
Mental Health Issues Facing Adolescents in the Juvenile Justice System: Part I

The Lack of Mental Health Resources

■ Marc A. Schindler

Marc Schindler is a staff attorney at the Youth Law Center in Washington, DC.

At the June meeting of the American Medical Association's Coalition on Adolescent Health, Mark Soler, Esq., President of the Youth Law Center based in Washington, DC, was one of the featured speakers. His presentation on mental health issues of adolescents in the juvenile justice system gave well-documented information of importance to child and adolescent psychiatrists in our role as advocates for youth. Mr. Soler agreed to have his staff write up this material for AACAP News.—Diane K. Shrier, M.D., Associate Editor, AACAP News, Liaison from the American Psychiatric Association to the AMA's National Coalition on Adolescent Health

This two part article will discuss two major mental health issues for adolescents in the juvenile justice system: Part I will explore the lack of mental health resources and services for youth in the system and Part II will discuss the mental health impact of increased prosecution of juveniles as adults (and consequent incarceration of youth in adult jails and prisons). For each issue, the scope of the problem will be discussed, its components analyzed, and recommendations made for future research and reform efforts.

It should be noted at the outset that minority youth are disproportionately over represented at every stage of the juvenile justice system. For example, although African-American juveniles ages 10 to 17 constitute 15% of the total population of the United States, they constitute 26% of juvenile arrests, 32% of delinquency referrals to juvenile court, 41% of juveniles detained in delinquency cases, 46% of juveniles in corrections institutions, and 52% of juveniles transferred to adult criminal court after judicial hearings (Snyder & Sickmund, 1995). It is clear then that the disproportionality is greater as youth go deeper into the system. In 1991, the public long-term custody rate for African-American youth was nearly five times the rate for white youth (Snyder & Sickmund, 1995), and in 1995, while 32% of the U.S. population ages 10-17 was classified as minority, minorities made up 68% of the detention center population on February 15, 1995 (Sickmund, Snyder & Poe-Yamagata, 1997). Overall, during the Office of Juvenile Justice and Delinquency Prevention's (OJJDP) one-day count in February 1995, minority youth outnumbered nonminority white youth in public custody facilities by more than 2 to 1, while in private facilities nonminority white youth slightly outnumbered minority youth (Sickmund, Snyder & Poe-Yamagata, 1997). Minority youth are also disproportionately over-diagnosed for conduct disorders, but are underserved by mental health services (Isaacs, 1992), and are also more likely to be transferred to adult court for prosecution and incarcerated in jails and prisons than white youth, even for the same offenses.

These disparate rates of involvement in the juvenile justice system, leading to incarceration, have a dramatic impact on minority youth as they become adults. The Sentencing Project has reported that one-third of all African-American males ages 20 to 29 in the United States are under the jurisdiction of the criminal justice system—either in jail, in prison, on probation, or on parole (Mauer, 1997). The primary factors contributing to this extraordinary level of social control over young black men are drug enforcement policies and prior criminal records of minority defendants. Since minority youth are disproportionately impacted by the juvenile justice system, where they pick up those prior records, the juvenile system in effect acts as a feeder system for minority youth into the adult criminal justice system.

The impact of these incredibly high rates of incarceration on minority families and communities is profound. For example, one of the consequences of an adult felony conviction in most states is the loss of voting rights for a period of time, and sometimes for life. Thus, as a result of increasing numbers of young black males being supervised in the criminal justice system, currently approximately 1.4 million black males (which represents 14%, or one in seven, of the 10.4 million black males of voting age) are now either currently or permanently disenfranchised from voting (Mauer, 1997). It is clear that the cumulative impact of such large numbers of black males being excluded from the electoral process will increasingly dilute the political power of the African American community. Another significant impact of incarceration (or even simply arrest), is the reduction of potential future wage earning and employability. For example, Richard Freeman's study of the impact of imprisonment on earnings potential concluded that among a sample of youth incarcerated in 1979 there was a 25% reduction in the number of hours worked over the next eight years (Mauer, 1997). Therefore, as we see increasingly disparate and shockingly high rates of incarceration for minority youth and adults, the result is likely to be a devastating impact on the minority communities in which many of these young men live, with the removal of large numbers of potential wage earners, a disruption of family relationships, and a growing sense of isolation and alienation from the larger society.

