Juvenile Justice 101
Directors' Message

On behalf of the Robert F. Kennedy Children's Action Corps and Georgetown University’s Center for Juvenile Justice Reform, we are pleased to bring in 2011 with a new periodical, The Connector: Working Together for Multi-system Youth. As a new partnership focused on cross systems issues takes shape between our two organizations, we are delighted to offer a resource that will provide valuable information to stakeholders working with multi-system youth, also known as "crossover youth." These are youth who span the child welfare, juvenile justice and related systems such as education, mental health, and substance abuse. Articles featured in "The Connector" on this topical area will highlight new initiatives, model programs, new and current research, and important policy updates and issues. In an effort to ensure that The Connector is as relevant as possible to your work, we welcome your recommendations (see sidebar on page two) for topics that you would like to see featured in future editions.

While many of you are familiar with the work of our two organizations, we would like to provide a brief overview of our efforts and why the alignment of our work on crossover youth is so timely and valuable. The Robert F. Kennedy Children's Action Corps (RFKCAC) operates a diverse range of programs—from secure or residential treatment, to detention diversion, to community-based outreach programs—and services that help children, youth, and families appropriately address the challenges they face. RFKCAC's work is based on the belief that every child deserves the chance to live a happy, healthy, and productive life. Its dedication to improve the lives of children and families through care, treatment, education, and advocacy stretches well beyond Massachusetts. This is due in part to a grant from the John D. and Catherine T. MacArthur Foundation to provide support to the Models for Change: Systems Reform in Juvenile Justice Initiative. That work is largely focused on systems integration as it relates to crossover youth and is guided by John Tuell, Janet Wiig, and Sorrel Concepcion. They bring a wide array of expertise on multi-systems integration and experience with Models for Change and we are delighted to have them as part of the RFKCAC team. More information on the work of RFKCAC can be found at its website: www.rfkchildren.org.

The Center for Juvenile Justice Reform (CJJR) at Georgetown University’s Public Policy Institute was founded in 2007 to support public agency leaders in the juvenile justice and related systems of care. Since then, the work of CJJR has also expanded to include private sector leaders. CJJR provides strong and sustained national leadership in identifying and highlighting the research on policies and practices that work best to reduce delinquency through the use of multi-systems approaches. In addition to the papers it releases, symposia it conducts, and the training it hosts at Georgetown University for public and private sector leaders, it currently has projects underway in 13 jurisdictions across the country in partnership with Casey Family Programs in which it is implementing its Crossover Youth Practice Model (CYPM). The CYPM takes the research conducted related to crossover youth over the past three decades and the learning from the work of CJJR and highlights five practice areas and over twenty practice elements that support better outcomes for crossover youth. In addition, CJJR hosts the MacArthur Models for Change Prosecutors National Resource Bank, connecting prosecutors to the progressive reforms in which the MacArthur Foundation and CJJR are involved. More information on the work of CJJR can be found at its website: cjjr.georgetown.edu.

As can be seen, RFKCAC and Georgetown's CJJR are well positioned to work together to further advance the development, implementation, and dissemination of best practices and policies that address the unique needs of multi-system youth. In fact, while the goals and mission of both organizations are congruous, we each offer unique approaches and capacity in our efforts to reduce juvenile delinquency, promote positive youth and child development, and hold youth accountable. In this regard, the foundation of RFKCAC's work is to provide direct service to youth and families, in addition to advocating on their...
behalf. Its capacity to do so has been expanded through the RFK Juvenile Justice Collaborative, a joint advocacy project between RFKCAC and the RFK Center for Justice and Human Rights focusing on juvenile justice issues. CJJR’s work is designed to support leadership development, while at the same time redesigning and strengthening the systems that serve our most vulnerable youth. In doing so, it is taking policy and practice improvements into the field, demonstrating them in communities across the country. These two competencies, when brought together form a strong ally to agencies and organizations working in this area.

Together RFKCAC and CJJR will present cutting edge information about multi-system youth and multi-system integration efforts through three primary mediums: a 2011 national symposium, a paper highlighting current policy and practice relating to crossover youth (which will be released at the symposium), and this periodical—The Connector. This first issue of The Connector features two initiatives in which both organizations are strongly invested: the Child Welfare & Juvenile Justice Systems Integration Initiative and the Crossover Youth Practice Model (CYPM). Its long history of direct service to both the child welfare and juvenile justice populations make RFKCAC an exciting new home to the Systems Integration Initiative; readers will learn more about this Initiative’s history and current role with RFKCAC as part of Models for Change in the article Celebrating 10 Years of Juvenile Justice—Child Welfare Systems Integration Work. As noted above, CJJR created the CYPM to address the needs presented by crossover youth. While the work of CJJR only began in 2007, its work through the CYPM has already had an extremely positive impact—read more in the article Improving Outcomes for Crossover Youth—A Practice Model. Advocacy updates will also be a regular feature in The Connector. On this topic in our first edition, we are pleased to introduce readers to the work of the RFK Juvenile Justice Collaborative.

Again, we thank you for taking an interest in The Connector: Working Together for Multi-system Youth and welcome you to contact us to learn more about RFKCAC and CJJR, or simply to share ideas for future issues of The Connector. Please anticipate reading the next issue in the Spring of 2011.

Sincerely,

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THE CONNECTOR
WORKING TOGETHER FOR
MULTI-SYSTEM YOUTH

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Models for Change: Systems Reform in Juvenile Justice Initiative is an effort to create successful and replicable models of juvenile justice reform through targeted investments in key states, with core support from the John D. and Catherine T. MacArthur Foundation. The Connector is created through the generous support of the John D. and Catherine T. MacArthur Foundation.
Celebrating 10 Years of Juvenile Justice—Child Welfare Systems Integration Work

Janet K. Wiig and John A. Tuell

Systems integration and coordination between the child welfare and juvenile justice systems is not an uncommon phenomenon today, as it was several years ago when communities across the country were just beginning to acknowledge the relationship between child maltreatment and juvenile delinquency. Today, there are many examples of communities that not only acknowledge the relationship, but also dedicate resources to addressing that relationship, improving how their systems work together to improve outcomes for children.

The Beginnings: Raising the Awareness
In 2000, the John D. and Catherine T. MacArthur Foundation began its support of the systems integration and coordination work with a grant to the Child Welfare League of America (CWLA) to create a Juvenile Justice Division. This work continues today under the auspices of the Robert F. Kennedy Children’s Actions Corps (RFKCAC). It was the beginning chapter, with personnel dedicated to a focus on the connections between the child welfare and juvenile justice systems and the establishment of the goal to develop an integrated multisystem approach to program development and service delivery.

A critical part of raising the awareness was to direct people’s attention to the data about the relationship between the child welfare and juvenile justice systems. This was accomplished through literature review, written publications, symposia, and invitations to jurisdictions to share their experiences with children involved in both systems.

Wiig, Widom, and Tuell’s (2003) Understanding Child Maltreatment and Juvenile Delinquency: From Research to Effective Program, Practice, and Systemic Solutions helped policymakers and practitioners learn what the research had documented about the crossover of the two populations and the risks of maltreated children becoming delinquents. The research summarized in that publication gave people a part of the foundation to persuade others that a focus on this population should be an important element in both their crime prevention strategies and their handling of children and youth. This publication also planted the seeds for the two systems to think about what goals they had in common and learn about systemic solutions that could help persuade others that investments to address these two populations together were worthwhile.

A quarterly newsletter, The LINK: Connecting Juvenile Justice and Child Welfare, began to bring to life the systems integration and coordination work with stories of jurisdictions that were already doing something about the relationship between child maltreatment and delinquency. Thus began the portfolio of work in this arena that would build over the ensuing years.

For five years, juvenile justice symposia directed at a national audience were conducted, showcasing the work of jurisdictions that were addressing the connection between the two systems and the needs of the involved children. These symposia, supported by the John D. and Catherine T. MacArthur Foundation, also highlighted critical issues in juvenile justice, issues that were the object of reforms the MacArthur Foundation had begun to advance through its Models for Change initiative.

Guiding the Process
A critical foundation piece to guide the development of jurisdictions’ work was the Guidebook for Juvenile Justice and Child Welfare System Coordination and Integration: A Framework for Improved Outcomes (Wiig & Tuell, 2008). This guidebook sets out definitions to broadcast the systems integration and coordination goals to help people think about the opportunities for reform and improved outcomes. It contains a four-phase strategic planning process that helps jurisdictions take a step-by-step approach to their integration and coordination planning, involving not just the child welfare and juvenile justice systems, but also the related systems of care: education, substance abuse, and mental health.

Beginning in 2004, King County, Washington, was the first site to use the guidebook along with the Juvenile Justice Division’s on-site consultation to aid in developing its integration and coordination efforts. It is probably the most mature site in terms of its development because it has a longer history of focus, has committed to a permanent multisystem governance structure for these efforts, and has joined the Crossover

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THE CONNECTOR 3
Q&A with Bruce Knutson—Director of Juvenile Court Services in King County, Washington

What was the primary impetus of the Juvenile Justice and Child Welfare Systems Integration Initiative (SII) in King County?

We were severely overcrowded within our juvenile detention facilities, and juvenile crime rates were high. We really wanted to change this in a positive way, we were faced with either building a second detention facility or doing things differently. So that effort turned out to be very successful... so successful that, in the last 10 years, the juvenile crime rate has reduced by over 50% and our detention placement has reduced by over 50%.

Although the juvenile justice system had a history of collaborative efforts, we hadn’t yet looked at child welfare and juvenile justice and how to better coordinate working with crossover youth. We felt strongly that there was a pipeline from the child welfare to the juvenile justice system. We were also feeling like we didn’t have a strong understanding of the “other” or know what the “other” was doing or what services were being provided to youth and families within shared cases.

How did you get started with the work itself? When did it begin?

Several representatives from King County, including at least one of our judges, attended a CWLA Juvenile Justice Symposium in June 2003 and came away very interested in working with our cross-over youth population. So at that point, Casey Family Programs (Seattle office) contacted CWLA staff. That conversation led to two one-day symposiums, which were attended by an array of child welfare and juvenile justice stakeholders in King County. As a result of that, leaders from the various systems all got together and committed to doing a better job of integrating our work. We developed a charter agreement that defined the goals and scope of the initiative that explicitly showed our commitment on the part of each agency...from providing resources to investing time and energy into the new SII—which we now call “Uniting for Youth.”

What were some of the hardest challenges you faced as you developed your systems integration efforts?

There is a large number of staff throughout these systems, so one of our challenges was educating and helping our staff understand how each other’s systems work and why it makes sense to work together. For such a large jurisdiction like ours, that’s definitely a challenge. One of the things we’ve done is implement a cross-systems training, which we do quarterly and have people from each of the systems present. To date, we’ve had about 1,200 people participate in the cross-systems training.

Wow—that is very impressive!

Yeah! So I think that’s been working well for us, but it’s definitely been a challenge.

The budget crisis throughout the country, and within King County, has been really challenging...But our collaborative efforts and seeing the incarceration and crime rates go down has helped us throughout this difficult economic time—otherwise, we would have been devastated. But at this point and time we have been able to do good work, maintain morale, and feel like we are doing better work for children and families and producing better results than ever before.

What is the status of the work today and what do you see for its future?

Uniting for Youth is still going strong. The commitment level of the leadership still exists today—we have met monthly every since 2004. There’s a solid commitment in place to maintain the cross-system training, which 1,200 have already participated. People consider this commitment to be strong and viewed as a permanent effort—not an initiative with an end date.

Bruce, thank you for sharing this information with our readers—it’s wonderful to learn about all the great work being done in King County!

Thank you as well.

Editorial Note: It should be noted that the King County Unified for Youth collaboration also has been participating in the CYPM initiative in 2010 and 2011.

Youth Practice Model (CYPM) developed by the Georgetown University’s Center for Juvenile Justice Reform and described in the accompanying article) to its systems integration work. King County, now working on its systems integration and coordination efforts under the banner of Uniting for Youth, has an extensive portfolio of products to support this work, including memoranda of understanding, protocols, and an information-sharing resource guide, to name a few. Several other jurisdictions, including Los Angeles County, South Dakota, the U.S. Virgin Islands, Connecticut, Arizona, and Colorado, received on-site consultation using the four-phase process from the guidebook.

Also used extensively to support the systems integration work is A Guide to Legal and Policy Analysis for Systems Integration (Heldman, 2006). This publication details the process of examining the legal, policy, and procedural mandates unique to each agency or organization to recommend changes that will contribute to improved coordination of initial decision-making, case management, and service delivery. It was developed through experience gained from efforts in numerous jurisdictions that have worked to improve cross-system practices and policies.

In 2006, the systems integration and coordination work became a part of Models for Change: Systems Reform in Juvenile Justice, a wide ranging juvenile justice reform effort funded by the MacArthur Foundation. The Juvenile Justice Division began work in the four core states (Illinois, Louisiana, Pennsylvania, and Washington) adding technical assistance and expertise in multisystems integration and coordination. It was recognized that any substantial system reform work would necessitate working across multiple disciplines to improve the work processes to achieve improved outcomes for youth. The strategic-planning process and tools developed in other jurisdictions have helped those four states to address critical issues across systems through building a better cross-system infrastructure. The work in these states and the numerous local sites within them also has added to the rich portfolio of tools and resources to aid in systems integration and coordination.

In 2008, as part of the Models for Change efforts, the MacArthur Foundation asked CWLA and the Juvenile Law Center to work together to create a technical-assistance resource for information sharing for Models for Change sites. Thus, the Models for Change Information Sharing Tool Kit was published. This Tool Kit is another important support for the systems integration and coordination work. It provides guidance to jurisdictions seeking to improve their information and data-sharing practices in the handling of juveniles and to reach the ultimate goal of improving outcomes for those youths. The Tool Kit is now widely available to jurisdictions as a posting on the Models for Change website.

Another critical foundation piece was the creation of CWLA’s National Advisory Committee on Juvenile Justice, a group of leaders from public and private agencies that worked to promote the integration of juvenile justice and child welfare through national and local advocacy efforts. The committee’s existence was also the genesis of the organizational placement of this work today. The committee chair for many years was Ed Kelley, CEO of the RFKJCAC, where the systems integration work under Models for Change is housed today.
Products—The Portfolio
Many of the products from the systems integration and coordination work in sites around the country are chronicled in the report *Child Welfare and Juvenile Justice Systems Integration Initiative: A Promising Progress Report* (Tuell, 2008). The following are some of the highlights from various sites.

