POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

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Advocacy and Collaborative Health Care for Justice-Involved Youth

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Children and adolescents who become involved with the justice system often do so with complex medical, mental health, developmental, social, and legal needs. Most have been exposed to childhood trauma or adversity, which both contribute to their involvement with the justice system and negatively impact their health and well-being. Whether youth are held in confinement or in their home communities, pediatricians play a critical role in promoting the health and well-being of justice-involved youth. Having a working knowledge of the juvenile justice system and common issues facing justice-involved youth may help pediatricians enhance their clinical care and advocacy efforts. This policy statement is a revision of the 2011 policy "Health Care for Youth in the Juvenile Justice System." It provides an overview of the juvenile justice system, describes racial bias and overrepresentation of youth of color in the justice system, reviews the health and mental health status of justice-involved youth, and identifies advocacy opportunities for juvenile justice reform.

INTRODUCTION

In 2017, approximately 809 700 persons under the age of 18 were arrested in the United States,[1] a number that has steadily declined from the peak of nearly 2.7 million in 1996.[2] Decreases in juvenile arrests coincide with concomitant decreases in the number of confined youth. In 2017, approximately 202 900 delinquency cases involved detention,[3] a 50% decrease from the peak of 405 700 in 2005.[3] Whether detained pending the resolution of their legal case or committed to a correctional facility by a judge, most youth quickly return to their home communities. In 2017, the median time in placement was 68 days (23 days for detained youth versus 114 days for committed youth).[4] Thus, pediatricians, whether practicing in juvenile correctional facilities or in communities, may have the opportunity to care for youth involved in the justice system.

Despite improving trends in juvenile arrests and confinement, justice-involved youth continue to experience significant barriers to reaching their full potential. Barriers such as racial and ethnic bias, exposure to

abstract

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adverse childhood experiences (ACEs), and unmet physical and mental health needs continue to interfere with the optimal health and development of youth involved with the justice system. Ideally, contact with the juvenile justice system would serve as an opportunity to improve the health and developmental trajectory of youth by identifying precipitants to involvement with the justice system and implementing services to address the young person's needs. Unfortunately, for many youth, involvement with the justice system serves as nothing more than another traumatic experience. Pediatricians, as trusted child advocates, are uniquely positioned to identify and respond to the needs of justice-involved youth and their families. Whether through the provision of clinical care, participation in advocacy activities aimed at reforming the juvenile justice system, or by addressing the root causes of juvenile delinquency, pediatricians have a critical role in improving outcomes for youth involved with the justice system.

OVERVIEW OF THE JUVENILE JUSTICE SYSTEM

In the United States, most children and adolescents suspected of committing a crime are typically placed under the jurisdiction of the juvenile justice system, which is separate from the criminal (adult) justice system. Although each state, and the District of Columbia, have a unique juvenile justice system with different structures and processes, the way a delinquency case progresses through the juvenile justice system is similar among most jurisdictions.[5,6] Law enforcement and non–law enforcement sources (parents, victims, schools) may refer youth under the age of 18 to the juvenile justice system. At the time of arrest, law enforcement agencies may refer the youth for further processing within the juvenile justice system or divert the case to an alternative program outside the system, known as diversion. At or around the time of arrest, adolescents may be held in facilities pending the resolution of their case (detention). If the legal agency refers a case to juvenile court, an intake officer reviews the case and decides whether to dismiss the case, handle the case informally, or proceed to formal processing in juvenile court (petition). Formal cases in juvenile court proceed to an adjudicatory hearing (trial) in which a judge may find a young person not guilty or adjudicated delinquent (guilty). In the case of adjudication, the case progresses to a disposition hearing (sentencing) in which a juvenile court judge orders the disposition (sanctions). Juvenile court judges have a wide range of disposition options, starting with less severe options such as community service and counseling, progressing to more severe options such as intensive probation or residential placement. Residential placement is the out-of-home placement of adjudicated delinquent youth and may include group homes, residential treatment facilities, and long-term secure facilities.

Not all minors accused of breaking the law progress through the juvenile justice system. The maximum age of juvenile court jurisdiction varies between states: 45 states have a maximum age of 17 and 5 states have a maximum age of 16.[7] Additionally, all states have transfer laws that remove youth from the jurisdiction of juvenile court and place them in the jurisdiction of criminal (adult) court in certain circumstances. Transfer laws and processes vary by state and are discussed in the section of this statement on juvenile transfer laws.