Lack of Mental Health Resources And Services

A. Introduction

In her 1982 report, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*, Jane Knitzer concluded that children in the juvenile justice system with emotional and behavioral disorders were largely neglected and ignored by public service systems. Ten years later, in the most comprehensive monograph available on the subject,

Joseph Coccozza (1992) reported that "the situation has not changed."

Sadly, currently, juvenile justice and mental health are still, in Knitzer's words, "the forgotten mandate."

B. Scope of the Problem

Although official reports on this problem go back at least three decades (Joint Commission on Mental Health of Children, 1969), there is still an absence of systematic empirical data on the prevalence of mental disorders among juvenile offenders. Research to date has been uneven and the quality of the results—as well as the findings—has varied greatly. Two reviews of the literature in 1992 (Otto, Greenstein, Johnson, & Friedman, 1992; Wierson, Forehand & Frame, 1992) both concluded that few well-controlled epidemiological studies existed at that time, and few studies have been conducted since then that have significantly improved our knowledge in this area. Many studies suffer from methodological difficulties, limited samples, and failure to consider all relevant variables (Edens & Otto, 1997).

Nevertheless, the available data indicate that the prevalence of mental disorders among juvenile offenders is quite substantial, and is significantly higher than among youth in the general population. The OJJDP estimates that 60% of young people in the juvenile justice system have behavioral, mental, or emotional disorders and are in need of treatment (Lieter, 1993).

Prevalence data on specific diagnoses reflect the problems with the research, and studies employing clinical interviews report significantly higher rates than those using behavioral rating scales, but in sum they paint a picture warranting great concern. Most studies report the prevalence of conduct disorders to be greater than 80%; substance abuse is reported between 25% and 50%; attention-deficit/hyperactivity disorder from 0% to 46%; affective disorders from 2% to 78%; anxiety disorders from 0% to 41%; psychotic disorders 1% to 6%; personality disorders between 2% and 17%; mental retardation between 7% and 15%; and learning disabilities and specific developmental disorders between 17% and 53% (Edens & Otto). With over 2.7 million youth under the age of 18 arrested each year (Sickmund, Snyder, & Poe-Yamagata, 1997), and more than a million of them having formal contact with the juvenile justice system, (Coccozza, 1997), the number of youth entering the system with serious mental disorders is likely to be extraordinarily high. The prevalence of co-occurring disorders is particularly noteworthy, with estimates of 50% to 75% of youth in the juvenile justice system with mental disorders also having serious substance abuse problems (Coccozza, 1997).

C. Specific Problem Areas

Specific problem areas span the range of the juvenile justice system, including assessment, treatment, training, and problems in institutional settings

1. Assessment

The juvenile justice system often does a poor job of assessing mental health problems and identifying treatment needs for youth in the system. One complicating factor is that "assessment" has different meanings at various points in the system (Barnum & Keilitz, 1992; Grisso, 1998). For example, at arrest, in addition to considering probable cause, the arresting officer often must assess whether the juvenile is competent to waive *Miranda* rights. On the question of detention, the intake official and ultimately the court must assess whether the youth is a danger to himself or to the community. As the juvenile court process unfolds, the court must assess whether the youth is competent to understand the nature of the proceedings and to assist in his defense. If the prosecutor moves to transfer a youth to adult criminal court, the court must assess whether the youth is amenable

to treatment available through services in the juvenile system. For disposition, the probation department and ultimately the court must assess what services or placement will meet the individual needs of the youth while providing adequate safety for the public. For youth who are incarcerated as their disposition, institutional personnel must assess for classification and housing, counseling and other treatment services, and application of restraints and isolation for behavior that violates institutional rules. Practitioners in the system often fail to make clear distinctions between these different components.