**King County, Washington**
King County, Washington, has made remarkable strides in systems integration and proves to be a model example of successful collaboration for many jurisdictions. The King County Uniting for Youth Initiative (formerly called the Systems Integration Initiative) has created many successful practice documents and procedures:

- A multiagency charter agreement that defines the goals, objectives, and a set of guiding principles to accompany the development of the dual jurisdiction protocol
- An interagency policy and protocol that details joint policy and procedures regarding how juvenile court probation and the state child protection agency work together in support of dual status youth and their families
- A resource guide for information sharing (a critical and often necessary tool for joint case assessment, planning, and integrated service delivery) to provide information on legal, policy, and practice matters regarding the exchange of case-related information
- The development and implementation of multiagency training for personnel to increase knowledge of each others’ functions and develop relationships that support shared responsibility and services

**Los Angeles County, California**
Los Angeles County built its work on a statute mandating a joint protocol (California Welfare and Institution Code section 241.1) for dual-system youth. It adopted and implemented a revised cross-system protocol that resulted in the following:

- A new multisystem assessment process that considers strengths, treatment needs, and risks from multiple disciplines
- Creation of a specially trained multidisciplinary team to conduct assessments, develop case plans, and produce a joint case disposition recommendation report

**South Dakota**
Child Welfare and Juvenile Justice leaders in South Dakota sought consultation to support the development of legislation to improve information sharing across systems, resulting in the passage of House Bill 1059. This bill provided for the sharing of “need to know” information between the Department of Social Services, the Department of Corrections, and the court at three key decision points in the juvenile justice system: preliminary hearing and detention status consideration, disposition, and reentry from a correctional or residential facility.

**Arizona**
In response to the National Center on Juvenile Justice’s findings on Arizona’s dual-jurisdiction youth, the Governor’s Office for Children, Youth, and Families organized an interagency taskforce to develop an agreement and framework to provide coordinated and integrated services to youth and families served by both systems. Arizona’s Interagency Coordination and Integration Initiative resulted in a blueprint to improve integration and coordination services and provide a roadmap of additional action steps to continue improving outcomes for youth and families. The blueprint describes the initiative’s strategies and action steps in relation to its stated outcome goals. Some strategies include the following:

- Disseminate guidance from state level to counties as to law and policies regarding information sharing
- Develop an infrastructure across agencies to support the exchange of information
- Focus efforts to provide needed resources without barriers presented by categorical funding
- Engage families actively in the identification of service needs and service delivery so their participation is insured to support dually involved youth
- Target families at greatest risk who have open cases in both the child protection and juvenile probation/corrections
- Develop a pilot focused on diverting younger siblings from the juvenile justice system

Always New Beginnings
The interest in this work keeps growing as is evidenced by new jurisdictions taking on the work and the progression of its development with such innovations as the CYPM. In fact, both King County and Los Angeles County have utilized their systems integration work and the portfolio of products to support their 2010–2011 involvement in the CYPM initiative. There continues to be the recognition that, to effectively address the relationship between the child welfare and juvenile justice systems and the allied systems of education, substance abuse, and mental health, a commitment to working together, a sound infrastructure, protocols, and other tools need to be in place to address the key working relationships.

New this year to the systems integration and coordination work is the Washington State Department of Social and Health Services (DSHS). DSHS received a grant from the MacArthur Foundation and is now part of the *Models for Change* effort. The focus of its grant is to do multisystem collaboration and coordination (MSCC). This work has the leadership support from the top of the organization, Secretary Susan Dreyfus, and it joins other MSCC work in Washington State under the state’s lead entity for *Models for Change*, the Center for Children and Youth Justice. This is an exciting effort that entails three arenas of focus: (1) integrated case management within DSHS for high needs, risk, and cost populations served by DSHS; (2) integrated case management between the Children’s Administration and the Juvenile Rehabilitative Administration; and (3) integrated case management with local jurisdictions.

The RFKCAC systems integration team is providing on-site consultation to the DSHS, and the DSHS is using the framework set out in the guidebook (Wig & Tuell, 2008). It has developed a sound infrastructure to support the development of this work and, in some ways, will be creating state analogs to the work that began in King County many years ago. This effort is a great example of the growth of systems integration and coordination work.

Finally, a key part of the new beginnings is the move to RFKCAC. The systems integration and coordination work, supported by the MacArthur Foundation under *Models for Change*,
is a part of the Juvenile Justice Collaborative that RFKCAC has formed with the RFK Center for Justice and Human Rights. It is a good fit for the systems integration and coordination work that has been done in that RFKCAC has a long history of service and advocacy to both the child welfare and juvenile justice populations. It is also a good fit in that the Juvenile Justice Collaborative offers a great blending of direct service, local advocacy, and federal advocacy for these two populations.

References


RFK Juvenile Justice Collaborative

The RFK Juvenile Justice Collaborative (RFK Collaborative) is a joint project of the RFK Children’s Action Corps (RFKCAC) and the RFK Center for Justice and Human Rights (RFK Center). The goal of the Collaborative is to increase national attention on juvenile justice issues by combining the practical, service-delivery experience of the RFKCAC with the national policy and advocacy expertise of the RFK Center. The RFK Collaborative also partners with national organizations and foundations to add value to juvenile justice advocacy and policy development.

During the past year, the RFK Collaborative has worked to raise the profile of juvenile justice issues, specifically highlighting the needs of youth reentering their communities after a time of confinement or out-of-home placement. More specifically, the continued work of the RFK Collaborative includes:

Educating decision-makers about the importance of effective policies and sufficient resources to support youth reentry, including:

- Improved federal coordination of and support for reentry through the Attorney General’s Reentry Task Force and Coordinating Council on Juvenile Justice and Delinquency Prevention.
- Program resources to improve youth reentry, including reauthorization of and funding for the Second Chance Act.
- Policies to reduce barriers for youth who need to return to school from the juvenile justice system.

Bringing the voice of impacted youth to advocacy:

- To strengthen its advocacy on youth reentry and education issues, the RFK Collaborative is developing a presentation on youth perspectives on education, a key indicator of reentry success. This presentation will present perspectives from youth served by RFK Children’s Action Corps programs.

In addition to the work described above, in 2010 the RFK Collaborative co-sponsored the production of a paper and symposium (produced and held by Georgetown University’s Center for Juvenile Justice Reform) on the educational needs of youth impacted by the juvenile justice and child welfare systems. This paper, and the symposium at which it was released, is titled Addressing the Unmet Educational Needs of Children and Youth in the Juvenile Justice and Child Welfare Systems and is available online at: http://cjjr.georgetown.edu/pdfs/ed/edpaper.pdf.

For more information about the RFK Collaborative, please contact Ed Kelley, RFKCAC (EKelley@rfkchildren.org) or Lynn Delaney, RFK Center (delaney@rfkcenter.org).
Improving Outcomes for Crossover Youth—A Practice Model

Macon Stewart

The Center for Juvenile Justice Reform (CJJR) at the Georgetown University Public Policy Institute has partnered with Casey Family Programs since 2007 to address the unique issues presented by children and youth who are known to both the child welfare and juvenile justice systems. These young people, often called “crossover youth,” move between the child welfare and juvenile justice systems or are known to both concurrently. A disproportionate number of these youth are youth of color and girls, and the entire population generally requires a more intense array of services and supports than youth known to each system individually. While the exact number of crossover youth may vary across jurisdictions, research has established that youth who have been maltreated are more likely to engage in delinquent behavior. A study by Chapin Hall has also increased our knowledge about one segment of this population, finding that in the State of Illinois, 9% of youth who left correctional placement in the juvenile justice system were in an out of home placement in child welfare one year after their release. The work undertaken in this partnership has been designed to better address the issues these youth present and meet their needs. It also seeks to reduce the number of youth that enters or reenters foster care, the number of youth that cross over, the number of youth in foster care that cross over and move into institutional placements in the juvenile justice system, and the disproportionate representation of youth of color in each system, particularly in the crossover population.

Crossover Youth Practice Model

Based on this cumulative and growing body of knowledge, CJJR has developed a practice model that describes the specific practices that need to be in place within a jurisdiction to reduce the number of youth that crosses over between the child welfare and juvenile justice systems, and achieves the outcomes noted above. The Crossover Youth Practice Model (CYPM) infuses this work with values and standards; evidence-based practices, policies, and procedures; and quality-assurance processes. It provides a template for how states can immediately impact how they serve crossover youth and rapidly impact outcomes.

The CYPM creates a nexus between research and the practice learning from the Juvenile Justice and Child Welfare Integration Breakthrough Series Collaborative, jointly conducted in seven jurisdictions by CJJR and Casey Family Programs in 2008 and 2009. It provides a mechanism whereby agencies will strengthen their organizational structure and implement or improve practices that directly affect the outcomes for crossover youth. This includes but is not limited to the following practices: creating a process for identifying crossover youth at the point in which they move from one system to another, ensuring that workers are exchanging information in a timely manner, including families in all decisionmaking aspects of the case, ensuring that detention or institutional care bias is not occurring at the point of the detention decision or case disposition for crossover youth, and maximizing the services used by each system to prevent crossover from occurring.

Participating in the CYPM has allowed each site to begin creating a seamless process from case opening to case closing that improves outcomes for crossover youth. Implementing the model helps to ensure that practices are consistent for all youth within a system and resources are shared between the systems to maximize their impact. The model emphasizes the importance of developing cross-systems data capacity and the need to use good data to make program and policy decisions.

Outcomes

The following are the overall goals for the sites participating in the CYPM:

1. A reduction in the number of youth placed in out-of-home care
2. A reduction in using congregate care
3. A reduction in the disproportionate representation of children of color
4. A reduction in the number of youth becoming dually involved or adjudicated

Data collection is a requirement for all sites participating in the CYPM. CJJR recognizes the challenge that collecting shared data sets presents for many sites. However, sites participating in the practice model have expressed an ability to collect cross-systems data electronically or manually and are committed to doing so.

Pre- and post-practice model baseline measures have and will be collected. These data reflect the larger spectrum of each system. A limited number of measures will also be collected on each phase of the practice model on a monthly basis. These data include demographics on all crossover youth identified and individual measures of well-being on a smaller subset of crossover youth. It is intended to ensure that the collection of these data will not be cumbersome in nature and will build on information that each system is currently collecting.

Target Population

For purposes of the CYPM, CJJR focuses on crossover youth who have current and simultaneous involvement in both the child welfare and juvenile justice systems in the following ways: (1) youth initially involved in the child welfare system who are subsequently referred to and become involved in the juvenile justice system; and (2) youth who are initially involved in the juvenile justice system and are subsequently referred to and become involved in the child welfare system because of suspicions of abuse/neglect in the home. Youth falling into these
What was the primary impetus of the Crossover Youth Practice Model (CYPM) being implemented in Hamilton County? When did it begin?

We applied in February 2010 and then we began our work in April 2010—so, recently.

Something kind of ironic is that one of the hardest challenges, budget cuts, was also an impetus for this work. When we applied to do the CYPM, our detention facility went from 160 down to 80 (another residential facility for youth who committed serious felony offenses went from 120 down to 60), so as a result of no longer admitting as many youth into detention, we really had to figure out different solutions that allowed us to safely support youth in the community. That really fit with elements of the CYPM; I think that the CYPM gave us an opportunity to look at other options and how to do them effectively. Rather than just cut the work we were doing, we had to figure out how to do it differently. We could have said, “We give up, we lost too much money,” but instead the CYPM put us in the right direction.

How did you get started with the work itself?

The very first thing we did was form a very small core leadership team, which was comprised by leadership from the Department of Job and Family Services (juvenile welfare and child protection services) and the juvenile court. We, with [consultants’] assistance, did form a guiding coalition and an advisory committee. We did have very committed leadership. However, there were too many players in the advisory committee, so we formed a few workgroups: [data and program evaluation, diversion, and joint assessment/case management and service coordination]. As we developed those workgroups, we made sure they had action items and very specific outcomes to achieve. Once those outcomes were achieved, the advisory committee reconvened and said, “Okay, what are our priorities now?” and would then create new outcomes goals and action items.

What do you think were the critical ingredients in the development of this work?

We did adhere to the model pretty strictly, especially about the structural framework.

We also had a little bit of a history of how we could do the work a little bit easier. . . . As a result of our model court work, through the National Council of Juvenile and Family Court Judges, we developed a culture in our system that also supported the work being done through the CYPM . . . there were already a lot of well-entrenched partnerships that had developed in our community, and there had been effective collaboration between public and private partners. Another benefit was that we had a history of data exchange and sharing across our two systems; the systems are not linked, but they do communicate and that helped us get started.

Aside from the budget cuts you mentioned before, what were some of the hardest challenges you faced as you developed your CYPM efforts?

We defined our population very broadly—which could be good or bad. We are not just targeting kids in agency custody, but we are taking kids that have an open voluntary case in child protective services. We defined it broadly because we wanted to see in three different target areas how CYPM would impact our youth. The volume did create some hardship for us, so then we needed to figure out a way to randomize the selection in a way that could be manageable on a pilot basis and then become operational. A consultant helped us with our pilot case load down to something manageable . . . we are now doing about 20 cases a month.

What guidance did you take in your development of the work? How important was that guidance?

One of the big things is the model itself. The structure of the model was incredibly helpful and gave us the framework to implement it. The on-site training and support, as well as the training in DC during the summer, has been really helpful. As we’ve established each phase a consultant has been here to really help achieve the next step. The consultants also provided training to management staff which really helped reinforce the work . . . it was nice for that staff to learn about the CYPM and receive training and support.

What is the status of the work today, and what do you see for its future?

Training and staff support is something that has been extremely helpful and will continue to be ongoing. There’s always some kind of cross-over youth training happening at least once a week within one of our entities.

Program outcomes (are) a piece we really want to be able to look at; we have three different subgroups within our target population, and we wanted to examine how the CYPM impacts each of those. We want to be able to show that the program is effective before we roll it across the system.