States and local jurisdictions mostly administer juvenile justice systems; however, the federal government has established guidelines for minimum protections of youth involved with the justice system. The Juvenile Justice Delinquency and Prevention Act (JJDPA), first enacted in 1974[8] and reauthorized by the Juvenile Justice Reform Act of 2018,[9] maintains 4 core protections for youth involved with the justice system:

- deinstitutionalization of status offenders: juveniles who have committed an offense that would not be a crime if committed by an adult (eg, curfew violation or running away) and juveniles who are not charged with any crimes may not be placed in secure detention facilities;
- removal from adult jail: with a few exceptions, juveniles should not be held in adult jails or lockups (this provision was strengthened in 2018, and states have 3 years to comply);
- sight and sound separation: juveniles held in adult facilities should be separated from incarcerated adults by both sight and sound; and
- racial and ethnic disparities: states must implement policy, practice, and system improvement strategies to identify and reduce racial and ethnic disparities among youth who come into contact with the juvenile justice system.

States that do not comply with these core protections are not eligible to receive federal grant funding provided through the JJDPA.

YOUTH INVOLVED WITH THE JUSTICE SYSTEM

Racial and Ethnic Disparities

Despite decreases in youth arrest and confinement rates, there remain significant racial and ethnic disparities throughout the juvenile justice system. As seen in Table 1, racial and ethnic disparities exist at virtually every decision point in the juvenile justice system.

TABLE 1 Racial and/or Ethnic Disparities in the Juvenile Justice System (All Data From 2018, Unless Otherwise Specified)

	White	African American	Hispanic	AIAN	AHPI
US population <18 y,[10] %	50	14	26	1	5
Juvenile arrest relative rate (RR)[11,a]	—	2.6	Not reported[b]	1.3	0.3
Cases referred to juvenile court RR[12]	—	2.9	0.9	1.2	0.2
Cases diverted RR[12]	—	0.6	0.8	0.8	1.0
Cases detained RR[12]	—	1.4	1.5	1.3	1.2
Cases adjudicated delinquent RR[12]	—	0.9	1.1	1.1	1.0
Adjudicated cases resulting in secure confinement RR[12]	—	1.4	1.4	1.2	0.9
Cases judicially waived to criminal court[12]	—	1.6	1.0	0.9	0.9
Juvenile residential placement RR[13]	—	4.6	1.4	2.8	0.2
Decrease juveniles in residential placement 2006–2015,[14] %	54	46	45	51	65
Decline in juvenile court delinquency cases 2005–2015,[15] %	53	44	38	40	57

AIAN, American Indian or Alaskan native; AHPI, Asian American, Hawaiian, or Pacific Islander; —, not applicable.

[a] Relative rates relative to white youth.

[b] Not all agencies provide ethnicity data; thus, arrest rates for Hispanic juveniles are not reported.

Empirical explanations for racial and ethnic disparities within the justice system are commonly grouped into 2 broad conceptual frameworks: differential treatment and differential offending.[16–18] The differential treatment hypothesis[16–18] attributes racial and ethnic disparities to "inequities—intended or unintended—in justice system practices."[18] Multiple studies have demonstrated racial bias against youth of color at all decision points in the juvenile justice system (arrest, referral to court, diversion, detention, petition, adjudication, probation, secure confinement, and transfer to criminal court).[16,19] Authors of a 2018 review article[19] examined official processing of youth of color at various juvenile justice decision points from January 2001 to December 2014. The authors of that review found that 79% of studies showed that status as a person of color had some disadvantaging effect for youth processed in the juvenile justice system. The negative impact of race was especially prominent at earlier decision points in the juvenile justice system (eg, arrest, referral to court, and preadjudication detention). Conversely, the differential offending hypothesis attributes racial and ethnic disparities within the juvenile justice system to "differences in the incidence, seriousness, and persistence of engagement in delinquent and criminal behavior."[18] The differential offending hypothesis does not ascribe differences in delinquent behavior to biological or genetic differences between races or ethnicities. Instead, the hypothesis posits youth of color are more likely to experience a variety of risk factors for delinquency (poverty, low-performing schools, harsh discipline practices in schools, increased police presence in communities, exposure to violence, incarcerated parents, toxic stress, etc) and thus more likely to commit certain types of crimes.[17] Much of the research supporting this hypothesis relies on the use of official records such as arrest rates, confinement rates, and/or conviction rates. Citing empirical data from official records, which are influenced by inequities in justice system practices (eg, overpolicing of historically disenfranchised neighborhoods, racial profiling, disparate sentencing of youth of color, differential treatment in the plea-bargaining process, implicit and/or explicit bias against youth of color), may overestimate the differences in delinquent and/or criminal behaviors between racial and ethnic groups and perpetuate bias within the literature. Furthermore, more research is needed to identify how social factors more commonly experienced by youth of color mediate racial and/or ethnic disparities in the juvenile justice system.