Moreover, at each of these points, consideration of youths' mental status is a critical element in the decision making process. Each assessment, however, seeks to answer different questions, and the key decision makers at each point in the process often

operate without adequate background information, and may lack necessary knowledge, training, and skills to make effective choices (Woolard, et al., 1992).

A second complicating factor is vagueness in laws that apply to youth with mental disorders. Few statutes set forth clear guidelines or directives for addressing the needs of such youth, and even statutory definitions of mental illness are "imprecise, ambiguous, and often tragically archaic" (Woolard et al., 1992).

There are also problems involving the instruments used for mental health assessments. In many jurisdictions none are used at all, and juveniles simply do not receive any mental health assessments at arrest, admission to detention, disposition, or placement in a program or institution. Where mental health assessments are conducted, there is no consensus about what should be covered in the assessment or who should conduct the assessment, and consequently there is enormous variation in the personnel involved, the questions asked, and the instruments used. Some assessments are superficial, consisting of one or two questions posed by custody staff. In other places, standardized

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tests such as the MMPI are administered, but they amount to testing overkill, and prosecutors, defenders, and the courts do not use the information effectively in placement or treatment decisions. Further, although co-occurring disorders are common, evaluation for alcohol and substance abuse is often not done at all, much less in coordination with mental health assessments.

2. Treatment

A second major problem area is in the provision of treatment. Again, there are several aspects of the problem. First, it is not clear whether youth in the system are legally entitled to treatment for mental disorders. Although a number of courts in the past embraced the concept of a constitutional "right to treatment" (Holland & Mlyniec, 1995), the U.S. Supreme Court has significantly limited any such right. In one case (*Estelle v. Gamble*, 1976), the Court ruled that prison officials may not be "deliberately indifferent to serious medical needs," which is a far cry from an affirmative right to treatment. When the issue was squarely presented to the Court (*Youngberg v. Romeo*, 1982), it ruled that the profoundly retarded individual in the case before it was entitled only to "minimally adequate training" and "habilitation" to protect his safety in a state institution, and freedom from unreasonable restraints. On the other hand, at least one federal court has recently held that juveniles confined in state institutions are entitled to rehabilitative treatment (*Alexander S. v. Boyd*, 1995). Some federal statutes entitle youth in the juvenile justice system to mental health services, such as counseling and other "related services" under the Individuals with Disabilities Education Act (1998), and arguably juveniles in custody under federal jurisdiction are entitled to "necessary psychiatric, psychological, or other care and treatment" (18 U.S. Code §5035). Some courts have found a basis for a right to treatment in state statutory or constitutional provisions (*Nelson v. Heyne*, 1974, *Creek v. Stone*, 1967).

Beyond the matter of entitlement to treatment is the question of what treatment should be provided. Researchers

have identified and evaluated a number of promising interventions for youth with mental disabilities in the juvenile justice system (Melton & Pagliocca, 1992), such as multi-systemic therapy (Schoenwald, Henggeler, Pickrel & Cunningham, 1996) and wraparound services (Milwaukee County Mental Health Division, 1998). The key to these interventions is a family-centered approach that provides comprehensive services through collaboration among juvenile justice, mental health, and other service systems.

Unfortunately, for the most part, effective, coordinated services are rarely seen in the juvenile justice arena. Most juvenile facilities provide crisis intervention and possibly group counseling, but not individual counseling or any other one-on-one therapies, let alone collaborations among a variety of service systems. Bureaucratic inertia, "turf" battles, concerns about confidentiality of information (Soler, Shotton, & Bell, 1993), and reliance on categorical funding streams (Burrell, 1993) are some of the major reasons. Moreover, where public officials have instituted new therapeutic interventions, with few exceptions there has been little in the way of rigorous evaluation of results. Finally, there has been little development of aftercare services, or linkages to community-based mental health pro-

grams for youth who are released from custody.