The advisory group has created six new target areas and corresponding workgroups. These focus areas will be pro-social support and engagement; mentors, permanency, costs [long-term commitment from a dedicated adult to provide support, guidance, and assistance]; kinship support; educational, vocational, and employment development and opportunities. . . . The final area that we are working on is the use of a mobile crisis team to provide immediate crisis support and service interventions to caregivers and providers caring for crossover youth—which we anticipate will reduce the likelihood of law enforcement contact and arrests and maintaining placement stability for that youth.

I think that wraps up our questions for now—thank you!

Thank you!

Implementation of the CYPM

The CYPM is being implemented in three phases. While there are some youth who cross over from the juvenile justice system to the child welfare system, research suggests the vast majority of crossover is from child welfare to juvenile justice and as such the practice model is designed predominantly with those youth in mind.

Phase I

Practice Area I: Arrest Identification and Detention

This practice area addresses the handling of a case from the point of arrest. It will identify protocols that need to be instituted to ensure that crossover youth are identified and appropriate assessment is occurring following the detention decision. It also emphasizes the early engagement of family and cross-system workers assigned to the family when the arrest occurs. This phase also encourages the review of the various entry points of youth from child welfare into juvenile justice, exploring what can be instituted to stop that initial contact from occurring.

Practice Area II: Decisionmaking Regarding Charges

This practice area addresses the need for a cross-system team approach when a youth already involved in the child welfare system has been arrested and the decision is being made about whether the case should be filed and referred to the court or diverted from the juvenile justice system. It will further emphasize the use of a team approach that includes the family at all decision points.
Phase II  
Practice Area III: Case Assignment, Assessment, and Planning  
This practice area has a strong emphasis on a variety of case management functions to be performed in a cross-systems manner, court operations for streamlining judicial oversight, and service delivery including but not limited to using evidence-based practices.

Phase III  
Practice Area IV: Coordinated Case Supervision and Ongoing Assessment  
This practice area builds on the capacity created in Phase II (Practice Area III) and also focuses on the entry of youth from the juvenile justice system to the child welfare system. It aims to strengthen the use of a cross-systems approach in working with families, improve educational and behavioral health supports provided across the two systems, and enhance community engagement.

Practice Area V: Planning for Youth Permanency, Transition, and Case Closure  
This phase focuses on permanency and case closure. It aims to enhance the permanency planning that occurs throughout the case and improving permanency outcomes for crossover youth. It also stresses the importance of engaging community supports to ensure a safe transition from the system for all youth.

Benefits of Institutionalizing a CYPM  
Nationwide, jurisdictions that have implementing the CYPM have found this more effective than other change models for several reasons:

1. The prescriptive nature of a practice model provides staff with a roadmap for what practice should look like—case opening to case closure—and reduces ambiguity about the specific directions the agency needs to take.
2. Because practice models include predominantly evidence-based practices, the approach removes some of the internal tension about whether a new practice will actually work, as evidence suggests it will.
3. A strong practice model embeds values and principles into the practice changes, supporting the culture changes that many leaders desire to make in organizations.
4. A practice model involves staff from all levels of the agency in the planning and execution of the work.

CYPM Sites  
The following is a listing of the sites participating in the national CYPM. CJJR is also implementing the CYPM in several communities independent of the national work:

- Denver County, Colorado  
- Hamilton County, Ohio (Cincinnati)  
- King County, Washington (Seattle)  
- Los Angeles, California  
- Miami-Dade County, Florida  
- Monroe County, New York (Rochester)  
- Multnomah County, Oregon (Portland)  
- Philadelphia, Pennsylvania  
- Berkeley County, Charleston County, and Georgetown County, South Carolina  
- Travis County, Texas (Austin)  
- Woodbury County, Iowa (Sioux City)

For more information regarding the CYPM, please go to http://cjjr.georgetown.edu.

Reference  
Cusick, G. R., Goerge, R. M., & Bell, K. C. (2009). From corrections to community: The juvenile reentry experience as characterized by multiple systems involvement. Chicago, IL: Chapin Hall Center for Children at University of Chicago.

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July 15–21, 2011

The Center for Juvenile Justice Reform at Georgetown University’s Public Policy Institute has announced its 2011 Certificate Program for Public Sector Leaders. The program is designed to advance cross-systems work to improve outcomes for youth involved in the juvenile justice and child welfare systems. Participants will attend a week-long program in Washington, DC where they will be taught by expert faculty on topics including multi-system integration, developing collaborative leadership skills, the effective use of communication strategies, reducing disproportionality in the child welfare and juvenile justice systems, and more. After the program, participants will develop a Capstone Project to implement systems reform in their home jurisdiction.

Applications are due by March 31, 2011

For more information, please visit the CJJR website at http://cjjr.georgetown.edu
The Changing Borders of Juvenile Justice: Transfer of Adolescents to the Adult Criminal Court

Through much of the 20th century, the juvenile court was the primary legal forum to respond to children who broke the criminal laws. With the rise in youth crime beginning in the late 1970s, legislators and commentators spoke ominously of a nation under siege by a rising generation of violent young criminals. These fears led many Americans to blame the juvenile court and demand that legislators “get tough” with violent and chronic young offenders.

In response to recurring epidemics of youth violence over the past three decades, 46 states made significant changes in laws that lowered the age and broadened the circumstances under which young defendants could be prosecuted in the criminal courts. Prosecution in the criminal court was designed to punish young offenders more harshly and for longer periods of time, thereby deterring them and other youths from further crimes.

But have these efforts been effective? Does the prospect of harsher sentences and adult time deter youth from committing crimes? Although there are strong proponents on each side of the argument, new evidence has raised questions about the effectiveness of the new laws.

Network researchers have examined whether the prosecution of adolescents as adults reduces crime and recidivism. Their research capitalizes on unique conditions in the New York City region, where the laws of two states, New York State and New Jersey, span the border of a single metropolitan area. On the New York side of the border, juveniles as young as 13 are charged in adult court, while on the New Jersey side, nearly all cases of juvenile offenders below the age of 18 are processed in juvenile court. By comparing similar offenders in the two settings who were arrested and charged with the same felony offenses during the same time period, the researchers were able to determine whether treating juveniles as adults in the legal system is an effective deterrent to crime.

They find that adolescents processed in the New York adult courts were more likely to be re-arrested, they were re-arrested more often and more quickly and for more serious offenses, and they were re-incarcerated at higher rates than those in the New Jersey juvenile courts. The results suggest that harsher sentences and adult punishment are ineffective deterrents to crime among the juveniles in this sample.

Teens Prosecuted in Adult Courts at Greater Risk of Repeat Offenses

The study examined more than 2,000 adolescents who committed one of three types of serious crimes (aggravated assault, armed robbery, burglary) during 1992 and 1993. The youth were tracked through 1999 to determine re-arrest rates for several types of crimes. By using the two groups from the same metropolitan area, with similar economic opportunity, access to weapons, drug use, gang influences, and other influences on crime, any differences in re-arrest between the two groups can be assumed to be due to the different court systems. The re-arrest rates were calculated after controlling for time on the street.

Table 1 shows that youth prosecuted in the adult courts in New York were 85% more likely to be re-arrested for violent crimes than those prosecuted in the New Jersey juvenile courts, and 44% more likely to be re-arrested for felony property crimes. The odds of re-arrest
were greatest for those youths with no prior arrest record who were prosecuted and sentenced as adults. Only for one type of crime, drug offenses, were youths in the adult courts less likely to be re-arrested. The chances of being re-incarcerated were 26% greater for youths prosecuted as adults. When the researchers compared the number of each type of offense during the follow-up period, the results were nearly identical.

Youths who received lighter sanctions – those whose cases were either dismissed or who received lighter sentences – also were less likely to be re-arrested; this was true in both states. In other words, teens whose cases are diverted from court or dismissed are less likely to be arrested again. More work is needed to determine whether this stems from the courts’ ability to identify those youth at greater risk for reoffending and give them a sanction, or if the mere fact of a sanction causes an adolescent to feel more like a criminal and then act more like one after release.

The research also showed that longer sentences did not reduce the likelihood of rearrest either in the juvenile or the adult court. But, the research did show that a history of prior arrests and re-arrests is a reliable predictor of future re-arrests. So too are several demographic factors: males are more likely to be re-arrested than females, and African-Americans are more likely to be re-arrested than other race-ethnicities. More study is needed to determine whether these differences stem from different behaviors of the individuals in the groups or from different arrest policies.

**Teens in Adult Corrections Face Harsher Settings and Experience More Developmental Problems**

In a related study, network researchers compared the correctional experiences of 425 adolescents placed in juvenile versus adult correctional facilities in 2000-2001. This research sought clues that might explain why adolescents adjudicated and sentenced in the criminal courts often have higher re-arrest rates and are more often returned to jail or prison. The research used a similar design in which youth in juvenile corrections were compared with matched samples of youths in nearby states where they were incarcerated as adults. The incarcerated youths were interviewed within three months of their scheduled release date and asked about their correctional experiences, the therapeutic and rehabilitative services they received, and their mental health and social outcomes. Four states were included in the study, each with varying programs and facilities where teenage offenders were incarcerated. The experiences of youth in juvenile correctional facilities in New Jersey and California were compared with those of similar groups of youth placed in adult correctional facilities in New York and Arizona.

The results suggest clear differences in the therapeutic and service contexts of each of these settings. Figure 1 shows that youths placed in adult correctional settings reported significantly weaker correctional climates along four critical dimensions: fairness, counseling and therapeutic services, educational and job training services, and program structure, compared with matched groups of youths placed in juvenile facilities. At the same time, the juvenile facilities were more chaotic. Adolescents in the juvenile programs reported higher rates of witnessing violence and violent victimization. They also reported higher rates of involve-
ment in several types of crimes while incarcerated as well as more drug use. Despite these unruly settings, they reported greater feelings of safety compared with youths placed in adult settings. This paradox may reflect the social networks that were dominant in the two different types of placements: older criminal offenders in more organized prison gangs were the dominant social group in the adult facilities, compared to the loosely organized groups of peers that populated the juvenile facilities.

This greater sense of danger, then, perhaps explains the higher rates of mental health problems reported by youths in the adult facilities. Figure 2 shows that the current levels of mental health symptoms of youths in adults corrections were significantly worse on two dimensions of mental health functioning compared with rates reported by youths in juvenile facilities. The significant dimension includes the important Global Severity Index, a scale that spans all of the dimensions of mental health in this assessment tool.

The same youths also reported higher rates of three dimensions of post-traumatic stress disorder. Figure 3 shows that youths in adult corrections had higher rates the same types of mental health problems experienced by soldiers returning from war and survivors of natural disasters.

There were also differences across the juvenile corrections facilities. Youths placed in larger juvenile justice facilities with a wider age range of inmates had similar outcomes to youths placed in the adult facilities. Youths sentenced as adults who spent some time in juvenile facilities before being administratively transferred to adult placements experienced fewer mental health problems and reported better service environments. These differences suggest that the size and diversity of populations in correctional placements are important dimensions of the correctional experience that interacts with the broader adult-juvenile legal categories to shape the correctional experiences of youths punished as adults.

**Policy Implications**

Policymakers and others advocating for harsher youth sentences argue that the threat of "adult time for adult crime" is a sound deterrent. The first study, however, shows the opposite: recidivism among 15- and 16-year-olds prosecuted in adult courts in New York is actually more common and more serious than it is in New Jersey, which refers adolescents who have committed similar offenses to juvenile courts. Youths sentenced in the criminal courts in New York were more likely to be re-arrested, their re-arrests were more frequent and their new offenses more serious, and they were more likely to be re-incarcerated within a few years.

The study also suggests that the longer sentences in adult courts are not responsible for the differences in re-arrest rates or in correctional outcomes. Rather, the second study finds that the adult courts may expose adolescents to harsher incarceration settings
and less effective probation supervision in the criminal justice system. One reason may be that a felony conviction has a more harmful effect on subsequent employment, citizenship, or other positive adult roles, factors that otherwise could lessen the tendency to return to crime. Another possibility is that prosecution in an adult court communicates to the adolescent that he or she is unsalvageable, and hence repeat offenses become a self-fulfilling prophecy. A third reason is the stark differences in correctional experiences for those youths who are incarcerated as adults. Not only do they receive fewer and weaker services, but they are confined with adult offenders during the critical developmental period of the transition from adolescence to adulthood. This environment obviously has its effects on mental health. But also, teens in adult corrections have limited exposure during this critical developmental stage to a broader set of social norms and a more diverse behavioral toolkit from the wider social networks of family, school or work, and community. Network researchers are not the only ones to reach these conclusions. Studies in Florida, for example, show similarly elevated risks of re-arrest for juveniles in adult court, and similarly toxic environments for those youths placed in adult correctional facilities.

Network researchers recommend that authority for making transfer decisions be returned to court judges who can consider criteria other than age and offense in determining how to prosecute an adolescent. Policies that result in a wholesale transfer of adolescents from juvenile to adult courts often fail to deter repeated instances of serious and violent crime. Although some of the most extreme cases may still need to be prosecuted in adult court, these should be the exception and not the rule. However, return of decision-making authority to judges must be accompanied by new models for decision-making. In the past, judges have not been able to consistently identify the most serious offenders, and there has been a tendency toward harsher sentencing that often reflected racial discrimination. If new models are not offered to judges, the same problems will recur. What is needed is a better method to distinguish between cases in which the community must be protected from predatory youth and those in which delinquent youth must be protected from negative effects of incarceration.