Although helpful as conceptual frameworks, the differential treatment and differential offending hypotheses represent an oversimplification of the causes of racial and ethnic disparities within the juvenile justice system. Racial and ethnic disparities within the juvenile justice system exist within the broader context of disparities in child health and well-being. Collectively, the sources of these disparities are rooted in inequities in the social and environmental determinants of health (eg, poverty, racism) and the failure of public policies to adequately address them. Key policy statements from the American Academy of Pediatrics (AAP), "The Impact of Racism on Child and Adolescent Health,"[20] "Poverty and Child Health in the United States"[21] and "Health Equity and Children's Rights"[22] provide insight on how these inequities impact the health and development of children and adolescents and how pediatricians can respond to mitigate their impact.

Children and Adolescents Exposed to ACEs

Research has established the significant impact of childhood trauma, adversity, or ACEs on the health and well-being of children and adolescents.[23] Multiple studies have documented high prevalence rates of childhood trauma among justice-involved youth, with many studies finding that over 90% of youth in the justice system have experienced at least one form of childhood trauma.[24–26] The National Child Traumatic Stress Network found justice-involved youth experience an

average of 5 different forms of childhood trauma.[27] Sixty-two percent of youth in the National Center for Child Traumatic Stress study experienced trauma within the first 5 years of life; Table 2 identifies the different types of trauma justice-involved youth experienced in this study.

Aware of the high prevalence of trauma and cognizant that incarceration itself represents a traumatic experience, advocates have called for the implementation of trauma-informed policies, procedures, and standards across the spectrum of juvenile justice settings. In 2015, the National Child Traumatic Stress Network published the *Essential Elements of a Trauma-Informed Juvenile Justice System*,[28] a guide that educates programs working with justice-involved youth to recognize and respond to the needs of youth who have experienced trauma. A 2012 report by the US Department of Justice provides recommendations on how to incorporate trauma-informed care practices throughout the spectrum of the juvenile justice system.[29] Recommendations include the following:

- make trauma-informed screening, assessment, and care the standard in juvenile justice services;
- abandon juvenile justice correctional practices that traumatize children;
- provide juvenile justice services appropriate to children's ethnocultural background;
- provide care and services to address the special circumstances and needs of girls in the juvenile justice system;
- provide care and services to address the special circumstances and needs of lesbian, gay, bisexual, transgender, and queer and/or questioning (LGBTQ) youth in the juvenile justice system;
- develop and implement policies in every school system that aim to keep children in school rather than policies that lead to suspension and expulsion;
- guarantee that all violence-exposed children accused of a crime have legal representation;
- help, do not punish, child victims of sex trafficking; and
- whenever possible, prosecute young offenders in the juvenile justice system.

For justice-involved youth receiving care in the community, the AAP Resilience Project (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Resilience-Project.aspx) is a great resource to educate pediatricians to incorporate trauma-informed care into their practice.