3. Training

A further problem is in the area of training. Most juvenile court personnel—judges, prosecutors, defense counsel, and probation officers—receive little or no training in mental disorders and related areas such as child and adolescent development (Puritz, et al. 1995). Thus, they are often ill-equipped to understand the results of evaluative tests, the mental health needs of particular youth, or appropriate treatment options. The adversarial system compounds the problem, because defense counsel feel obligated to pursue any mental disability as a potential defense or mitigating factor, and prosecutors often feel compelled in their role to minimize such factors. In addition, most staff in dispositional placements likewise receive little or no training in identifying mental health needs of youth, dealing with problem behavior related to or deriving from mental disabilities, or providing appropriate treatment.

4. Problems in Institutions

These problems are particularly serious in institutional settings. Each year more than 500,000 youth are admitted to local juvenile detention facilities prior to adjudication in juvenile court, and more

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than 65,000 are admitted to long-term juvenile correctional facilities pursuant to adjudication and disposition (Snyder & Sickmund, 1995). While upwards of 60% of these youth have mental disorders, some quite severe, the conditions in such institutions often exacerbate their problems.

Overcrowding is endemic in juvenile facilities (Parent et al., 1994), heightening tension levels and threats of violence, putting serious strain on health and education services and other programming, and leading to increased use of restraints and isolation (Lerner, 1986). A national study of all secure juvenile facilities found that 2,000 youth and 650 staff were injured in the 30 days prior to the survey, and 970 youth committed more than 1,400 acts of suicidal behavior in the same period (annualized, 11,000 youth committing 17,000 suicidal acts). Civil rights cases have documented extraordinarily punitive practices at individual facilities, including tying youth by their wrists and ankles to the four corners of their beds for disobeying orders of custody staff, and stripping youth to their underwear, putting them in four-point restraints, and injecting them with psychotropic drugs as "treatment" for suicidal behavior (*Hollingsworth v. Orange County*, 1990; *Robert K. v. Bell*, 1984).

Recent reports on juvenile facilities in Georgia and Louisiana also indicate that youth with mental disorders regularly receive extended isolation and beatings from staff in several facilities in both states (Human Rights Watch, 1995, 1996). For example, in a recent Department of Justice report on conditions in a Louisiana facility, an expert noted the case of a confined 16-year-old with an IQ of 59 who had been prescribed psychotropic medication for mental health symptoms, including bizarre thoughts and command hallucinations. Despite one psychiatrist's recommendation for aggressive treatment to address the youngster's history of sexual abuse, and another psychiatrist's statement that the youth's behavior was inappropriate for the setting in which he

was placed, a full two years later there was no indication of any effort to implement any of the recommendations and the youth was required to spend many of his waking hours and all nights in a locked cell (Ray, 1998).

