the law of the jurisdiction for public school students should be available to all juveniles placed in a training school. The academic program should meet all requirements necessary for the transfer of earned credits to public schools within the state and should be certified to award academic diplomas to juveniles who meet the requirements for the award of such diplomas during their placement.

4.2162 Vocational Education

All juveniles should receive career counseling to provide them with knowledge of a wide range of career options and with sufficient information and to choose among vocational and academic areas of emphasis.

A vocational education curriculum should be available to juveniles age 14 and over who choose to participate. Participating juveniles should receive at least 3 hours of vocational instruction per week in addition to academic studies, and those who at age 15.5 decide to undertake vocational education as their major area of emphasis should receive at least 15 hours of vocational instruction per week. An employability plan, based on extensive counseling regarding career options, should be developed for each juvenile participating in their vocational education program.

Limits should be established for "work-experience" training consisting of institution-maintenance activities. In no case should those activities constitute the primary focus of a vocational education program.

4.2163 Special Education

Special education programs should be available to meet the needs of juveniles who are educationally disadvantaged. Juveniles who should be provided with special education include those who:

a) Exhibit subaverage general intellectual functioning, possibly in conjunction with deficient adaptive and/or physical impairments which inhibit their ability to learn;

b) Exhibit average general intellectual functioning, although have a visual, hearing, or speech impairment or emotional disturbance that significantly inhibits their ability to learn; and

c) Despite average intelligence, adequate hearing, vision, motor capacity, and emotional adjustment, exhibit a substantial deficiency in learning and conceptualizing which is frequently demonstrated by their inability to read or clearly and consistently understand spoken language.

In utilizing intelligence quotient and achievement tests to determine whether a juvenile requires special education, primary reliance should be placed on those tests which are appropriate for the juvenile's ethnic and cultural background.

4.217 Health and Mental Health Services

Training schools should provide programs to protect and promote the physical and mental well-being of juveniles placed therein, to discover those in need of short-term and long-term medical and dental treatment, and to contribute to their rehabilitation by appropriate diagnosis and treatment.

Training schools should undertake treatment of health problems, without cost to the juvenile or his/her family including medical care and correction of health defects of a cosmetic nature. Procedures should be established for assuring the continuation and completion of treatment begun in a facility whenever a juvenile remains subject to the disposition of the family court following release from the training school.

Health services available to juveniles placed in a training school should be of equal quality to those available in the community.

4.2171 Initial Health Examination and Assessment

Each juvenile, as part of the admittance procedures, should be examined for apparent injuries, and for fever or other signs of illness. The examining officer should also note the juvenile's level of consciousness and level of gross motor function. Written standing orders should define the conditions which require prompt medical or nursing attention.

All juveniles placed in a training school should undergo a health assessment at the first possible opportunity after admission. Exceptions should only be made for juveniles with a written record of a thorough health assessment which is sufficiently current so that no substantial change can be reasonably expected. Health assessment should include physical examination within 24 hours of admission, the taking of a medical history, the taking of a mental history if necessary, screening for vision and hearing defects. Conditions which might affect behavior, such as epilepsy or diabetes, should be reported to the appropriate assessment team in a manner compatible with medical ethics and the rights of the patient.

4.217 Responsibility Toward Patients

Appropriate permission should be obtained for the performance of significant medical and dental procedures. Permission for such procedures should be obtained from a juvenile's parents or guardian unless the juvenile has a legal right to receive the medical or dental service without that consent.

All medical and dental care should be rendered with consideration for the juvenile's dignity and feelings. Medical procedures should be performed in privacy and in a manner designed to encourage the juvenile's subsequent utilization of appropriate medical, dental, and other health services.

The use of any procedures, techniques, or medications that have not previously passed rigorous scientific tests which demonstrate both their safety and their effectiveness, or that pose an unnecessary threat to the juvenile's physical or mental well-being, should be prohibited.

4.2173 Diet

Training schools should provide an adequate, varied diet and well-prepared and well-served meals supervised by a licensed dietician who should receive special training pertaining to allergic reaction, hyperactivity, and other mental, emotional and physical reactions of susceptible youth to particular food substances.

Weekly menus should be prepared and copies should be posted and maintained centrally within the facility. All deviations from the weekly menu should be recorded.

To the extent possible, food ordering and preparation should take into consideration ethnic tastes and food preferences of the juveniles.

4.2174 Mental Health Services

Psychiatric services in training schools should concentrate on diagnosis and training of staff who have daily contact with juveniles. Diagnosis should be utilized to determine whether the juvenile is appropriate for the training school program and to assess the juvenile's treatment needs. Staff training and consultation should be utilized primarily to assist childcare workers and other staff with direct treatment responsibilities in helping their charges through group and individual approaches.