TABLE 2 Prevalence of Trauma Types Among Justice-Involved Youth[27]

Trauma Type	Percentage of Youth	
	Male	Female
Traumatic loss or bereavement	59	65
Domestic violence	51	56
Impaired caregiver	48	57
Emotional abuse	46	54
Community violence	41	30
Neglect	31	30
Physical maltreatment and/or abuse	39	41
Physical assault	27	24
School violence	23	23
Serious injury or unintentional injury	20	19
Sexual maltreatment and/or abuse	16	32
Sexual assault and/or rape	9	39

Female Youth

Because of larger relative declines in the arrest rates of male youth, the proportion of justice-involved girls and young women has increased.[30] Recent data reveal that female youth accounted for 29% of youth arrests[31] and 15% of youth residential placement.[32]

Available literature suggests that in comparison with male youth, justice-involved female youth experience higher rates of trauma exposure, sexual and physical abuse victimization, and mental illness[25] and are more likely to have been involved with the child welfare system.[33]

In 2015, the Office of Juvenile Justice and Delinquency Prevention issued policy guidance aimed at improving system and programmatic responses for justice-involved female youth.[34] Key recommendations from the report include the following:

- prohibition of placement of minor sex trafficking victims in the juvenile justice system;
- development of alternatives to detention and incarceration for female youth; and
- competency of all programs and services to serve girls and young women in, or at risk of entering, the juvenile justice system.

LGBTQ Youth

Studies report LGBTQ youth compose 13% to 15% of youth in the juvenile justice system,[35–37] but this may be an underestimate because many jurisdictions do not collect information on sexual orientation or gender identity, and youth may not disclose this information because of fear of mistreatment.[35] Most research on LGBTQ youth in the juvenile justice system is focused on sexual orientation and does not include data on transgender or gender-diverse

youth. Like youth from historically disenfranchised racial and/or ethnic groups, LGBTQ youth experience more risk factors for involvement with the juvenile justice system and differential treatment within the system. LGBTQ youth experience higher rates of physical and sexual violence, familial rejection, bullying, mental health problems, and other risk factors that increase the likelihood of system involvement.[36,37] Literature suggests LGBTQ youth face bias and maltreatment across the spectrum of juvenile justice settings. One study found that LGBTQ and gender-diverse youth were more likely to be detained for truancy, warrants, probation violations, running away, and child sex trafficking.[38] Another study found LGBTQ youth reported youth-on-youth sexual victimization at a rate of nearly 7 times that of heterosexual youth (10.3% vs 1.5%).[39] Multiple reports have found LGBTQ youth in detention facilities experience increased rates of emotional abuse, physical abuse, and time in isolation.[36,37,40] The Prison Rape Elimination Act of the Juvenile Facility Standards of 2003[41] includes provisions to keep LGBTQ youth safe in detention facilities and include, but are not limited to, the following:

- staff must receive training on how to communicate effectively with LGBTQ and gender-nonconforming youth;
- facilities are required to ascertain whether youth are (or are perceived to be) lesbian, bisexual, gay, and/or transgender or gender nonconforming;
- the use of isolation and/or solitary confinement is limited; and
- case-by-case housing decisions are required for transgender and intersex adolescents.

Although the Prison Rape Elimination Act standards provide basic protections for detained LGBTQ youth, they do not set comprehensive standards that promote the overall well-being of confined LGBTQ youth. The Annie E. Casey Foundation[37] and The Equity Project provide best practices and guidance for the development and implementation of more comprehensive standards.[42]

Medical Care for Transgender Youth

Medical care for transgender youth in confinement, including access to hormone therapy, is variable. In a 2015 article, authors analyzed state statutes and department of corrections policies regarding medical services and treatment of transgender inmates and found that 13 states allow for the initiation of hormone treatment and 21 states allow for the continuation of hormone treatment; the authors were unable to identify relevant policies or statues in 10 states.[43] The 2015 National Commission on Correctional Health Care (NCCHC) position statement "Transgender, Transsexual, and Gender Nonconforming Health Care in Correctional Settings"[44] makes recommendations for the health management of transgender patients held in confinement. Recommendations include the following:

- health staff should manage transgender patients in a manner that respects their biomedical and psychosocial needs;
- the management of medical or surgical transgender care should follow accepted standards developed by professionals with expertise in transgender health;
- there should be no blanket administrative or other policies that restrict specific medical treatments; and
- transgender patients who received hormone therapy with or without a prescription before incarceration should have therapy continued without interruption.