D. Recommendations

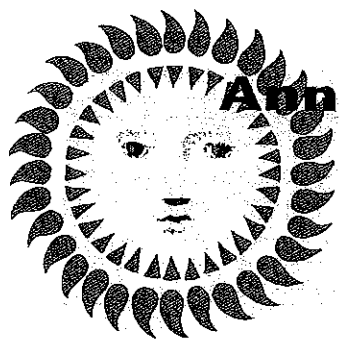
- More research needs to be done to determine the prevalence of specific mental disorders among youth in the juvenile justice system, particularly large-scale multi-state epidemiological studies. Alcohol and substance abuse should be included in such research, to determine the prevalence of co-occurring disorders. The only large-scale study currently underway focuses solely on youth entering the Chicago juvenile detention facility (Teplin, Abram, & McClelland, 1998). Although limited to that one facility, the study is carefully planned and can be a model for studies in other detention facilities and in state juvenile corrections institutions.
- Minimum standards and model instruments for mental health assessments should be developed, including core issues and questions that should be covered in all assessments, specific issues that should be addressed at each particular stage of the juvenile justice process, minimum training and experience for individuals conducting such assessments, and proper and improper uses for the results of such assessments. Both the minimum standards and the model instruments should address co-occurring disorders.
- The myriad definitions of mental illness in federal and state statutes and regulations should be clarified and recommendations made for greater consistency.
- To improve treatment services, several steps should be taken.
- Interdisciplinary and interagency collaborations to bring together juvenile justice, mental health, and other necessary services should be developed. Most current service coordination efforts involve schools, medical, child welfare, and sometimes mental health services, but usually exclude youth in the juvenile justice system.
- Rigorous evaluation of promising treatment methodologies, and far more extensive dissemination of reports on effective treatment methodologies, evaluation studies, and specific issues such as confidentiality and computerized data-sharing should be conducted.
- Funders should support conferences to bring together medical and mental health professionals, juvenile justice practitioners, advocates for children, and researchers to discuss treatment methods and potential interagency efforts.
- Federal statutes and regulations should be reviewed to identify and clarify available treatment resources, and a parallel effort should be made in the states.
- A national survey of institutional settings should be undertaken to assess overcrowding, security issues, medical care, (Parent, et al., 1994), adequacy of mental health services and the use of isolation and restraint.
- Mental health services in juvenile facilities in many states should be reviewed to assess for use of adequate assessment instruments, the need for hiring of additional professional staff, training of custody staff, and strict limits on use of isolation and restraint are all critical needs.
- The U.S. Department of Health and Human Services should grant waivers to states to allow them to use Medicaid funds for mental health services for incarcerated youth.
- As the recent revelations of widespread abuse of mentally disordered youth in Georgia and Louisiana juvenile facilities demonstrate, there should be increased monitoring of such institutions by medical and mental health professionals, civic organizations, public interest legal advocacy groups, and the Civil Rights Division of the U.S. Department of Justice.
- The "Prison Litigation Reform Act of 1995," (PLRA) which makes it more difficult for incarcerated individuals to bring litigation in federal courts over abusive and dangerous conditions of confinement, should be amended to delete jurisdiction over incarcerated juveniles.

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Mental Health Issues Facing Adolescents in the Juvenile Justice System: Part II

Prosecution of Juveniles as Adults

■ Marc A. Schindler

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At the June meeting of the American Medical Association's Coalition on Adolescent Health, Mark Soler, Esq., President of the Youth Law Center based in Washington, DC, was one of the featured speakers. His presentation on mental health issues of adolescents in the juvenile justice system gave well-documented information of importance to child and adolescent psychiatrists in our role as advocates for youth. Mr. Soler agreed to have his staff write up this material for AACAP News — Diane K. Shrier, M.D., Associate Editor, AACAP News, Liaison from the American Psychiatric Association to the AMA's National Coalition on Adolescent Health

This article is the second in a two part series on adolescents in the juvenile justice system. Part I (AACAP News, January/February 1999) provided an overview of mental health issues for these adolescents. Part II will focus on the issue of prosecution of juveniles as adults. The scope of the problem will be discussed, its components analyzed, and recommendations made for future research and reform efforts.

Prosecution of Juveniles as Adults

A. Juvenile Crime and Public Reaction
Between 1987 and 1994, the rate of arrest for violent crimes committed by juveniles in this country rose by 70% (Sickmund, Snyder & Poe-Yamagata, 1997). The increase was led by juvenile arrests for murder, which more than doubled from the mid-1980s to the early 1990s. The homicide rate upsurge was completely firearm-related, as young people committed murder with guns much more frequently than ever before (Snyder, Sickmund & Poe-Yamagata, 1996). At the same time, the media increasingly focused its attention on violent juvenile crime (Dorfman, et al., 1995), and pundits, politicians, and news anchors increasingly used the term "superpredator" to describe a coming generation of violent youth (Dilulio, November 1995, December 1995; Simon, 1996; Traub, 1996).

There are good reasons to pause before jumping to conclusions regarding juvenile offenders. For one thing, arrest rates usually substantially overstate the

real extent of juvenile crime, since most youth commit crimes in groups, and police often arrest everyone in the group (leaving until later the question of who actually committed the crime) (Jones & Krisberg, 1994). Even measured by arrest rates, only 6% of juvenile arrests in 1992 were for violent crimes, and the percentage was exactly the same in 1994 (Snyder & Sickmund, 1995; Snyder, Sickmund, & Poe-Yamagata, 1996). Further, between 1994 and 1996, the juvenile homicide arrest rate *dropped* by 30% and the overall rate for violent crime arrests of juveniles *decreased* by 12% (Federal Bureau of Investigation, 1996). In addition, the "superpredator" hypothesis was debunked by many researchers (Mauer & Young, 1996).