For more information
MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice
Temple University, Department of Psychology
Philadelphia, PA 19122
www.ajjj.org

The Research Network on Adolescent Development and Juvenile Justice is an interdisciplinary, multi-institutional program focused on building a foundation of sound science and legal scholarship to support reform of the juvenile justice system. The network conducts research, disseminates the resulting knowledge to professionals and the public, and works to improve decision-making and to prepare the way for the next generation of juvenile justice reform.
Health Care for Youth in the Juvenile Justice System
Committee on Adolescence
Pediatrics 2011;128;1219; originally published online November 28, 2011;
DOI: 10.1542/peds.2011-1757

The online version of this article, along with updated information and services, is
located on the World Wide Web at:
http://pediatrics.aappublications.org/content/128/6/1219.full.html
POLICY STATEMENT

Health Care for Youth in the Juvenile Justice System

abstract

Youth in the juvenile correctional system are a high-risk population who, in many cases, have unmet physical, developmental, and mental health needs. Multiple studies have found that some of these health issues occur at higher rates than in the general adolescent population. Although some youth in the juvenile justice system are in the care of health care providers in their community on a regular basis, others have had inconsistent or nonexistent care. The health needs of these youth are often identified when they are admitted to a juvenile custodial facility. Pediatricians and other health care providers play an important role in the care of these youth, and continuity between the community and the correctional facility is crucial. This policy statement provides an overview of the health needs of youth in the juvenile correctional system, including existing resources and standards for care, financing of health care within correctional facilities, and evidence-based interventions. Recommendations are provided for the provision of health care services to youth in the juvenile correctional system as well as specific areas for advocacy efforts. 

INTRODUCTION

Youth in the juvenile correctional system are a high-risk population who, in many cases, have unmet physical, developmental, and mental health needs. Multiple studies have found that some of these health issues occur at higher rates than in the general adolescent population. Although some youth in the juvenile justice system are in the care of health care providers in their community on a regular basis, others have had inconsistent or nonexistent care. The health needs of these youth are often identified when they are admitted to a juvenile custodial facility. On-site correctional health care providers must not only try to identify these health issues but also determine if there has been active medical management in the community. Pediatricians and other health care providers play an important role in the care of these youth, and continuity between the community and the correctional facility is crucial.

EPIDEMIOLOGY OF JUVENILE ARRESTS

In 2008, 11 million juveniles younger than 18 years were arrested. Two-thirds of those arrested were referred to juvenile court, and 10% were referred to the adult criminal court system. One-third of all juveniles arrested were female. Gender differences exist in patterns of arrest-related charges such that adolescent girls are more likely to have runaway and prostitution/vice offenses, whereas boys have a
higher proportion of arrests in all other categories (e.g., violent and property crimes). Girls are also more likely than adolescent boys to fight with family members and become involved in domestic disturbances.8 Racial differences were seen in juvenile arrest patterns. Although black youth only represent 16% of the 10- to 17-year-old population in the United States, they represented 52% of the Violent Crime Index arrests and 33% of the Property Crime Index arrests (see Table 1). The greatest racial disparities were seen with some of the most serious crimes—murder, robbery, and assault.9 Reasons for these racial disparities are complex and involve social context as well as individual characteristics and are not well understood. When comparing minority youth to white youth, differing opinions exist about the relative contributions of several factors including possible differential involvement in various offenses and inequalities in the treatment of minority youth compared with white youth once within the juvenile justice system.10 Youth arrests and delinquent behavior have been related to lower socioeconomic status (SES), family disruption (marital separation, divorce), living in households with only 1 biological parent, less residential stability (length of time living in 1 location), poorer neighborhood collective efficacy (capacity of residents to achieve social control over the environment), and educational failure.11-15 Overall, poverty is likely to be the underlying factor that most influences trends in juvenile crime.16 SES plays a significant role for black and Hispanic youth, because they are more likely to live in poverty than their white counterparts.12 Educational failure is correlated with unemployment/underemployment. Studies have found that employment can prevent or reduce delinquent behavior. Lower educational attainment is most likely to affect black and Hispanic youth, who have higher dropout rates than their white counterparts.13 Family structure influences youth socialization and the capability to control the youth’s behavior.12 Family structure, itself, is not the cause of a youth’s behavior. Rather it is linked to other factors, as illustrated by the correlation between single-parent households and increased probability of living in poverty.15 Black youth are most likely to be living in a single-parent household, and Hispanic youth are less likely than white youth to be living with both parents.14 Not all juvenile arrests result in a custodial placement in either a short-term detention facility (usually ≤3 months) awaiting adjudication or a longer-term postadjudication residential facility. Custody rates are higher for male adolescents than female adolescents. Girls are more likely to be held for technical violations, such as violating the terms of probation, or status offenses, such as running away, rather than more serious illegal activities (see Table 1). Data on custody rates are similar to data on arrest rates, which demonstrate disproportionate contact of minority youth with law enforcement. Although minority youth represent only 39% of the US juvenile population, they represented 65% of the national juvenile custody population in 2006.9 These data become particularly relevant when considering unmet mental and physical health needs, because poorer health status is related to lower SES, and lower SES is more likely to be found among minority youth (see "Sociodemographic Factors and Health Status").

In 2006, the median time in custodial placement was 65 days, including both short-term and long-term facilities. Eighty percent of postadjudicated youth were in the facility for at least 30 days, and 57% were in the facility for at least 90 days. Twelve percent were still in placement at 1 year.9 A significant number of youth are incarcerated for a period of time that would permit health care providers to diagnose, assess, and treat them for identified health problems.

**Sociodemographic Factors and Health Status**

The categories of health needs of youth in the correctional system are similar to those of their peers in the community. They include dermatologic, respiratory, dental, gastrointestinal, genitourinary, and metabolic problems as well as developmental and mental health issues. Other categories are influenced, in part, by the youth’s engagement in high-risk behaviors such as violence, substance abuse, and sexual activity, which may be more prevalent than those of their peers in the general population.3,14 Some health issues result from living in impoverished and abusive environments (e.g., traumatic brain injury [TBI], lead exposure, positive tuberculosis [TB] test results, and poor dental care). Others are acquired health problems (e.g., hy-
pertension, diabetes) that are neglected or remain undiagnosed. In some instances, youth have had inadequate health care, because they have been runaways or living in inconsistent living situations that do not allow for continuity of care.

Underlying the poorer health status of youth in the juvenile justice system is SES. Just as lower SES is correlated with juvenile delinquency, lower SES—specifically, income inequality—has been shown to correlate with teen births, overweight, and mental health problems.

Minority youth, including black and Hispanic youth, who are overrepresented in the juvenile justice system in the United States, are more likely to live in lower-SES environments and have been found to have overall poorer health care than their white counterparts. Studies have shown significant disparities between white and minority youth aged 0 through 17 years in insurance coverage, lack of a usual source of care, use of the emergency department, and not receiving adequate mental health care, dental care, or prescription medications. Factors other than SES may also be important. A recent review of the literature confirmed racial/ethnic disparities in adolescent health care. However, the results also suggested that some disparities are not totally understood and seem to be independent of SES.

EXTENT OF MEDICAL PROBLEMS

Few studies have provided a broad national perspective on the health needs of youth in the juvenile correctional system in the United States. The most recently published information is from the Survey of Youth in Residential Placement (SYRP). The findings in this report are based on interviews with a nationally representative sample of 7073 youth in custody during the spring of 2003. The information was obtained by using audio computer-assisted self-interview methodology and included youth at both short-term detention and longer-term residential treatment facilities. The survey revealed high rates of mental health and substance abuse problems as well as traumatic experiences with documented rates that exceeded those of the general adolescent population. More than two-thirds of youth in this survey reported a health care need, including injury, problems with vision or hearing, dental needs, or "other illness.

Although more than 20 years old, another study with a national scope was conducted in 1991 by the National Commission on Correctional Health Care (NCCHC). The study included 1801 youth from 39 short-term or long-term correctional facilities in the United States. These youth had higher rates of substance abuse, trauma, unprotected sexual activity, history of sexually transmitted infections (STIs), suicidal ideation, and reported violence than those in a general high school population.

In the following sections, the data regarding general physical health issues are reviewed, and mental health and substance use/abuse diagnoses are addressed.

GENERAL PHYSICAL HEALTH ISSUES

In addition to the SYRP and NCCHC studies, 3 other studies that involved either a single facility or a region have provided important information. Two studies similarly found that approximately half of youth in these facilities had an identified medical problem. The first study, the results of which were published in 1980, included youth admitted during an 11-year period to a secure detention facility in New York; the second study, the results of which were published in 2000, included youth from 15 detention and longer-term facilities in the Maryland Juvenile Justice System. The third study involved youth admitted to a detention center in Alabama in the mid-1990s and found that although most youth (76.9%) denied preexisting conditions or complaints at the time of admission, 10.6% had a medical condition that required medical follow-up after release.

There are a few specific health concerns that require particular attention in this population.

Dental

The preponderance of dental needs was documented in a 30-year-old study in a detention center in New York, in which almost all of the youth (90%) required dental care. A more recent study of youth in a juvenile detention center in Dallas County, Texas, conducted between 1999 and 2003, found that among a random sampling of 419 dental screenings of 12- to 17-year-olds, half of them had untreated decay and fewer than one-fifth had preventive sealants. High-urgency dental problems defined as infection, tooth or jaw fracture, pulpitis, or severe periodontal disease with bleeding were found in 6.2% of the subjects. Moderate-urgency conditions, including cavitated asymptomatic decay or moderate gingivitis, were found in 13.1%. One of the challenges noted by the authors was the inability to provide comprehensive treatment plans except in the case of long-term detainees.

Injury

Traumatic injuries are commonly identified in this population. These injuries are caused by multiple etiologies that range from accidental to deliberate. The Maryland study found that almost one-fifth of the youth experienced an injury including burns, head trauma, and musculoskeletal

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injury, and that 12% of these youth had not had previous treatment. As demonstrated in the NCCCHC study, interpersonal violence is an important cause of injury in this population. Approximately 70% of the surveyed youth had been involved in at least 1 fight during the previous year, and one-quarter of them had experienced an injury that required medical attention. Threequarters of youth in the NCCCHC study reported fights that involved a weapon. There was a relationship between substance use and physical fights, use of weapons, and gang membership.

More details are described in the report of a study from a secure residential facility in North Carolina that examined the types of traumatic injuries experienced by 10- to 17-year-old youth. More than half of the youth had an injury that required medical attention. One-third of the injuries were related to sports, 20% related to fights, 13% self-inflicted, 9% related to suicide attempts, 8% related to horseplay, and 11% attributed to "other." The most common traumatic injury was musculoskeletal (one-third). One-quarter of the injuries were significant enough to necessitate referral for further evaluation to an outside facility.

A previous history of TBI is particularly significant in this population, because it can affect mental health and behavioral issues. Studies of detained adolescents have found high rates of TBI. Compared with youth without TBI, those with a positive history were more likely to have a psychiatric diagnosis, report earlier onset of criminal behavior and substance use, have more lifetime substance use problems, and more previous-year criminal acts, report lifetime suicidality, and demonstrate impulsivity or fearlessness in the year preceding incarceration.

Tuberculosis
Residents of correctional facilities have among the highest rates of TB infection and are housed in an environment with an increased risk of exposure. For those reasons, it is recommended that adolescents in correctional facilities be screened annually for TB. A positive Mantoux skin test result is considered to be 10 mm or greater, which is a lower threshold than that for an adolescent without additional risk factors.

Reproductive Health
Sexual Activity/Contraception
The 1991 NCCCHC study remains one of the best nationally representative samples evaluating sexual activity and contraceptive use among incarcerated youth. The study used a survey method based on the Centers for Disease Control and Prevention (CDC)’s Youth Risk Behavior Surveillance System, which allowed for comparison with a general high school population. Incarcerated youth reported higher rates of sexual activity and were more likely to report 4 or more lifetime sexual partners. Incarcerated youth also had much lower self-reported use of contraception or condoms at their most recent sexual intercourse.

STIs/HIV
Data from the CDC’s 2009 Sexually Transmitted Disease Surveillance Report demonstrated that youth in the juvenile detention system have among the highest rates of STIs (Table 2). Similar data were collected in another study that represented 12 juvenile correctional facilities in 5 jurisdictions between 1996 and 1999. Because of unprotected sex with multiple partners, prostitution, or injection drug use, youth in correctional facilities are also at increased risk of HIV and hepatitis C virus infection. In addition, they are at risk of hepatitis B virus infection when the vaccination series is incomplete. High rates of STIs, alcohol and drug use, and lack of consistent condom use also contribute to increased risk of HIV infection.

Although the risk of STIs/HIV infection is high in incarcerated youth, many facilities fail to screen for either STIs or HIV. A study that used 2004 data from the Juvenile Residential Facility Census found that only 18.5% of the facilities offered STI testing for all adolescents on admission and that 8.3% of the facilities did not even have STI testing available. Some facilities only provided STI testing services when requested by the youth or deemed medically necessary, which is especially problematic, because STIs are commonly asymptomatic. Even fewer facilities tested all youth for HIV or hepatitis C virus infection, and these tests were much less likely to be available. One of the challenges associated with HIV testing by traditional methods is that it involves a blood draw and use of an outside laboratory. Youth may refuse phlebotomy and can be released from a short-term detention setting before obtaining the results. Currently available rapid HIV tests provide the option of a less invasive oral test and can provide results within 20 minutes while the youth waits. Providing opt-out HIV testing is recommended by the CDC as a part of routine healthcare, even in correctional facilities.
Pregnancy/Fatherhood

The SYRP found that 14% of incarcerated youth have children; males (15%) were more likely to have fathered a child compared with 9% of females who reported having a child. This rate is much higher than that of the general population of 12- to 20-year-olds, in which 2% of males and 6% of females have children. In addition, 12% of incarcerated youth were expecting a child. Overall, one-fifth of youth were currently a parent or expecting a child.

These recent national data confirm previous reports in which incarcerated teenagers report higher pregnancy rates than those in the general adolescent population; more than one-third of the females report ever having been pregnant. An analysis of data from the 2004 Juvenile Facilities Census revealed that at least 2.1% of girls are pregnant while in juvenile justice residential facilities at any particular point in time. One study found that one-quarter of males had fathered a pregnancy, and 40% of those fathers reported responsibility for more than 1 pregnancy. The 2004 Juvenile Facilities Census found that only 15% to 17% of facilities test all girls for pregnancy on admission. Although a small proportion (4.5%–6.6%) fail to even provide pregnancy tests, the remainder of the facilities test only when it is medically necessary or requested by the adolescent.