Youth Involved With the Child Welfare System

Youth with current or past involvement with the child welfare system, often referred to as crossover or dual-status youth, are overrepresented in the juvenile justice system. Although national data are lacking and estimates vary by jurisdiction, studies reveal the prevalence of dual-status youth in the juvenile justice system commonly exceeds 50%.[45,46] When compared with youth who are not involved in both systems, dual-status youth are younger at the time of first arrest, detained more often, and have more significant mental health and educational needs.[33] The JJDPA requires states to establish polices and systems to incorporate child welfare records into juvenile justice records to establish and implement treatment plans of justice-involved youth.

MEDICAL AND MENTAL HEALTH CARE FOR CONFINED YOUTH

Confined youth have a constitutional right to adequate medical and mental health care[47,48]; however, because of the lack of clearly defined federal standards and differences in state laws regarding the provision of health care for confined youth, on-site medical and mental health care services vary widely between jurisdictions and correctional facilities.[49] States, counties, or private contractors may provide health care services for confined youth.[50] Federal law prohibits the use of Medicaid funds for inmates of a public institution,[50] and local governments (states, counties, cities) are responsible for funding health care services for confined youth.

In addition to state laws governing the provision of health care for confined youth, detention facilities may seek voluntary accreditation from the NCCHC. The NCCHC published "Standards for Health

Services in Juvenile Detention and Confinement Facilities" and provides accreditation for health services in juvenile detention facilities.[51] The AAP, American Academy of Child and Adolescent Psychiatry (AACAP), American College of Obstetricians and Gynecologists (ACOG), and the American Public Health Association support the NCCHC standards, which address 9 general areas: health care services and support, patient care and treatment, special needs and services, governance and administration, safety, personnel and training, health records, health promotion, and medical legal issues.[51] The NCCHC recommends physical, mental, and oral health screenings after admission, a comprehensive health assessment within 7 days of admission, and appropriate follow-up care. Although NCCHC accreditation is voluntary, it is important for providers in confinement facilities to be aware of these standards and juvenile correctional facilities to adopt and comply with the standards.

The 2011 AAP policy statement "Health Care for Youth in the Juvenile Justice System"[52] provided a detailed overview of the physical and mental health needs of confined youth and the provision of health care services for youth in correctional facilities. Since the 2011 policy statement, there have been few additional nationally representative studies on the health status of justice-involved youth published. The Survey of Youth in Residential Placement (SYRP) of 2010[53] remains the most comprehensive nationally representative examination of the health needs of confined youth. The SYRP found 69% of confined youth reported an unmet health care need, including injury, problems with vision or hearing, dental needs, or "other illness." The SYRP did not inquire about specific illnesses or injuries. Common health concerns for these youth include traumatic injuries, oral health needs, sexually transmitted infections (STIs), and reproductive health needs.[53,54]

Few studies have been used to examine chronic illness in incarcerated youth, and incarcerated youth may have difficulty accessing care before confinement.[52] Quality coordinated care within the justice and medical systems can identify and manage chronic illnesses during confinement. The NCCHC recommends that systems identify and enroll youth with chronic illnesses in a chronic disease management plan.[51]

Reproductive and/or Sexual Health

The 1991 NCCHC study[55] remains the only nationally representative sample evaluating the history of sexual activity and contraceptive use among confined youth. Confined youth reported higher rates of sexual activity, increased likelihood of 4 or more lifetime sexual partners, and lower rates of contraception or condom use during their most recent sexual intercourse. Multiple smaller studies have revealed similar results,[56–59] and these behaviors place justice-involved youth at risk for unintended pregnancy as well as STIs and HIV infections. It is important for adolescents to receive counseling on safe sex practices, which include barrier methods, hormonal contraception, long-acting reversible contraception, and emergency contraception, and receive timely and appropriate reproductive health care during confinement. Reproductive health care includes assessment of youth's self-reported sexual behaviors and practices, STI and HIV testing and treatment, trauma counseling, necessary emergency contraception, and counseling on all other forms of contraception as recommended by the AAP.[60] The NCCHC recommends evaluating all youth assigned female sex at birth for pregnancy risk after admission. Early pregnancy identification allows youth to consider options regarding their pregnancy and parenthood.