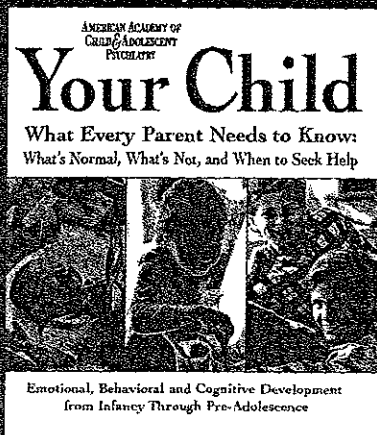
Nevertheless, few public officials took a cautious approach. From 1992 to 1995, legislatures in 47 states and the District of Columbia passed laws that "toughened" their juvenile justice systems. Juvenile codes were amended to focus on punishment and accountability instead of the traditional rehabilitation and treatment. In 25 states, legislatures gave criminal and juvenile courts new sentencing options. Forty states changed or eliminated confidentiality provisions to open up juvenile court records (Torbet et al., 1996).

Most important, 47 states changed their laws to allow increased prosecution of juveniles as adults. They have done this in a variety of ways: (1) by increasing the number of offenses for which juveniles can be transferred to adult court after a judicial hearing, (2) by lowering the age at which juveniles can be transferred, (3) by designating certain offenses for which juveniles are automatically prosecuted in adult court, (4) by saying that for some offenses there is a presumption that the juvenile should be prosecuted in adult court, but the juvenile can

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try to prove that he is amenable to treatment, and get a "reverse waiver" back to juvenile court, and (5) by giving prosecutors the authority to decide in individual cases whether young people should be charged in juvenile court or adult court.

In a related effort, "get tough" legislation now pending in Congress—"The Violent and Repeat Juvenile Offender Act of 1997"—would allow juveniles to be held in adult jails, right next to (and subject to verbal harassment from) adult inmates (S. 10, 1997).

B. Health Consequences for Juveniles

The changes in state "transfer" laws (and the changes proposed by pending federal legislation) will have profound consequences for youth, since they mean that many more young people will be incarcerated in adult jails and prisons. More than 12,000 juveniles are transferred to adult court by judges each year, and many more are prosecuted as adults as a result of increased direct filings in criminal court by prosecutors. In addition, in 1994, an estimated 180,000 16- and 17-year-olds were prosecuted in criminal courts because they were legally defined as adults under state law (Sickmund, Snyder & Poe-Yamagata, 1997). The increased incarceration of juveniles in adult facilities is contrary to juvenile justice policy over the last 25 years. In 1974, in response to evidence of widespread abuse of children in adult jails (*Detention and Jailing of Juveniles*, 1973), Congress passed the Juvenile Justice and Delinquency Prevention Act. That statute prohibits states from confining juveniles in adult jails except for brief periods after arrest (the removal provision), and, during such brief periods, requires sight and sound separation of juveniles from adult inmates (the separation provision). Although it took the states a number of years to comply with the Act, at the present time 45 states are in compliance with the removal provision and 48 states are in compliance with the separation provision.

During the time the states were coming into compliance, terrible tragedies

occurred. A 15-year-old girl in Ohio ran away from home and returned voluntarily, but was ordered into the county jail for five days by a judge "to teach her a lesson." On the fourth night she was sexually assaulted by a deputy jailer. Seventeen-year-old Chris Peterman was held in the jail in Boise, Idaho, for not paying \$73 in traffic fines. Over a 14-hour period, he was tortured and finally murdered by other prisoners in the cell. Robbie Horn, 15 years old, was repeatedly ordered into jail in Kentucky for truancy and running away from home. After an