For youth who are pregnant while incarcerated, there are additional challenges. As found in the 2004 Juvenile Facilities Census, almost one-quarter of the facilities do not offer access to obstetric services. Similarly, another study that involved 430 short-term and long-term facilities in 41 states found that prenatal services were lacking in one-third of them, and 60% reported at least 1 obstetric complication. Pregnancy among incarcerated teenagers is complicated by other existing problems including substance abuse, posttraumatic stress disorder, previous sexual abuse, and additional considerations regarding postdelivery options. In addition to altered activity schedules and changes in menu options related to the higher caloric requirements of pregnancy, postpartum depression and other psychological problems require particular attention. Because most juvenile justice facilities do not have arrangements for infant residency or visitation, the adolescent and her family may be expected to make a plan for foster care placement.

MENTAL HEALTH

Overview

The available literature indicates that the prevalence of psychiatric and substance abuse disorders among youth in correctional facilities exceeds that of the general adolescent population. In a review of the worldwide literature from the 1960s through the 1990s, Roberts et al. determined that the mean prevalence of psychiatric disorders in the general adolescent population was 16.5% (range: 6.2%–41.3%). In comparison, prevalence rates in the juvenile justice population range from 50% to 100% when disruptive behavior disorders are included.

Inclusion of disruptive behavior disorders, such as conduct disorder, in the psychiatric disorder prevalence estimates is controversial, because most teenagers would not be incarcerated unless they came to the attention of authorities because of significant disruptive behaviors. To some extent, engaging in disruptive behavior is part of normal adolescent development. Multiple studies have found that most adolescents in the general population participate in behaviors that would be considered delinquent. These behaviors, which include imitation of antisocial models/styles and social reinforcement, are usually transient. Most of the adolescent offenders (85%) known to the criminal justice system stop offending by the age of 28 years. Furthermore, severe, persistent antisocial behavior over time is only found in approximately 5% of males.

The wide range in the prevalence of mental health disorders among youth in the juvenile justice system is indicative, in part, of the limitations of the studies in the literature. These limitations include the use of nonstandardized measures and different diagnostic tools; noncomparable sociodemographic variables; data that are not generalizable because they are specific to an individual facility, state, or other locale; variation in the timing of the evaluation from the detention setting to after adjudication; and bias when samples only include youth referred for psychiatric evaluation. It is also important to consider the fact that for some youth, when mental health resources in the community are not sufficient, the juvenile justice system may be the placement of last resort by default.

Prevalence of Psychiatric and Substance Use Disorders

Until the SYRP report, the 1991 NCCHC study was the only published study that included a national sampling of multiple juvenile custodial sites in the United States. In the NCCHC study, all of the mental health and substance use behaviors were self-reported through a modified version of the CDC's Youth Risk Behavior Surveillance instrument. The data from that survey are summarized in Table 3. The more recent SYRP study found that at least half of youth reported problems with anxiety, anger, and loneliness, and approximately one-fifth had a previous suicide attempt. In addition, only 56% of the general population of 12- through 20-year-olds report a lifetime use of alcohol.
TABLE 3 Mental Health and Substance Use Data From the 1991 NCCHC Study

<table>
<thead>
<tr>
<th>Category</th>
<th>Male (n = 1574, %)</th>
<th>Female (n = 219, %)</th>
<th>Total Sample (n = 1803, %a)</th>
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<tr>
<td>Suicidal ideation previous year</td>
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<td>40</td>
<td></td>
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<td>Suicidal plan previous year</td>
<td>17</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Suicide attempt previous year</td>
<td>15</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Tried smoking</td>
<td></td>
<td></td>
<td>87</td>
</tr>
<tr>
<td>Smoked whole cigarette by age 12 y</td>
<td></td>
<td></td>
<td>51</td>
</tr>
<tr>
<td>Alcohol use, &gt;20 d lifetime</td>
<td>49</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Cocaine use</td>
<td>30</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Marijuana use, &gt;40 times</td>
<td>10</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Use of other illegal drugsb</td>
<td>13</td>
<td>26</td>
<td></td>
</tr>
</tbody>
</table>

* Not all youth indicated gender on the survey

b Other illegal drugs used 10 or more times in lifetime: lysergic acid diethylamide (LSD), phenocyclidine (PCP), ecstasy, hallucinogenic mushrooms, speed, ice, heroin, and pills without prescription.

compared with 74% of youth in custody, and only 40% of the general population has used any illegal drug compared with 85% of youth in custody. Details from the SYRP are summarized in Table 4.

Although the NCCHC and SYRP reports have provided information on youth from multiple sites across the United States, these 2 studies are limited by only providing information based on youth self-report rather than from diagnostic evaluation tools. Between 2002 and 2006, the results of several studies that were designed to eliminate some of the previous study-design problems were published. The authors of these reports, Teplin et al50 Wasserman et al51,52 and Shufelt and Cocozza,49 used randomly selected youth; the Diagnostic Interview Schedule for Children (DISC) as a standardized screening and assessment instrument; and included more ethnically/ racially diverse samples. These studies yielded a smaller prevalence range of 45.7% to 70.4% for having either a psychiatric and/or substance use disorder (see Tables 5 and 6). The studies by Teplin et al50 and Shufelt and Cocozza,49 specifically, were able to show that the high rates of psychiatric illness were not just a reflection of disruptive behavior disorders. Both studies found similar results: 60.9% (Teplin et al) and 66.3% (Shufelt and Cocozza) had either a psychiatric or substance use disorder when conduct disorder was not included among the diagnoses. When Shufelt and Cocozza removed substance abuse disorders from the analysis, 43.5% of the youth still had a mental health diagnosis. In general, substance abuse is concerning because youth who start using and abusing drugs during early adolescence are more likely to have serious delinquency and longer deviant careers, antisocial personality disorders later in life, and more risk behaviors. Overall substance abuse is associated with poor academic performance and more psychiatric disorders.54

Multiple studies worldwide have found that youth with psychiatric diagnoses can have more than 1 psychiatric diagnosis (comorbidity) or co-occurring psychiatric and substance abuse disorders.29,41,50,55,60 The study by Shufelt and Cocozza49 found that 79% of those with a psychiatric diagnosis had 2 or more diagnoses. In another study with youth in the juvenile justice system, McClelland et al12 found that approximately half of the youth had multiple substance use disorders; 80% of those with an alcohol use disorder also abused other drugs, and half of those with a drug disorder also abused alcohol. Co-occurring psychiatric and substance use disorders were found in the Shufelt and Cocozza study, in which 60.8% of those with a psychiatric diagnosis also had a substance use disorder. In that study, co-occurring substance use and psychiatric disorders were more common when there was a history of disruptive behaviors or symptoms suggestive of mood disorders. Because co-occurring major psychiatric and substance use disorders are common and develop in a close time frame, more dual-diagnosis treatment programs are needed to simultaneously address both issues.

Racial/Ethnic Differences

Racial/ethnic differences in the diagnosis of mental health disorders have been found in multiple studies. The well-designed study by Teplin et al50 found that incarcerated black youth have the lowest rate of mental health diagnoses, non-Hispanic white youth have the highest rate, and the rate for Hispanic youth falls between that of these 2 groups. However, as discussed in the literature, interpreting rates of mental health diagnoses and then evaluating racial/ethnic disparity within the juvenile justice system may be problematic. Concern has been raised that minority youth may be more likely to have their behavior interpreted as criminal rather than in need of mental health service.47 In addition, minority youth may be more reluctant to admit to experiences with mental illness, or they or their families may have a cultural bias against seeking care.63,64

TABLE 4 Lifetime Substance Use Data From the SYRP

<table>
<thead>
<tr>
<th>Substance</th>
<th>% of Youth in Custody</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>74</td>
</tr>
<tr>
<td>Marijuana or hashish</td>
<td>84</td>
</tr>
<tr>
<td>Cocaine or crack</td>
<td>30</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>26</td>
</tr>
<tr>
<td>Acid or lysergic acid diethylamide (LSD)</td>
<td>19</td>
</tr>
<tr>
<td>Inhalants</td>
<td>19</td>
</tr>
<tr>
<td>Heroin</td>
<td>7</td>
</tr>
</tbody>
</table>
TABLE 5  Design of Selected Studies That Evaluated Psychiatric and Substance Use Diagnoses in Youth in the Juvenile Justice System

<table>
<thead>
<tr>
<th>Author</th>
<th>Year Conducted</th>
<th>Location</th>
<th>No of Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teplin et al.</td>
<td>1995–1998</td>
<td>Cook County Juvenile Detention Center</td>
<td>1829</td>
</tr>
<tr>
<td>Wasserman et al.</td>
<td>1998</td>
<td>Texas: probation intake in 8 counties</td>
<td>991</td>
</tr>
<tr>
<td>Wasserman et al.</td>
<td>2001</td>
<td>New Jersey and Illinois secure placement</td>
<td>292</td>
</tr>
<tr>
<td>Shufelt and Coccozza</td>
<td>2006</td>
<td>Louisiana, Texas, and Washington: 29 programs and facilities</td>
<td>1400</td>
</tr>
</tbody>
</table>

Gender Differences

Gender differences are also evident. Females are more likely than males to have any psychiatric diagnosis and, specifically, to have higher rates of mood and anxiety disorders (Table 6). With respect to substance use disorders, in general, males and females have similar rates, but the study by Teplin et al.20 found that females are more likely than males to use substances other than alcohol and marijuana. Although both genders experience sexual (10%–24%) and physical (11%–58%) abuse, all forms of abuse, including emotional abuse, are more common in girls. As such, posttraumatic stress disorder is also more commonly diagnosed in females. Long-term outcomes for delinquent adolescent females reveal greater persistence of emotional problems and worse outcomes complicated by relationship and parenting issues, drug problems, and suicidality.53

Suicide

Suicide and suicidality have been a long-standing concern for juveniles in confinement. The 1991 NCHC report and the 2003 SYRP both revealed high rates of suicidal ideation among incarcerated youth. In addition, 2 nationally representative studies explored suicidality in more detail. One study, the results of which were published in 2006,66 found that suicide was the leading cause of death in juvenile justice facilities in the United States between 2000 and 2002. A second report, published in 2009,57 and entitled “Characteristics of Juvenile Suicide in Confinement,” described the results of a retrospective evaluation of all identifiable juvenile deaths in confinement from 1995 to 1999. For the deaths related to suicide, the mechanism was hanging in all but 1 case. There were several important findings in this report. Sixty percent of the suicides occurred between 3 PM and midnight, which included a time frame in which youth were most likely to be around other people. Suicides were also most common during waking hours for those confined to their rooms. In addition, the potential for suicidality among these youth should have been recognized by staff, because 70% had been assessed by a mental health professional—half of them within the previous 6 days. Two-thirds of them had a diagnosis of depression, and half were taking a psychotropic medication. Seventy percent of the youth had a history of suicidal ideation, and almost half had had a previous suicide attempt. Precipitating factors were identified more than half of the time and included fear of transfer or placement, recent death of a family member, failure in the program, recent suicide in the facility, and parental failure or threats not to visit.

Recent studies5,7 found that facilities with suicide-prevention training and suicide risk screening shortly after admission to the facility had a lower suicide rate. This is an area for improvement, because the 2009 study57 found that only one-fifth of the facilities had the 7 key components deemed necessary for suicide prevention. These components include written protocols, intake screening, suicide-prevention training, safe housing, observation, mortality review, and cardiopulmonary resuscitation certification. The report also discussed the need to further evaluate room confinement, including the role of isolation in suicidal behavior.
Psychotropic Medications

National data are lacking on the use of psychotropic medications for youth in the juvenile justice system. However, as summarized by Desai et al.,

2 studies representing data from 2 states found that psychotropic medications were used for approximately half of the youth in detention facilities and more than two-thirds of youth in longer-term facilities. The fact that the majority of youth are prescribed these medications emphasizes the need for psychiatric services to appropriately diagnose and manage these youth. Mental health services are needed at the time of admission to a correctional facility for youth who are already on psychotropic medications and to evaluate youth who may need to initiate medications. In addition, subsequent evaluation is needed to decide whether ongoing use is needed during confinement. Attitudes of the parents and youth need to be considered when prescribing these medications, and continuity of care between community prescribing physicians and the juvenile justice facility is crucial.

The American Academy of Child and Adolescent Psychiatry has published a document that addresses mental health assessment and treatment for youth in the correctional system. In this document, the authors recommend that psychotropic medication should only be used as part of an individually developed comprehensive treatment plan. Medication should augment other treatment interventions including individual, group, and family therapy along with behavioral interventions such as regular exercise, improved sleep hygiene, and staff/family support. The need for previously prescribed medications should be assessed on the basis of current symptoms and level of functioning. New medications should be used cautiously after review of potential risks and benefits, adverse effects, and alternatives with both the youth and the parent/guardian when the youth is a minor.

SCREENING AND ASSESSMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS

Ideally, youth with mental health and substance abuse problems would be identified and treated in the community rather than being first identified and addressed within the juvenile justice system. One recent study found that improvement in mental health services could reduce involvement with the juvenile justice system, particularly among youth with the most serious offenses. The one author suggested that substance use screening before admission to detention might allow community diversion of some youth, optimize treatment choice, and minimize restrictive detention. However, optimal screening procedures have not been established, and many communities have limited availability of psychiatric and substance abuse services.

To better address the mental health needs of youth in the juvenile justice system, a panel of experts was convened to create guidelines and a road map for best practices in the juvenile justice setting. The recommendations included (1) valid and reliable mental health screening within 24 hours of admission, (2) a more extensive assessment by a mental health professional as soon as possible to determine needs, (3) use of multiple sources of information (records, family, schools, etc.), (4) rescreening before release and preparation for transition out of custody, and (5) regular repeat screenings while in custody. These recommendations are consistent with existing standards from the NCCHC.

One of the commonly used screening tools for mental health and substance abuse specifically developed for the juvenile justice system is the Massachusetts Youth Screening Instrument—Second Version (MAYSI-2). This 52-item screening instrument takes 10 minutes to complete and is validated as a self-report response tool that requires no clinical expertise to administer, score, or interpret; is low cost and can be used by a range of ages, different ethnic groups, and both genders; and has good psychometric properties. This tool can be completed by using audio computer-assisted technology for youth who have literacy problems. The MAYSI-2 is designed as a screening tool only, and staff trained in mental health should be available for further assessment. This tool should never take the place of well-trained staff who can recognize symptoms of mental health disorders and substance use withdrawal.