The 2010 SYRP revealed 13% of confined male and 5% of female youth were expecting children.[53] ACOG recommends incarcerated pregnant adolescents receive the same pregnancy care (pregnancy counseling, prenatal and perinatal care, and abortion services) as nonincarcerated adolescents.[61] A unique challenge for pregnant incarcerated women and adolescents is the use of mechanical restraints, commonly known as shackling. ACOG[62] notes that shackling interferes with the ability of the health care clinician to assess and evaluate the health of the woman and fetus and may put the health of both at risk (increased risk of falls, increased risk of venous thrombosis due to limited mobility, interference with normal labor and delivery, and interference with mother-child bonding).[61] ACOG, the American Medical Association, and many other professional organizations have called for prohibiting, or severely restricting, the use of shackles to restrain pregnant women.[62] The Juvenile Justice Reform Act of 2018 prohibits the use of restraints on pregnant women and adolescents during labor, delivery, and postpartum recovery unless there is an immediate threat of harm to self or others (states have 2 years to phase out the use of restraints).[9]

Infections

It is important for health care clinicians to give special attention to screening, immunization, and treatment of specific infections among justice-involved youth.

Tuberculosis

The NCCHC recommends screening all youth for tuberculosis after entry into the justice system unless the local health department determines the community's prevalence does not warrant screening.[51] The 2018 AAP

Red Book: 2018 Report of the Committee on Infectious Diseases outlines methods for assessing risk and screening youth for exposure.[63] The Centers for Disease Control and Prevention also provides recommendations for prevention and control of tuberculosis in detention facilities.[64]

STIs and/or HIV

Data from the Center for Disease Control and Prevention's *Sexually Transmitted Disease Surveillance 2011*[65] found confined youth have elevated rates of STIs (Table 3).

Although HIV prevalence data for confined youth are not available, the same risk factors for STIs place them at risk for HIV infection. In 2017, youth aged 13 to 24 made up 21% of all new HIV diagnoses in the United States.[66]

Routine screening, education (including safe sex practices; abstinence; and barrier, hormonal, long-acting reversible contraception; and emergency contraception), and treatment of STIs and/or HIV among confined youth may decrease the overall disease burden and improve sexual and relationship health. The NCCHC recommends STI testing (chlamydia, gonorrhea, HIV, and syphilis, of which there is significant prevalence) be offered to all youth within 48 hours of arrival.[51]

Immunizations

There is a lack of nationally representative data regarding the immunization status of confined youth, but facility-level data suggest they have significantly lower immunization coverage rates. In a study of one juvenile detention facility in California, authors found only 3% of adolescents had received all recommended immunizations before their first detention.[67] Barriers to full immunization coverage among justice-involved youth may include poor access to health care and lack of a medical home before confinement.[67]

Although immunization requirements for confined youth vary between jurisdictions, confinement may be an opportunity for justice-involved youth to receive immunizations. Studies have revealed that detention and/or secure placement of youth may be associated with higher immunization coverage rates.[67,68] Implementing routine immunization policies in juvenile detention facilities may increase immunization coverage for confined youth. Use of state immunization registries can help determine necessary immunizations.

Mental Health Disorders

Although estimates vary, the prevalence of mental health disorders among justice-involved youth commonly ranges from 50% to 80%.[69–73] Common mental health disorders include depressive disorders, anxiety disorders, disruptive behavior, attention-deficit/hyperactivity disorder, posttraumatic stress disorder, and substance use disorders.[69]

The variable data on the prevalence of mental health disorders among juvenile justice-involved youth are indicative of the limitations of the studies in the literature (use of nonstandardized measures, different diagnostic tools, measurement at different levels of the juvenile justice system, and data specific to individual facility or state). Furthermore, the high prevalence of mental health disorders is interconnected with the high prevalence of trauma and ACEs found in this population.[74,75] Most justice-involved youth experience trauma and polyvictimization from a young age. These experiences, and resulting toxic stress response, may result in maladaptive behaviors such as increased stress reactivity, impulsivity, hyperarousal, and decreased ability to self-regulate.[76] Youth who have experienced multiple traumatic events are at increased risk of delinquency, contact with law enforcement, involvement with the juvenile justice system, school suspension and dropout, volatile relationships, and substance use.[77] Polyvictimized youth are also more likely to receive diagnoses of externalizing disorders such as conduct disorders, oppositional defiant disorder, and antisocial behaviors.[72,78] There is increasing recognition that for many youth, these diagnoses may be rooted in complex trauma and polyvictimization.[79,80]

Substance Use

As illustrated in Table 4, the prevalence of substance use in confined youth exceeds that of the general adolescent population. However, it is important to consider that for many justice-involved youth, substance use may be the instigating factor of their arrest or confinement.