The increased incarceration of juveniles in adult facilities is contrary to juvenile justice policy

argument with his mother, he was ordered back into the jail by a juvenile court judge. Within half an hour, he hanged himself. Kathy Robbins, also 15, was locked in the county jail in rural California for being in the town square on Saturday night after the 10:00 p.m. curfew. After a week in jail, she hanged herself. Another girl in Indiana was locked in jail for stealing a bottle of shampoo. She had a history of mental health problems, but the staff did not pick that up, and she, too, hanged herself (S. Rep. No. 105-108, 1997). More recently, in Ohio, six adult prisoners murdered a 17-year-old boy while he was incarcerated in the juvenile cellblock of an adult jail (Delguzzi, 1996).

The problem of suicide by young people in adult facilities is especially noteworthy. A landmark U.S. Department of Justice study in 1980 reported

that juveniles are almost eight times more likely to commit suicide in adult jails than in juvenile detention facilities (Flaherty, 1980). This 8-to-1 ratio is particular grounds for concern in view of the fact that a national survey of juvenile facilities reported that 970 young people committed 1,400 acts of suicidal behavior in the 30 days prior to the survey, which represents 11,000 young people committing 17,000 suicidal acts each year (Parent et al., 1994).

The dangers of confining juveniles in adult jails are demonstrated by the experience in Kentucky, one of the few states that has *not* been in compliance with the jail removal provision of the Juvenile Justice and Delinquency Prevention Act. Over a 13-year period, there were four suicides, one attempted suicide, one accidental death, three sexual assaults, and two other assaults involving juveniles in Kentucky jails. Nine of the incidents involved status offenders—truants, runaways, and "incorrigible" youth—who would not even have been considered criminals if they were adults (S. Rep. No. 105-108, 1997).

The dangers are similar when young people are incarcerated in prisons. A 1990 study found that juveniles in adult institutions are five times more likely to be sexually assaulted, twice as likely to be beaten by staff, and 50% more likely to be attacked with a weapon than youth in juvenile facilities (Forst, Fagan & Vivona, 1989). As Professor Jeffrey Fagan of Columbia University notes, "because they are physically diminutive, they [juveniles] are subject to attack. They will become somebody's 'girlfriend' very, very fast." (Ziedenberg & Schiraldi, 1998). The prevalence of sexual assault is so common it appears to have become widely expected and accepted, as one corrections officer indicated, a young inmate's chances of avoiding rape were "almost zero... he'll get raped within the first twenty-four to forty-eight hours. That's almost standard." (Ziedenberg & Schiraldi, 1998). Thus, we should not be surprised when we hear about a recent case such as occurred in Florida, where a 17-year-old mildly retarded boy who had pleaded guilty to sexual battery was

strangled to death by his 20-year-old cellmate. (Lyons, 1997)

Many states, however, have no place to put juveniles transferred into their adult systems except in prison. A 1995 survey of state Departments of Corrections conducted for the National Institute of Corrections found that 27 states house those under 18 in the *general population* of their prisons, or, as the study said, "in protective custody if needed" (Lis, Inc., 1995). Putting young people in the general population of a prison is an invitation to rape and assault; locking them up in "protective" isolation or administrative segregation for long periods (many have multi-year sentences) is a guarantee of severe mental and physical deterioration.

These legislative developments are especially disturbing in view of the strong evidence that prosecution of juveniles as adults leads to *more* crime, not less. The two leading studies on this compared youth in Florida prosecuted as adults with those prosecuted as juveniles (Bishop, et al., 1996) and compared 16-year-olds in New York, who are considered adults and prosecuted in criminal court, with 16-year-olds in nearby New Jersey, who are considered juveniles (Fagan, 1995). Using samples that were matched for age, present offense, prior offenses, and other characteristics, both studies found that juveniles sent to the adult system were almost 30% *more* likely to be re-arrested than those prosecuted in juvenile court. In addition, those prosecuted in the adult system committed new offenses sooner, and committed more serious offenses, than those in the juvenile system.