When therapeutic mental health services are provided, the juvenile's family should be involved insofar as is possible and consistent with the needs of the juvenile. Individual therapy should only be conducted by psychiatrists, psychologists who have a doctoral or masters degree in psychology, or individuals with masters degrees in social work and counseling.

All juveniles placed in training schools should be informed upon entry that they may request of any training school employee a personal consultation with either a psychiatrist or psychologist. Consultation with either a psychiatrist or psychologist, selected by the training school, should be provided as quickly as possible.

4.218 Recreational Services

Training schools should provide opportunities for exercise and constructive and entertaining leisure-time activity. The opportunities should be in addition to the physical education requirements that may exist under the education laws of the jurisdiction. Activities should be balanced between individual-type and team-type activities of both indoor and outdoor varieties. At least 2 hours of recreation should be provided on school days and 3 hours on nonschool days, not including unsupervised periods spent primarily in such activities as watching television.

4.223 Services

Camps and ranches should offer a broad range of services including, but not limited to, the specific service areas described below.

A treatment plan should be prepared jointly by each juvenile and his/her assessment team. Each assessment team should be composed of a childcare worker, a caseworker, and a teacher. The plan should provide a structured schedule of activities, counseling, and education, but should not involve intensive psychotherapy because juveniles with deep-seated emotional or psychological problems should be treated at facilities closer to community resources.

The primary emphasis of the treatment strategy of a camp or ranch should be on a work-oriented program. However, remediation resources should be available to juveniles requiring specific academic attention as an adjunct to their vocational training experience.

Camps and ranches should have contractual relationships with local physicians and hospitals for the delivery of medical and dental needs which cannot be fulfilled by the staff. These arrangements should include screening and assessment of incoming juveniles, 2-hour emergency care procedures and routine medical care procedures. Each camp or ranch should have a written medical care plan detailing by name and telephone number the person or institution to be contacted for each category of medical care.

4.233 Services

Inhouse services at all group homes should include shelter, food, recreation, temporary financial assistance, and individual and/or group counseling. Juveniles placed in group homes should have access, as their particular needs require, to services in the community which are not provided inhouse. Among the community services which should be available to such juveniles are medical, psychiatric, and dental care; psychiatric evaluation, counseling, and therapy; vocational training; vocational and/or employment counseling and evaluation; employment placement; and academic upgrading. Supplementary services in these areas may also be provided by the group home.

Before or upon admission to a group home, a juvenile and, whenever possible, his/her family should assist in the preparation of an assessment of needs and the development of a plan establishing goals to be achieved during the juvenile's stay. In helping the juvenile to accomplish these goals, the group home's role should be similar to that of a properly functioning natural home, including the provision of necessities; assisting juveniles to overcome difficulties in a broad range of areas; and serving as a place to which juveniles can turn in time of need.

A single case record for each juvenile admitted to a group home should be maintained.

4.252 Services

The foster home should be a family setting. Concentration should be upon comfort and privacy in the living arrangements, the parenting skills of the houseparents and accessibility of the home to schools, recreation, and special resources such as medical clinics required by the juveniles placed therein.

4.263 Services

Although detention centers should not be considered as treatment facilities, detained juveniles should be provided with educational, medical, recreational, and other services appropriate to their needs, and an adequate and competent staff.

Upon admission, or as soon as possible thereafter, there should be an assessment of a juvenile's needs including an examination by a physician within 24 hours of admission, and a determination of the juvenile's educational level.

Contractual arrangements should be made with a nearby hospital for all medical services which cannot be appropriately provided within the facility or where contractual arrangements can result in better or a broader range of services. A medical record should be maintained and all should be provided for pursuant to the physician's instructions. Each juvenile should also be afforded reasonable access to psychiatric counseling and crisis intervention services in accordance with his/her needs.

The educational program provided in detention facilities should seek to assist detained juveniles to keep up with their studies to the greatest extent possible. Remedial education services should be provided for those juveniles who require it.

The recreational program should provide opportunities for exercise and constructive leisure-time activity. At least 2 hours of recreation should be provided on school days, and 3 hours of recreation on nonschool days, not including unsupervised periods spent primarily in such activities as watching television.

4.32 Services

A broad range of services should be available to persons subject to community supervision. Ordinarily such services should be provided by the community rather than directly by the supervision agency.

Upon placement under community supervision, the person supervised and, whenever possible, his/her family, should assist in the preparation of an assessment of needs and the

development of a plan establishing the goals to be achieved during the supervision period.

The family court should have the authority to order supplemental services to families when such services are necessary to enable the juvenile or family to participate in a nonresidential program. Among the supplemental services which should be available are homemaker services for a juvenile's family and cash payments directly to the juvenile when supervised independent living is appropriate.

Whenever specific supplemental or other services ordered by the family court are not available, an application to review and modify the disposition decision should be submitted pursuant to Standard 3.189.