

# Virtual Mentor

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## Policy Forum

### Health Care for Incarcerated Adolescents: Significant Needs with Considerable Obstacles

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In 1999 an estimated 717 036 juveniles were incarcerated in the United States [1]. Many youth remain in detention a short time while others convicted of serious crimes spend years incarcerated. The Juvenile Justice and Delinquency Prevention Act of 1974 mandated that youth not be housed with adults. Nonetheless, on June 30, 2000, an estimated 7600 youths were incarcerated in adult facilities [2]. Each state defines the limits of the juvenile age range as it applies to detention practices and the choice of being tried in juvenile rather than adult court.

#### Health Problems of Incarcerated Youth

Many health problems afflict detained youth. Communicable diseases, especially sexually transmissible infections, hepatitis, and positive tuberculosis testing are commonly encountered [3,4]. Although human immunodeficiency virus infection (HIV) remains low in this age group, delinquent youth engage in risky behaviors [5,6] and some are infected, [4] often asymptotically but with immune suppression. Universal HIV testing for all newly admitted youth may be wise, but debate around this issue continues because of concerns regarding coercion to agree to testing and stigmatization of HIV.

Approximately 10 percent of incarcerated girls are pregnant and 40 percent have been pregnant in the past [4]. This presents a dilemma for practitioners because of varying restrictive state laws regarding minors and abortion services as well as the individual practitioner's moral beliefs. Menstrual disorders, along with injuries [7], and orthopedic problems, gastrointestinal disorders, cancer, and dermatologic concerns also afflict these youth.

Little recent data shed any light on health screening practices of detention facilities, but in 1974 only 64 percent of juveniles were tested for TB and 53 percent for sexually transmissible infections [8]. In 33 percent of the surveyed facilities, nonmedical personnel did the screening [8].

#### Facilities

Correctional facilities can be divided into 2 large categories: local detention facilities and state-run institutions for longer-term incarceration. Detention facilities administered by local governments hold youth awaiting court decisions, ie, pre-adjudicated. These facilities are used for short-term punishment or until sentenced youth are transferred to long-term facilities. Some local governments operate camps and treatment programs such as mental health units. The states generally run long-

term institutions such as training schools or youth prisons. Some states use private group homes and prisons.

The federal government and court rulings have set minimal standards of care [9]. Each state, however, regulates the local facilities and may conduct inspections with variable oversight. The American Academy of Pediatrics and the Society for Adolescent Medicine have published position papers on care of juveniles in correctional facilities [10,11]. Voluntary accreditation by several national bodies such as the National Commission on Correctional Health Care and the American Correctional Association assures minimal standards but cannot assess actual day-to-day practices. In 2004 the NCCCHC published an updated version of *Standards for Health Services in Juvenile Detention and Confinement Facilities* [12]. For the first time they contain 7 performance measures meant to determine the actual outcomes of health services. Despite these advances there is no universal accrediting body, nor is there universal standardization of care for incarcerated juveniles in the US.

### **Funding**

Funding for medical and mental health services continues to be tenuous. Local governments and states must cover the cost of most health services because federal restrictions under 42 CFR 436.1004(a) do not allow inmates in detention centers to participate in Medicaid [13,14]. This regulation is often misinterpreted too broadly; juveniles in treatment facilities, in pre-adjudication group homes, in private facilities, and in small nonprofits may be eligible for Federal Financial Participation (FFP) [13]. Early and Periodic Screening and Diagnosis Treatment (EPSDT) funding provides payment for health screening. Private insurance often covers health care costs, especially if the care is off-site. Because local and state tax revenues are inconsistent, funding for juvenile corrections generally and for medical care specifically is unstable. However, when a person's freedom is limited, the limiting authority has a legal and moral obligation to provide medical and mental health services that meet community standards [9].

### **An Insular System**

Correctional systems by their nature are closed to outside scrutiny and can become insular and unresponsive to the concerns of the community. Added to this is a perception by some that delinquents do not deserve care or are to blame for their plight. Few effective lobbying groups speak out in support of incarcerated youth. The state of Missouri is an exception in that a group of citizens is charged by state law to advocate for incarcerated youth in the state legislature. States and local jurisdictions need to enact legislation that will give the press and appropriate citizen groups access to their detention facilities.

### **Health Care Workers**

Health care workers in these facilities face many challenges. Physical plants are often old and decaying. The health care staff may assume that the patients are difficult and unpleasant, especially if they have not been appropriately trained to deal with incarcerated youth [15]. Weak leadership, poor salaries, and onerous rules make detention health care careers undesirable. For these reasons, physicians with

inappropriate credentials are the only available caregivers in some places. Minimal rules requiring only a license to practice can result in practitioners working outside their field of expertise. Physicians employed in corrections should be trained and board certified in a primary care specialty, pediatrics, adolescent medicine, family practice, or possibly emergency medicine. Part-time employees can also create problems because of poor attendance and lack of commitment.

Many prisons are isolated, and the medical staff has little outside contact, which sometimes fosters their identification with the correctional staff and the assumption of a punitive role. A number of groups have urged affiliation with university medical systems to help maintain a focus on caring and renewal [16]. When private for-profit companies provide care they may limit access. Regardless of the size or structure of the program, the medical director should report to a health authority, not the facility correctional administrator. This prevents conflicts of interest and undue pressure to limit health care.

Other conflicts of interest exist. Medical personnel who provide care should not collect forensic evidence from youths [12], nor be involved in psychiatric or psychological evaluations regarding fitness for trial or culpability.

The medical staff's primary interest must be the welfare of each individual patient. There may also be opportunities to advocate for therapeutic rehabilitation instead of a sole institutional focus on punishment. Juvenile courts were founded to change the emphasis from retribution to rehabilitation. Recently there has been more concentration on punishment, and the medical staff should, when appropriate, act to counter this tendency.

Many systems lack relationships with outside agencies that could foster continuity of care for youths who leave detention and reenter the community. Public health departments and clinics should have arrangements to take responsibility for the care of these youth. Although probation officers may be reluctant to coordinate services, a court order can be beneficial in selective cases to ensure medical follow-up. Each system needs a quality assessment and improvement program that is administered by separate staff whenever possible. Small facilities can hire outside experts to do the reviewing. Health care programs must demonstrate meaningful improvement in health services over time.

### **Research**

Research in correctional facilities is regulated by the Code of Federal Regulations [17]. In the past, inappropriate research projects were conducted in prison. This practice led to severe restrictions on prisoner research. Although the protection of prisoners is paramount, too often overzealous interpretation of safeguards has led to an absence of research that would appropriately address the legitimate needs of prisoners. For instance, juvenile delinquents suffer disproportionately from abuse, trauma, and sexually transmissible infections. Progress in understanding these problems can only be made if research is permitted. Institution Review Boards (IRBs) that act autonomously and without proper training may be reluctant to authorize safe and

appropriate studies. The federal government needs to revisit the regulations and work to help IRB's make appropriate decisions.

Practitioners in correctional systems provide care to a vulnerable and needy population. This is a career that, though rewarding, can be filled with many ethical dilemmas and professional challenges.

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