Beyond the dangers of suicides, rapes, and other assaults, adult institutions and the adult court system have even less in the way of health and mental health services for juveniles than the juvenile justice system, which, as noted above, has significant deficiencies throughout. Jails and prisons also have little or nothing in the way of recreation or exercise programs for juveniles, education or special education programs, or training for staff on the special needs of children (S Rep No 105-108, 1997). And even with respect to adult inmates, jails and prisons are notoriously inadequate. As of January 1996, prisons in 36 states were under court order or consent decree for overcrowding

and violations of civil constitutional rights of inmates (National Prison Project, 1996).

C Recommendations

- Data should be collected and analyzed throughout the country on the impact of new state transfer statutes, including demographics of youth transferred, current and prior offenses, sentences they receive, conditions in jails and prisons where transferred youth are incarcerated, and any disparate racial impact of the new laws.
- Guidelines should be developed to provide that only the most violent and unredeemable youth should be transferred to adult court, particularly in states that allow prosecutors discretion in choosing whether to proceed in juvenile or adult court.
- Juvenile facilities for transferred youth, separate from adult inmates, should be developed within the Departments of Corrections in those states that do not now have such facilities. The juvenile facilities should meet state and national standards for juvenile corrections facilities.

Medical and mental health professionals should do the following:

- Work with correctional authorities in the states and local communities to insure that juveniles in jails and prisons get adequate medical and mental health screenings at admission, full evaluations soon thereafter, and short and long-term services as needed.
- Work with the American Bar Association, which is developing standards for the conduct of transfer proceedings.
- Work with national corrections and detention organizations to develop standards for conditions, policies, practices, and staff training in adult jails and prisons holding youth.
- Visit local and state adult facilities which hold transferred youth in order to observe conditions and practices and to talk with incarcerated youth. Juvenile and adult criminal court personnel (judges, prosecutors, defenders, probation officers), state and local legislators, corrections agency commissioners, ministers, governors and mayors should be taken along on such visits with them.

- Educate local, state, and national legislators, corrections officials, governors, mayors, juvenile and adult court personnel, and other public officials on the dangers of holding youth in adult jails and prisons, and oppose any attempts to change state or federal laws to prosecute more juveniles as adults.
- Promote the development of needed mental health, educational, and other services and resources in the juvenile justice system, and advocate for less transfer of youth to the adult system.
- Help to put a human face on this problem by talking with reporters, editorial writers, colleagues, and the public about the dangers of locking up young people in adult institutions.
- Work with professional colleagues, juvenile and adult court personnel, public officials, civic and community groups, and other advocates for children to build constituencies for reform and to promote rational and effective policies.

Building a Constituency for Change

It is clear that a reasonable chance of successfully addressing the challenges discussed above will require responses with a multitude of sustained and varied strategies. In an effort to move forward effectively in these areas, the Youth Law Center has developed a major new initiative to protect minority youth in the juvenile justice system and promote rational and effective juvenile justice policies. Titled "Building Blocks for Youth," the initiative combines research on the impact of new adult-court transfer legislation in the states; assessment of the legal and policy issues in privatization of juvenile justice facilities by for-profit corporations; analyses of decisionmaking at critical points in the justice system; direct advocacy on behalf of minority youth in the system, particularly with respect to conditions of confinement and effective legal representation; constituency-building among African-American and other minority organizations, as well as

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religious, health, mental health, law enforcement, corrections, and business organizations at the national, state, and local levels; and development of effective communications strategies to provide timely and pertinent information to these constituencies. Each of these components is integral to the structure of the entire effort, and they will "build" on each other. Thus, the research, analysis of decisionmaking, and direct advocacy will all yield information and products that will support the constituency-building and communications components. In this multi-year effort, the Center will partner with a diverse coalition of organizations, including the Communications Consortium Media Center, the Juvenile Law Center, Pretrial Services Resource Center, the National Council on Crime and Delinquency, the Center on Juvenile & Criminal Justice, Minorities in Law Enforcement, and the Center for Third World Organizing. The effort will be funded by several major foundations and federal agencies ♦

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