There is no standardized approach used in the juvenile justice system to screen for substance use/abuse. It is important to screen for the use or abuse of alcohol, tobacco, and the gamut of other drugs, including illicit, prescription, and nonproprietary substances. Possible methods include self-report, which is the least expensive method but requires youth to understand the questions and have accurate recall and honest disclosure. Bioassays with urine or hair are most commonly used by detention facilities and are easy to collect. However, although these tests provide objective data, urine is only sensitive for most drugs used in the previous 2 to 3 days. Hair analysis has significant problems including external contamination, which can lead to false-positive results and differences in binding for different drugs and with different types of hair.

Specific screening for substance use was addressed in a recent report from the Office of Juvenile Justice and Delin-
quency Prevention. Only 61% of juvenile facilities screened all youth for substance abuse, and 19% reported no screening. An additional 20% only screened youth identified by court or probation officers or facility staff. Other reasons to assess were if they had drug- or alcohol-related charges or by parent/youth request. Approximately one-third of the youth were screened on the day of admission; another one-third were screened 1 to 7 days after admission. Three-quarters of the facilities that conducted screenings used staff-administered questions, and 55% used self-report by standardized instruments or checklist inventories. Overall, 75% of the facilities used urine-based drug screening; however, one-third of all facilities only tested a subset of admitted youth or only when use was suspected or a request was made by the court or probation officer.

ON-SITE PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES
The decision to initiate or change medical treatment of psychiatric disorders in detention is challenging, but acute symptoms may need to be treated with some urgency. Medications should be used to manage symptoms and minimize distress, but not to manage behaviors alone. As discussed in the practice parameter from the American Academy of Child and Adolescent Psychiatry, it is ideal to determine the youth's legal disposition and placement before initiating or changing medication regimens. Unlike in longer-term, postadjudication facilities, the length of stay in detention is usually too short for most counseling interventions to treat major psychiatric disorders. However, trained personnel can provide observational data, and short-term counseling interventions can provide support and facilitate the use of problem-solving strategies to prevent problem-escalating interpersonal behaviors. A more extensive evaluation may also be required before making a disposition to residential or community-based mental health treatment. Family involvement is critical at that stage, because it is the key determinant of treatment engagement and success. Whenever the youth is returning to the community, an essential part of the disposition is to include identification of a behavioral health home and care plan.

In 2002, 53% of the facilities that reported mental health evaluation data had in-house mental health professionals who evaluated all admitted youth. Another one-third evaluated some youth. Facilities that provided mental health treatment on-site were more likely to also have a mental health professional evaluate all the youth. Larger facilities were more likely than smaller ones to screen all youth for suicide risk and to evaluate all youth for mental health needs. Privately operated facilities (62%) were more likely to evaluate all youth than were public facilities (41%).

Two-thirds of the facilities that reported substance abuse services provided them on site; the majority (97%) of them provided drug education, and two-thirds provided individual or group therapy with a substance abuse treatment professional. However, it was also common (60%) for the counseling to be provided by someone not specifically trained in substance abuse treatment. Only 2 of 10 facilities had ongoing specialized treatment for substance abuse, and 1 in 10 had no substance abuse treatment services. Most facilities used in-house services, whereas only 20% relied on off-site services.

HEALTH CARE STANDARDS: THE NCCHC
Standards for care of youth in a juvenile correctional facility have been published by the NCCHC, which also serves as an accreditation organization. The latest version of the standards for youth was published in 2011. These standards are used for facility accreditation but are valuable to help inform facilities about both the minimal and ideal health care for incarcerated youth. The currently published standards do not specifically distinguish between detention centers, which typically involve shorter lengths of stay, and longer-term postadjudication residential facilities. However, at a minimum, the standards state that all youth should be screened immediately on arrival at the intake facility by qualified health care professionals or health-trained staff to identify and meet urgent health needs and to screen for any potentially contagious conditions or dangerous behaviors such as suicidal ideation. The subsequent length of stay would determine further evaluation.

According to the standards, all youth must receive a comprehensive health assessment within 7 days of arrival with hands on assessment by a physician, physician assistant, or nurse practitioner. This assessment includes a complete medical, dental, and mental health history, review and update of immunizations, screening for TB, measurement of vital signs, physical examination, and genitourinary examination, including a gynecologic assessment, as indicated by gender, age, and risk factors. The need for laboratory and/or diagnostic tests for communicable diseases, including STIs, are determined by the responsible physician.

A mental health screening that provides a full assessment by qualified mental health professionals or mental health staff using a structured interview is to be conducted within 14 days of admission and includes past history, suicidal behavior, victimization,
exposure to traumatic events, substance use, violent behavior, cerebral trauma or seizures, and psychotropic medication. In addition, an oral health screening is to be performed by a dentist or health care professional trained by the dentist within 7 days of admission, and an oral examination is to be performed by a dentist within 60 days of admission.

Facilities are required to provide an opportunity for the adolescent to request health care on a daily basis, and all requests must be triaged within 24 hours. The facility must provide 24-hour emergency mental health and dental services. Discharge planning must include arrangements for follow-up or referrals to community providers and a supply of current medications to last until that follow-up can occur.

A recently published study\textsuperscript{15} that assessed whether juvenile detention facilities follow the standards set out by the NCCHC found significant deficits when comparing reported practices to published standards. Data were analyzed from the Juvenile Residential Facilities Census (2000, 2004) and Census of Juveniles in Residential Placement (2003), which are conducted by the Office of Juvenile Justice and Delinquency Prevention of the US Department of Justice. Most juvenile correctional facilities are not accredited by the NCCHC, and in the absence of mandatory accreditation, it is not clear whether most facilities would fail to meet the standards or just choose not to be accredited. Data from 2004 showed that overall, fewer than half of the facilities were compliant with recommended health screening and assessments. Few detention facilities met even minimal levels of care, although better care was seen as the length of stay increased.

CONTINUITY OF CARE

Continuity of care, both on entering the facility and when transitioning back to the community, is crucial for youth in the juvenile corrections system. However, continuity of care is a challenge. One study\textsuperscript{16} found that fewer than half of families showed interest in care deemed important by the on-site medical staff, and a large proportion of families were not successfully contacted. These youth had nonideal medical care before admission; only half of the youth had care in the previous year, and only one-third of them were able to identify a source of regular medical care. The juvenile justice system may be the only place where these youth have received a recent comprehensive medical history or physical examination.\textsuperscript{15}

As custodial placement comes to an end, transitions are difficult, particularly for youth who have experienced disruption and failure and who have limited internal resilience and external support. Transitions of communities, residences, schools, programs, therapists, friends, and family members as well as adjustment to a less restrictive environment can be difficult. Continuity of care starts at the time of admission to the facility. If the youth already has a primary care provider, it is crucial for the medical staff to be able to contact that clinician to verify previous diagnoses and treatment. For cases in which the youth does not have a primary care provider, resources to establish primary care should be provided. Providing summaries of medical care for the primary care provider, appropriate subspecialist, or mental health specialist on discharge back to the community is also extremely important. In some cases, a chronic medical condition may be first diagnosed while the youth is in custody. Facilitating the transition to a provider who can ensure continuity is key, because it is not uncommon for youth to return to the correctional facility with unmet chronic health needs. For some conditions, such as STIs or TB, public health facilities may be able to help with follow-up.\textsuperscript{15}

COMMUNITY-BASED INTERVENTIONS FOR INCARCERATED YOUTH

Traditional cognitive behavioral therapy (CBT) is helpful for both internalizing and externalizing behaviors, including anger management, depression, and posttraumatic stress disorder. However, it may not be the best choice for many delinquent youth. There are several promising interventions that have been shown to be effective in treating youth with mental health issues. In some cases, these interventions have been shown to reduce recidivism.\textsuperscript{27} Programs that broadly address multiple domains, including the adolescents' family, school, peers, and community, are the most effective. These programs are intensive and highly structured and include social skill development, behavior management, attitude adjustment, and cognitive perceptions. Many of these programs are community-based interventions conducted in the youth's home environment and directly engage the family members. Examples include multisystemic therapy, functional family therapy, and wraparound therapy. In another program, multidimensional treatment foster care, youth are placed with families trained to provide a structured therapeutic environment as an alternative to incarceration. The biological family is taught the system with the goal of returning the youth home. Multisystemic therapy and functional family therapy have been found to be particularly effective for youth with co-occurring mental health and substance use disorders. Some of the challenges with implementing these
programs are the high initial upfront costs and the labor-intensive nature of the interventions. When assessing interventions, it is also important to note that the Girls Study Group found that interventions for boys may not directly translate to girls. Protective factors, such as caring adults, school success, school connectedness, and religiosity, may be less effective for girls who have experienced physical and sexual assault, neglect, and neighborhood disadvantage. More research is needed to understand the interaction between risk and protective factors in girls to best design successful intervention programs. Programs for girls need to address victimization, which is commonly found in these youth.

As evidenced by the interventions described above, the approach in the juvenile court system is generally rehabilitative rather than punitive. The Office of Juvenile Justice and Delinquency Prevention advocates a comprehensive strategy that includes supporting the adolescent’s family and engaging core institutions, such as schools, businesses, and religious organizations, in helping to develop mature and responsible youth. This strategy utilizes the principle that delinquency prevention is the most effective approach while recognizing that there is a need for graduated sanctions that protect the community. The best prevention involves targeting risk factors for delinquency, such as drugs and firearms in the community, family conflict, abuse and neglect, poor commitment to school, and negative peer influences, while focusing on protective factors such as a resilient individual temperament; close relationships with family, teachers, other adults, and peers; and promoting school success and avoidance of drugs and crime. Reentry plans need to address education, mentoring, prosocial activities, and positive community involvement.

EDUCATIONAL NEEDS
As summarized in the recently published findings of the SYRP, educational difficulties and low commitment to academics are risk factors for delinquency. In this nationally representative survey, one-fifth of the youth reported that they were not enrolled in school at the time they entered custody. This rate is 4 times higher than that for the general population. In addition, 61% had been expelled or suspended, compared with 8% of the general population. Although only 28% of youth in the general population are functioning below grade level, 48% of those in custody reported being below the level expected for their age. Similarly, a higher percentage (25%) of youth in custody reported being held back in school, compared with 11% among peers in the general population. Although the majority (92%) of youth reported attending school while in custody, only half of these youth reported that the school program was of good quality, and most youth did not spend as many hours in school as did the general population.

Learning disabilities are also much more common among youth in custody; rates of 30% have been reported by youth in custody, which is 7 times higher than that of the general population. Despite the requirements of the federal Individuals With Disabilities Education Act, which states that youth in custody must be identified and given special education services, even in short-term facilities, only 46% reportedly receive these services. The SYRP report concluded that there is a need to obtain more information on how custodial facilities address educational needs, including an assessment of the curricula used, the provision of special educational services, and whether individual educational needs are being met for each youth in custody.

JUVENILE TRANSFER LAWS/DEATH PENALTY
In the past decade, an increasing number of states have enacted laws that require that juvenile cases be transferred to adult courts for certain offenses. A parallel increase has been seen in the number of juveniles incarcerated in adult facilities for certain felonies. When convicted in adult court, these juveniles commonly receive longer sentences than those sentenced in juvenile courts. Although these laws were enacted with the thought that they would be a deterrent for juvenile crimes, 6 studies, conducted in 5 different states, with approximately 500 to more than 5000 participants each, showed the opposite effect. Compared with youth retained in the juvenile court system, recidivism rates were higher for juveniles whose cases were transferred to adult criminal court. This was particularly true for violent offenders for whom transfer may actually be promoting rather than deterring further criminal involvement.

Juveniles in adult prisons report learning more about criminal behavior from adult inmates and having fear of victimization; these juveniles were least likely to say they would not reoffend. Juveniles incarcerated in adult prisons compared with juvenile facilities have an eightfold increase in suicide, fivefold increase in being sexually assaulted, and twofold increase in likelihood of being attacked with a weapon by other inmates or beaten by staff. Adult facilities have much less emphasis on rehabilitation and family support than do juvenile facilities, and juveniles have expressed both resentment and a feeling of injustice when tried and punished in the adult system.
At the extreme, issues of whether to invoke the death penalty for adolescents have been debated in the past. In 2004, the American Academy of Pediatrics and the Society for Adolescent Health and Medicine issued a joint statement opposing the death penalty for juvenile offenders. In 2005, the Supreme Court ruled that it was unconstitutional to impose capital punishment of individuals who committed crimes as a juvenile. Age 18 was determined to be the age for death-penalty eligibility. This age was based on currently available scientific research that indicates that juveniles do not have the cognitive maturity or sense of responsibility found in adults. This was echoed in the most recent ruling by the Supreme Court in May 2010, in which life without the possibility of parole was not permitted for juveniles who committed nonhomicide crimes.

FINANCING

Financing of health care for incarcerated adolescents presents many challenges. All incarcerated persons are entitled to health care under the US Constitution (see Estelle v Gamble, 429 US 97); however, such a constitutional guarantee does not include access to federally funded health benefits programs such as Medicaid or the Children’s Health Insurance Program (CHIP), and it does not apply to private health insurance plans. Section 1905 of the federal Social Security Act specifically prohibits federal money from being used for medical care of inmates in a federal institution and has been applied equally to adolescents.

There is also a federal prohibition on the use of Medicaid benefits for any month during which the individual is a resident of a public institution. Many states have terminated Medicaid benefits rather than suspend them to avoid improper use of federal funds. Because financing for medical care in juvenile justice facilities then largely relies on state and local resources, the extent of medical care provided can be limited. When Medicaid benefits are terminated, there is also commonly a lag in reinstatement when the youth is released back into the community. This occurs even when screening for eligibility is offered before release and application assistance is provided. Although current law allows states to suspend rather than terminate benefits for incarcerated youth, many states do not follow this procedure for administrative or other reasons. Other states have passed legislation specifically to address this issue and require that Medicaid be suspended and not terminated for at least 6 months while in detention. Ideally, continuation and utilization of active benefits while the youth is incarcerated or detained would ensure that correctional facilities can provide more comprehensive medical care. Continuation of active benefits would also facilitate continuity of care and may prevent some recidivism, especially for those with mental illnesses that require medication. In order for Medicaid benefits to remain active for youth in the juvenile justice system, federal law must be amended to ensure both continuation of benefits and funding for the federal government share of Medicaid. Advocacy is needed at both the federal and state levels to ensure provision of necessary medical services for these youth.