Recognizing the high prevalence of mental health disorders and substance use among justice-involved youth and the lack of appropriate care in many juvenile facilities, many jurisdictions have implemented programs (ie, mental health courts, substance abuse courts) aimed at providing community-based alternatives to detention for those with mental health and/or substance use disorders.[33] Several diversion programs are effective at decreasing recidivism and/or improving

TABLE 3 STI Rates Among Adolescents Aged 12–18 Years in Juvenile Correction Facilities, 2011 (Last Year Data From Juvenile Correctional Facilities Were Included)

Disease	Overall Positivity, %	
	Female	Male
Chlamydia	15.7	7.4
Gonorrhea	4.4	1.2

TABLE 4 Prevalence of Substance Use Among Confined Youth and the General Adolescent Population

Substance	Lifetime Prevalence Among Confined Youth,[53,a] %	Lifetime Prevalence at Grade 12, General Population, 2018,[81,b] %
Alcohol	74	59
Marijuana or hashish	84	44
Cocaine/crack	30	4/1.5
Ecstasy	26	4
Methamphetamine	22	0.7
Acid/LSD	19	5
Heroin	7	0.8
Any illegal drug (excluding marijuana)	50	19

LSD, lysergic acid diethylamide.

[a] Self-reported data from the SYRP, a nationally representative sample of 7073 youth in custody in 2003.

[b] Self-reported data from the Monitoring the Future National Survey on Drug Use.

behavioral health outcomes in justice-involved youth[82]; however, there is significant variability in the design and implementation of these programs, leading to limitations in studying their collective impact.[82] Further studies to identify eligible youth and effective diversion services and programs may improve outcomes in justice-involved youth.

Screening and Assessment for Mental Health and Substance Use Disorders

NCCHC standards recommend screening all confined youth for current or past mental illness and legal and illegal drug use at the time of arrival to the facility.[51] A 2014 survey[83] of juvenile facilities across the United States found 88% of facilities screened all or some youth for substance use and 99% of facilities reported screening all or some youth for mental health needs. Generally, mental health screening involves nonclinical staff using a standardized screening tool.

On-site Psychiatric Care and Psychotropic Medications

The decision to initiate or change medical treatment of psychiatric disorders in confined youth is challenging. The AACAP published recommendations for mental health assessment and treatment of youth in the correctional system.[84] The AACAP recommends psychotropic medications only be used as part of an individually developed comprehensive treatment plan. To ensure treatment can proceed in a safe and supervised fashion, AACAP guidance recommends determining the youth's legal disposition and placement before initiating or changing medication regimens.[85]

National data are lacking on the use of psychotropic medications for justice-involved youth; however, state- and facility-level data suggest these youth receive psychotropic medications at a higher rate than the general adolescent population. In an analysis of juvenile facilities in 55 California counties, authors found the average proportion of youth receiving psychoactive medication was 17%.[86] In a study of 668 youth in 3 detention facilities in 1 state, authors found that 10% had psychotropic medication dispensed within 1 month of intake.[87] In comparison, from 2005 to 2010, 6% of adolescents reported use of psychotropic medication within the past month.[88]

Suicide and Suicidality

Studies consistently demonstrate justice-involved youth are at increased risk for suicidal thoughts and behaviors. In a longitudinal study of 1829 youth detained at 1 facility over a 3-year period, authors found 36% had ever felt like life was hopeless, 10% had thought about killing themselves in the past 6 months, and 11% had attempted suicide in the past.[89] In a 2015 literature review, authors found that 19% to 32% of justice-involved youth had suicidal ideations in the past year and 12% to 16% had attempted suicide in the past year.[90]

The 2014 Juvenile Residential Facility Census (JRFC) found that suicide was the most common cause of death for youth in residential placement.[83] From 2000 to 2014, there was an average of 7 suicides per year in juvenile detention facilities across the United States.

The JRFC report found that 93% of reporting facilities screened some or all youth for suicide risk. Available studies indicate facilities with annual suicide prevention training and suicide risk screening shortly after admission reported lower suicide rates.[91,92] Only one-fifth of facilities had the 7 key components deemed necessary for suicide prevention.[91,93] These components include written protocols, intake screening, suicide prevention training, safe housing, observation, mortality review, and cardiopulmonary resuscitation and certification.