RECOMMENDATIONS

The current and predicted ongoing shortage of child and adolescent psychiatrists, the separation of mental health and drug and alcohol treatment services and personnel, the limited access to health care dollars for youth in detention, and the institutional variability in procedures and human and monetary resources will continue to provide a challenge to meet a reasonable standard of health care for this population. The following recommendations are provided for caring for youth in the juvenile correctional system.

1. Delivery of Medical Care

Youth incarcerated in the juvenile corrections system should receive the same level and standards of medical and mental health care as nonincarcerated youth accessing care in their communities.

a. Health care services should be equivalent to those recommended by guidelines of the American Academy of Pediatrics (Bright Futures [see www.brightfutures.aap.org]). Although the extent of health services provided during the period of incarceration may be mitigated by the length of stay in the facility, shorter-term facilities, at a minimum, should focus on the identification and treatment of immediate medical and psychiatric issues such as injury; infectious diseases (TB, scabies, lice); alcohol, tobacco, and other drug use/addiction, including withdrawal; psychiatric emergencies including suicidal ideation; and identification of chronic medical or mental health problems that require continuation of daily medications.

b. For youth incarcerated for more than 1 week or in longer-term facilities, recommended pediatric and adolescent comprehensive preventive services should be provided. In addition to a comprehensive history and physical examination, youth should receive a dental screening and mental health screening for psychiatric illness and substance use/abuse. Assessments should focus on developmental and psychosocial issues. Immunizations should be provided as recommended by the American...
Completion of the hepatitis B immunization series should be confirmed. Screening for hepatitis C with serologic testing should be considered for high-risk youth, including those who have a history of injection drug use, are HIV-positive, or have signs or symptoms of liver disease, per current CDC recommendations.\textsuperscript{9}\textsuperscript{9} Juveniles with signs or symptoms of hepatitis should also be tested for serologic markers for acute infection with hepatitis A and hepatitis B. For most youth, the first Papanicolaou test is not indicated until 21 years of age. If clinically indicated per published guidelines, a pelvic examination should be performed for a Papanicolaou test (see pelvic examination and male reproductive health statements).\textsuperscript{90,\textsuperscript{91}}

d. Screening of pubertal girls should include pregnancy testing. Because of the high rates of sexual activity, all pubertal girls should be screened for pregnancy. Nonjudgmental counseling regarding options should be provided for pregnant youth, and accessibility to prenatal services should be provided on-site or in the community. Prenatal vitamins, including iron and folate supplementation, should be provided to all pregnant girls at the time pregnancy is diagnosed and continued throughout the course of the pregnancy. For both female and male youth who are parents, parenting classes should be included in the educational offerings.

e. On-site mental health and substance abuse professionals should be available to provide both evaluation and treatment services. Mental health services can be provided by staff either hired by the facilities or through a contractual arrangement with an outside community provider. Services should include psychiatric services to facilitate continuation of medications from the community mental health provider and ongoing evaluation and treatment. Psychiatrists should have training in child and adolescent psychiatry and preferably be board certified. Tobacco, alcohol, and drug-cessation programs should be available during the period of incarceration. Attention should be paid on an ongoing basis to the medical and mental health status of youth, because new issues can arise during their time in confinement. Correctional staff should receive training in suicide prevention, and specific attention should be paid to youth confined to their rooms in the housing unit. The practice parameter from the American Academy of Child and Adolescent Psychiatry provides specific recommendations on the provision of mental health services within the juvenile correctional system.\textsuperscript{89}

f. Regular physical activity and nutritionally balanced meal plans appropriate for adolescents should be provided in all facilities. Given the current national epidemic of obesity, attention to these aspects of a healthy lifestyle is even more critical.

g. Pediatricians should encourage all correctional care facilities to adopt and comply with the NCCHC’s "Standards for Health Services in Juvenile Detention and Confinement Facilities."\textsuperscript{78} Accreditation is encouraged as a means to reach desired levels of health care. Information regarding accreditation can be found at www.ncchc.org.

2. Developmentally Appropriate Confinement Facilities

Children and adolescents should be housed in facilities that are able to ad-
dress their specific developmental needs.

a. Pediatricians, adolescent health care specialists, mental health professionals, and drug and alcohol treatment providers should be consulted about health care policies and procedures governing all correctional care facilities in which children and adolescents are incarcerated.

b. Children and adolescents should be detained or incarcerated only in facilities with developmentally appropriate programs and staff trained to deal with their unique social, educational, recreational, and supervisory needs.

c. If children and adolescents must be housed in adult facilities, they should have routine access to the same developmentally appropriate environment and be separated by sight and sound from the adult population.

3. Integration of Available Systems of Care

a. Coordination between juvenile justice system health care providers and community providers is essential. Health care information elicited in the juvenile corrections setting should, at a minimum, be shared with the adolescent and, as appropriate (when not violating confidentiality), with the parent/legal guardian to allow for continuity of care and prevent unnecessary duplication of services. Pediatricians are a crucial link in the process of ensuring continuity of care between the community and the juvenile correctional system. Information should also be shared between the relevant community providers and correctional health care staff both on admission and at the time of release to ensure continuity of care. If the youth does not have a medical home, correctional staff should make every effort to identify a medical home within the community for that youth. Pediatricians should also coordinate with probation officers who are frequently entrusted with ensuring appropriate follow-up once the youth reenters the community.

b. Electronic medical records available within the community should also be accessible by correctional health care staff. Existing publicly accessible immunization databases, such as state immunization data banks, should be used to document care provided in correctional facilities. With the evolving use of electronic medical records, consideration should be given to the need to share information between correctional institutions and community providers to ensure continuity of care.

c. All youth incarcerated in the juvenile corrections systems should maintain eligibility for their existing health insurance benefits. Uninsured youth should be able to be enrolled in Medicaid while incarcerated. Both Medicaid and private insurance should be available for all youth without suspension or termination during incarceration and without a lag for reinstatement on reentry into the community. Youth without insurance coverage before incarceration should be automatically made eligible for Medicaid at the time of incarceration so that access to appropriate care may be facilitated. Advocacy is needed at both the federal and state levels to amend existing regulations and ensure the provision of necessary medical services for these youth.

4. Treatment and Intervention

a. Evidence-based mental health and substance abuse treatment interventions that have been shown to reduce recidivism should be adopted to improve long-term outcomes for incarcerated youth. Pediatricians should advocate for adequate funding for implementation of programs such as multisystemic therapy and functional family therapy with the recognition that an increased investment in the short-term will lead to cost savings in terms of improved long-term outcomes.

b. Resources should be invested in interventions that address the risk and protective factors involved with juvenile delinquency. There should be emphasis on investing in interventions that address the related family and community factors associated with delinquency. Specific emphasis should be placed on factors that will improve SES such as educational achievement and employment, because these factors are highly correlated with both juvenile delinquency and overall health status.

c. More nationally representative data are needed on the health needs of youth in the juvenile justice system. Funding is needed to collect nationally representative data on youth involved in the correctional system to better inform programming needs and desired outcomes and help guide the choice of appropriate cost-effective interventions.

5. Advocacy

Pediatricians should work with their AAP chapters, the juvenile justice sections of their state judiciary and bar associations, and state and local governmental officials.

a. Pediatricians should advocate to ensure that the appropriate legislation and funding is available to provide for medical, educational, and behavioral health needs of juve-
niles while confined and on reentry into the community.

b. Pediatricians should advocate for adequate health insurance for all medical and behavioral health services for youth both during and after incarceration to ensure that resources are available to provide adequate and continuous care.

c. Pediatricians should support both efforts to decrease the number of youth incarcerated by advocating for interventional programs in the community that address risk and protective factors and legislation that requires education of law enforcement officers about at-risk youth and teaches skills to manage interactions with these youth.

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**ERRATA**

**Flick et al. Cognitive and Behavioral Outcomes After Early Exposure to Anesthesia and Surgery.** *Pediatrics. 2011;128(5):e1053–e1061*

An error occurred in this article by Flick et al, titled “Cognitive and Behavioral Outcomes After Early Exposure to Anesthesia and Surgery” published in the November 2011 issue of *Pediatrics* (2011;128[5]: e1053–e1061; originally published online October 3, 2011; doi:10.1542/peds.2011-0351). On page e1054, in the Introduction, paragraph 1, line 5, this reads: “drugs include N-methyl-D-aspartate glutamate receptor agonists and γ-aminobutyric acid antagonists.” This should have read: “drugs include N-methyl-D-aspartate glutamate receptor agonists and γ-aminobutyric acid antagonists.”

doi:10.1542/peds.2011-3305


An error occurred in the American Academy of Pediatrics clinical report “Prevention and Management of Positional Skull Deformities in Infants” published in the December 2011 issue of *Pediatrics* (2011;128[6]:1236–1241; originally published online November 28, 2011; doi: 10.1542/peds.2011-2220). On page 1237, third column under Prevention, the fourth sentence should read: “Prolonged placement indoors in car safety seats and swings should be discouraged.” We regret the error.

doi:10.1542/peds.2011-3592


An error occurred in the American Academy of Pediatrics policy statement “Health Care for Youth in the Juvenile Justice System” published in the December 2011 issue of *Pediatrics* (2011;128[6]:1219–1235; originally published online November 28, 2011; doi: 10.1542/peds.2011-1757). On page 1219, the number of arrests cited in the first sentence under the heading “Epidemiology of Juvenile Arrests” was inadvertently printed incorrectly. It should read: “In 2008, approximately 2.11 million juveniles younger than age 18 were arrested.” We regret the error.

doi:10.1542/peds.2011-3723

**Chipps B et al. Longitudinal Validation of the Test for Respiratory and Asthma Control in Kids in Pediatric Practices.** *Pediatrics. 2011;127(3):e717–e747*

An error occurred in this article by Chipps B et al, titled “Longitudinal Validation of the Test for Respiratory and Asthma Control in Kids in Pediatric Practices” published in the March 2011 issue of *Pediatrics* (2011;127[3]: e737–e747; originally published online February 21, 2011; doi: 10.1542/peds.2010-1455) on page e738, Fig 1. Questions 3 and 5. This figure shows the Test for Respiratory and Asthma Control in Kids (TRACK) tool. Question 3 states, “During the past 4 weeks, to what extent did your child's breathing problems, such as wheezing, coughing, or shortness of breath, interfere with his or her ability to play, go to school, or engage in usual activities that a child should be doing at his or her age.” The correct answer choices are “Not at all,” “Slightly,” “Moderately,” “Quite a lot,” and “Extremely.” Question 5 states, “During the past 12 months, how often did your child need to take oral corticosteroids (prednisone, prednisolone, Orapred, Prelone, or Decadron) for breathing problems not controlled by other medications?” The
correct answer choices are "Never," "Once," "Twice," "3 times," and "4 or more times." The corrected Fig 1 follows.

In the Acknowledgments, the correct spelling for the writer who provided editorial assistance is Hema Gowda, PharmD.

doi: 10.1542/peds.2011-3725

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1. During the past 4 weeks, how often was your child bothered by breathing problems, such as wheezing, coughing, or shortness of breath?

- Not at all: 20
- Once or twice: 15
- Once every week: 10
- 2 or 3 times a week: 5
- 4 or more times a week: 0

2. During the past 4 weeks, how often did your child's breathing problems (wheezing, coughing, shortness of breath) wake him or her up at night?

- Not at all: 20
- Once or twice: 15
- Once every week: 10
- 2 or 3 times a week: 5
- 4 or more times a week: 0

3. During the past 4 weeks, to what extent did your child's breathing problems, such as wheezing, coughing, or shortness of breath, interfere with his or her ability to play, go to school, or engage in usual activities that a child should be doing at his or her age?

- Not at all: 20
- Slightly: 15
- Moderately: 10
- Quite a lot: 5
- Extremely: 0

4. During the past 3 months, how often did you need to treat your child's breathing problems (wheezing, coughing, shortness of breath) with quick-relief medications (albuterol, Ventolin®, Proventil®, Maxair®, ProAir®, Xopenex®, or Primatene® Mist)?

- Not at all: 20
- Once or twice: 15
- Once every week: 10
- 2 or 3 times a week: 5
- 4 or more times a week: 0

5. During the past 12 months, how often did your child need to take oral corticosteroids (prednisone, prednisolone, Orapred®, Preluone®, or Decadron®) for breathing problems not controlled by other medications?

- Never: 20
- Once: 15
- Twice: 10
- 3 times: 5
- 4 or more times: 0

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Total

FIGURE 1

Test for Respiratory and Asthma Control in Kids (TRACK). TRACK is a trademark of the AstraZeneca group of companies. ©2009 AstraZeneca LP. All rights reserved 278550 5/09.


A minor clarification has been made in the American Academy of Pediatrics policy statement "Recommended Childhood and Adolescent Immunization Schedules—United States, 2012" published in the February 2012 issue of Pediatrics (2012;129[2]:385–386, doi:10.1542/peds.2011-3630). In Fig 3: Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind—United States, 2012, the bullet in footnote 9 that previously read:

Inadvertent doses of DTaP vaccine are counted as part of the Td/Tdap vaccine series.
now reads:

An inadvertent dose of DTaP vaccine administered to children aged 7 through 10 years can count as part of the catch-up series. This dose can count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11–12 years.

and appears as the first bullet rather than the second (i.e., the 2 bullets have switched positions).

The corrected schedule is now posted online at http://pediatrics.aappublications.org/ and Red Book Online. Please note that it will differ from the version that appeared in the print journal.

doi:10.1542/peds.2012-0319
| Updated Information & Services | including high resolution figures, can be found at: http://pediatrics.aappublications.org/content/128/6/1219.full.html |
| References                      | This article cites 64 articles, 8 of which can be accessed free at: http://pediatrics.aappublications.org/content/128/6/1219.full.html#ref-list-1 |
| Post-Publication Peer Reviews (P3Rs) | 2 P3Rs have been posted to this article http://pediatrics.aappublications.org/cgi/eletters/128/6/1219 |
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NYC JUVENILE JUSTICE SYSTEM
ACRONYMS
September 2012

| ACS | Administration for Children’s Services: NYC agency in charge of all non-secure juvenile delinquency placement facilities for NYC youth as of 9/1/12 and all limited secure juvenile delinquency placement facilities for NYC youth as of 9/1/13 as part of CTH |
| AIM | Advocate, Intervene, Mentor: an ATP run by Probation that is an intensive mentoring and advocacy program for high risk youth; all 5 boroughs by 9/1/12 |
| ATD | Alternative to Detention: a program that may be ordered by the Court as a condition of paroling the respondent due to the RAI score; ATDs are run in each borough by a community-based provider (Bronx Connect - BX; Choices Unlimited - BK; Choices - Manh; Quest - QU and Ready - SI) and by Probation (ICM) |
| ATP | Alternative to Placement: the most intensive dispositional alternative a Court can order that maintains the respondent in the community |
| CTH/C2H | Close to Home: New York’s 2012 plan to keep all NYC adjudicated juvenile delinquents who are placed by the Court away from home in facilities within, or very near to, NYC overseen by ACS |
| DYFJ | Division of Youth and Family Justice: branch of ACS which oversees all juvenile justice-related facilities and programs including all detention and Close to Home placement facilities |
| ECHOES | Every Child Has an Opportunity to Excel and Succeed: Probation’s ATP program in collaboration with The Children’s Aid Society’s WorkLINC program; goal is increase social and emotional competencies and employability; available to all 5 boroughs but the program is located in Upper Manhattan. |
| EOA | Exploration of Alternatives: component of the dispositional process which can be ordered by the Court to establish which ATP best suits the needs of each juvenile delinquent |
| ESP | Enhanced Supervision Probation: the most intense level of Probation (also known as Level 3); below an ATP program |
| FFT | Functional Family Therapy: an evidence-based treatment modality used by JJ1 |
FYJP  Family & Youth Justice Programs: branch of DYFJ which oversees all the secure and NSD Detention Facilities and Youth Justice Programs such as JJI and Confirm

ICM  Intensive Community Monitoring: Probation’s ATD program; more intensive than the community-based ATDs

JJI  Juvenile Justice Initiative: ACS’s ATP program which uses an evidence-based therapeutic model (MST, FFT, MTFC) to work intensively with both the respondent and his family in their home and community; all 5 boroughs.

MST  Multi-Systemic Therapy: an evidence-based treatment modality used by JJI

MTFC  Multi-dimensional Treatment Foster Care: an evidence-based treatment modality used by JJI

NSD  Non-Secure Detention: non-secure group home-like detention facilities run by DYFJ where the Court can order a respondent held on an Open or NSD-only remand while their case is pending

NSP  Non-Secure Placement: dispositional placement facilities run by private, non-profits which will be overseen by ACS as part of CTH effective 9/1/12

OCFS  Office of Children and Family Services: NYS agency in charge of all limited and secure juvenile delinquency placement facilities as of 9/1/12 and all secure juvenile delinquency placements as of 9/1/13; will provide some oversight to ACS as it takes over non-secure and limited secure placements

OYFD  Office of Youth and Family Development: branch of DYFJ which oversees all aspects of Close to Home including the non-secure placement facilities

RAI  Risk Assessment Instrument: tool completed by Probation and used by the Court for the initial parole/remand determination

SDM  Structured Decision-Making: Probation’s rubric for standardizing dispositional recommendations in the I&R

YLS  Youth Level of Service: Probation’s risk and needs assessment instrument which determines the risk prong of the SDM

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Juvenile Justice Glossary of
Legal Terms & Acronyms

A

Adjournment: A recess or postponement of a case to a later date.

Adjudicate: The legal process of resolving a dispute.

Adjustment/Diversion: “Diversion” or “adjustment” allows a juvenile to avoid formal court processing through the completion of services or other consequences (e.g., community service). The agency responsible for diversion in New York City is the Department of Probation.

ACS (Administration for Children’s Services): The NYC agency responsible for all detention facilities (secure and non-secure) and for non-secure delinquency placements as part of Close to Home. As of September 1013, also responsible for limited-secure placement facilities.

Admission: An assertion or acknowledgment that the fact or facts at issue are true. When made under oath such an assertion is legally binding.

Allegation: An unproven fact declared or asserted by a party in a legal proceeding.

Appearance: The participation in the proceedings by a party in an action, either in person, by electronic means or through an attorney.

Assigned Counsel (18 B): An attorney assigned by a judge to represent an adult party, who cannot afford one. Also referred to as 18 (b) or panel attorneys, they are generally chosen from a list of lawyers previously approved by the Appellate Division of the Supreme Court.

Assistant Corporation Counsel: A lawyer who represents city in the prosecution of juvenile delinquency cases.

ATD (Alternative to Detention): In juvenile delinquency proceedings, youth may be paroled to ATD, meaning that they are released home on the condition that they attend an designated program after school.

ATP (Alternative to Placement): In juvenile delinquency proceedings, youth may be released to an Alternative to Placement program as the disposition of their case. (For instance, a youth may be given 12 months probation with the condition that s/he participates with JJL.)

Attorney for the Child: The attorney appointed by the court to represent a youth in a delinquency or PINS proceeding. Previously called “Law Guardian.”
**B**

**Bench warrant:** An order issued by the court, ("from the bench") for the arrest of a person.

**C**

**Close to Home:** ACS plan to keep adjudicated NYC juvenile delinquents who are placed out-of-home at disposition, within or very near NYC.

**Conditional Discharge:** A release from confinement or an obligation if certain requirements are met.

**Consent:** A competent person voluntarily agrees, approves, or permits some action.

**Counsel:** One or more lawyers who represent a client.

**Court Attorney:** A lawyer, employed by the court, who assists the judge with legal research, drafting decisions, and reviewing orders.

**Criminal Case:** An action, which can only be initiated by the government or state, brought against an individual who has committed a crime. Fines, jail time, and other conditions can be imposed upon the defendant if he or she is found guilty.

**D**

**Delinquency- see Juvenile Delinquent:** A D Petition is a petition filed in court alleging delinquent acts were committed by an individual.

**Designated Felony Act:** An act committed by a person age 13, 14, or 15, which if committed by an adult, would constitute one of the following crimes: murder, kidnapping, arson, assault, manslaughter, rape, sodomy, or robbery.

**Detention/Jail:** A facility which houses a youth while his or her case is being processed in family or criminal court.

**Detention Services:** The program area within ACS DYFJ that is responsible for operating secure and non-secure detention centers.

**Dismissal:** The termination or ending of an action or claim without further hearing.

**Dispositional Hearing:** A hearing that takes place after the fact-finding hearing where the judge determines the most appropriate resolution of a case based on the evidence presented.

**Diversion:** The involvement of a family with a Family Assistance Program (FAP) prior to the filing of a PINS petition.
DJJ (Department of Juvenile Justice): The Department of Juvenile Justice was the City agency responsible for the care of youth in detention prior to the merger with ACS. As of 1/2011, DJJ no longer exists.

DYFJ (Division of Youth and Family Justice): DYFJ is the division at Children’s Services which includes detention, Close to Home/Non-secure placements, the Juvenile Justice Initiative (JJI) and the Family Assessment Program (FAP).

E

EOA (Exploration of Alternatives): Component of the dispositional phase of a case which can be ordered by the court to determine which ATP best meets the needs of the juvenile delinquent

EOP (Exploration of Placement): A pre-dispositional directive by the Court to ACS in PINS cases to find a suitable place where a child can be placed.

F.

Fact-Finding Hearing: A trial to determine, beyond a reasonable doubt, whether the young person committed the acts alleged on the petition.

FAP (Family Assessment Program): The DYFJ ACS PINS diversion services.

Felony: A criminal act punishable by imprisonment for more than one year.

G

Guardian Ad Litem: An individual, usually an attorney, appointed by the court to represent an infant, an adult who is mentally or physically unable to speak for themselves, or to stand in place of a parent who is unable to appear in court.

H –I

I&R (Investigation & Report): A court-ordered report prepared by Probation to assist at Disposition. Probation uses the Youth Level of Service (YLS) instrument to make an assessment and the Structured Decision Making matrix to make recommendations.

Incarceration: A catch-all term that includes detention, jail, placement and prison.

J-K

Juvenile Delinquent (JD): A person who is under 16 years old, but is at least 7 years old, who commits an act which would be a "crime" if he/she were an adult, and is then found to be in need of supervision, treatment or confinement. The act is called a "delinquent act." All juvenile delinquency cases are handled in Family Court.

JJI (Juvenile Justice Initiative): An ACS ATP program.
Juvenile Offender (JO): A person under the age of 16 that is accused of committing a serious felony offense. Juvenile Offender cases are handled in criminal or supreme court.

Law Guardian, now referred to as Attorney for the Child: An attorney assigned by a judge, who represents children in family court, often employed by The Legal Aid Society. Children are assigned an attorney on every Child Abuse & Neglect, PINS, and Delinquency case.

Misdemeanor: An offense punishable by a fine or imprisonment of 15 days or more up to one year.

Mental Health Services- Mental Health Study (MHS) & Full Evaluation and Testing (FET): The New York City Health and Hospitals Corporation, which is responsible for administering the public hospital system, operates Family Court Mental Health Services. MHS performs on-site court-ordered psychological and/or psychiatric evaluations in all boroughs except Staten Island, where SOMH/South Beach PC operates a Family Court Services clinic.

Neglect: Where parent or person legally responsible for the care or custody of a child (less than 18 years of age) is responsible for such child lack of proper care, including those where the child suffers psychological or physical damage for any reason. A Neglect petition “N Docket” is filed against the parent or person legally responsible in family court alleging acts of neglect.

NSD (Non-Secure Detention): Non-secure detention is an alternative to secure detention for some remanded youth. NSD provides structured residential care for alleged juvenile delinquents in a less restrictive setting (e.g. similar to a group home, but youth are not permitted to go anywhere unaccompanied by staff).

NSP (Non-Secure Placement): Dispositional placement facilities operated under the supervision of ACS DFYJ as part of Close to Home.

Office of Court Administration (OCA): The administrative branch of the New York State court system. OCA is overseen by the Chief Judge of the Court of Appeals, and supervises the standards, administrative policies, and operations of the trial courts throughout the state.

OCFS (Office of Children and Family Services): OCFS is the state agency responsible for the operation of facilities for youth placed at disposition on delinquency petitions. Currently, NYC youth placed “secure” and “limited secure” are held in these facilities. As of September 2013, only NYC youth placed “secure” will be held in these programs.
Order: A written direction or command delivered by the court or a judge.

Order of Protection or Temporary Order of Protection (OP or TOP): An order issued by a judge directing that a respondent refrain from committing acts which are defined as family offenses against a designated person. These include harassment; disorderly conduct; menacing; reckless endangerment; and assault. An order of protection may also direct the respondent to stay away from the home, school, or place of employment of designated persons; refrain from acts or omissions that create an unreasonable risk to the health, safety, or welfare of the child.

P- Q

Petition: The written document that forms the basis for a Family Court proceeding.

PINS (Person in Need of Supervision): A youth less than 18 years of age who does not attend school in accord with the provisions set forth in the education law, or who is incorrigible, ungovernable or habitually disobedient and beyond the lawful control of parent or other lawful authority. These acts if committed by an adult would not constitute a crime, but are subject to family court jurisdiction as a result of the respondent being a minor. A PINS petition is a petition filed in family court that alleges these acts and is most often initiated by the parent or person legally responsible but can also be brought by a police officer or an authorized agency.

Parole/Released home: On a juvenile delinquency case, a youth may be paroled to the custody of a parent or person legally responsible.

Placement/Prison: A facility which houses an individual who has been adjudicated as a juvenile delinquent in family court or been convicted of a crime in criminal court.

Probation: A disposition ordered by a judge in which the youth is not held in custody, but is released under supervision for a certain period of time during which he or she must fulfill certain conditions.

Probation Department: In Family Court, the NYC agency responsible in delinquency cases for the intake and adjustment process, for preparing court-ordered I&Rs, for providing court-ordered supervision, and for providing Alternative to Placement programming.

R

RAI (Risk Assessment Instrument): Tool completed by Probation and used by the Court for initial parole/remand decisions.

Remand: A remand on a juvenile delinquency case is a temporary “placement” of a youth into a DYFJ secure or non-secure detention center while that youth’s case is pending in court. Residential Facility: A facility authorized by the county’s social services agency to care for children in foster care or who have been otherwise detained.
Residential Placement: A child may be placed out of home in a residential placement. An RTC or Residential Treatment Center is an institutional placement operated by an agency contracted with ACS. An RTF, or Residential Treatment Facility, is an institutional placement operated by an agency contracted with OMH. An RIC, or Rapid Intervention Center, has replaced the DRC, or Diagnostic Reception Center, and is a 30 day diagnostic placement that focuses on stabilizing and evaluating children in order to make appropriate recommendations for placement.

STU

Secure Detention: Locked facilities that house alleged juvenile delinquents and juvenile offenders while awaiting resolution of their cases (e.g. Crossroads Juvenile Center in Brooklyn and Horizon Juvenile Center in the Bronx).

SDM (Structured Decision-Making): Matrix used by Probation to standardize dispositional recommendations in the I&R.

Violation: An offense less serious than a misdemeanor. An offense, other than a "traffic infraction" for which a sentence to a term of imprisonment in excess of fifteen days cannot be imposed. An offense against the penal law but one which does not constitute a criminal offense.

W

Warrant: A court order requiring the arrest of an individual. The Family Court has the power to issue warrants for the arrest of adult respondents in a variety of circumstances despite the fact that the Family Court handles only civil, not criminal proceedings. For example, an arrest warrant may be issued, in any proceeding where a summons served on the respondent would be ineffective, or in emergencies involving children in a respondent’s care. In addition, an adult may be arrested without a warrant for the violation of a temporary or final order of protection.

Y

YLS (Youth Level of Service): Instrument used by Probation to assess needs in the I&R.

YO (Youthful Offender): Status granted to certain youth up to the age of 18 who are adjudicated in criminal court.