Informed Consent and the Right to Refuse Care

According to NCCHC standards, "all examinations, treatments, and procedures are governed by informed consent practices for juvenile care that are applicable in the jurisdiction. A juvenile may refuse specific health evaluations and treatments in accordance with the laws in the jurisdiction."[51] NCCHC standards also state that youth may not be punished for refusing medical or mental health treatment.[51]

Continuity of Care

It is ideal for justice-involved youth to receive comprehensive and coordinated physical and mental health care during confinement and in their communities. Barriers to such

care include lack of preventive care in the community, lack of an established medical home, and disruptions in Medicaid or Children's Health Insurance Program coverage. Federal law prohibits the use of Medicaid funds for inmates of a public institution.[94] As a result, many jurisdictions terminate Medicaid eligibility at the time of entry into secure detention facilities.[94] In 2018, Congress passed legislation prohibiting states from terminating Medicaid eligibility for incarcerated juveniles.[95] States may suspend Medicaid coverage during incarceration, but before release, they must conduct a redetermination of eligibility and restore coverage, if eligible. States remain prohibited from using Medicaid to cover incarcerated juveniles.

Identifying and connecting youth with a medical home before release may have long-term benefits to their overall health and well-being. Winkelman et al[96] showed that youth with any justice involvement (detained, paroled, probation, or arrest) were more likely to have an emergency department (ED) visit in the last year compared with youth not involved with the justice system. Similarly, justice-involved youth are more likely to be hospitalized than their peers, and their use of the ED and inpatient services, as measured in person-years, is significantly higher than that of youth not involved with the justice system.[96] Use of the ED and increased hospitalization days by justice-involved youth may contribute to increased health care costs and represents an opportunity to improve the continuity of care for these youth once they return to their communities. It is ideal for these youth to be connected to medical homes and pediatricians who are prepared to address their needs.

Continuity of care starts at the time of admission to the facility. If the youth already has a primary care provider (PCP), it is crucial for the medical staff to contact the PCP to verify previous diagnoses and treatment(s).[97] For cases in which the youth does not have a PCP, medical staff can provide resources to establish primary care. Providing summaries of medical care for the PCP, appropriate subspecialists, or mental health specialists at the time of release to the community is also important. Additionally, detention facilities and jurisdictions can establish policies and procedures that ensure eligible uninsured youth are enrolled in Medicaid or the Children's Health Insurance Program before release from detention and have access to health care coverage as they reenter their home communities.[98,99]

DEVELOPMENTALLY APPROPRIATE CONFINEMENT FACILITIES

Conditions of Confinement

Youth may be confined in a variety of confinement facilities (short-term detention facilities, long-term secure facilities, camps, residential treatment facilities, etc); however, most are confined in locked facilities, many of which resemble adult jails and prisons in form and function (restricted by gates, fences and locked doors, regular use of restraints such as handcuffs and shackles, locking youth in their room for sleep and/or punishment, use of punitive discipline strategies, etc). For youth with a history of trauma, confinement in such facilities may exacerbate symptomatology related to trauma.[100] The trauma of confinement extends beyond the physical environment. Since 2000, systemic abuses of confined youth have been documented in 29 states.[101] Thirty-eight percent of confined youth fear being physically attacked, 50% report detention staff applies punishments without cause, and 33% report the use of unnecessary force.[101] In 2017, the National Council of Juvenile and Family Court Judges passed a resolution urging states to establish independent monitoring systems (independent bodies responsible for receiving and investigating complaints) for confined youth, with a special focus on the use of isolation, use of mechanical restraints, use of force, access to programming, levels of violence, and access to families.[102] Several jurisdictions have implemented independent monitoring systems for confined youth.[103] The Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative provides guidance and technical assistance for jurisdictions interested in monitoring and improving conditions of confinement.[104]

Isolation and Solitary Confinement

Solitary confinement is "the involuntary placement of a youth alone in a cell, room, or other area for any reason other than as a temporary response to behavior that threatens immediate harm to the youth or others."[105] While in isolation, youth may be denied access to educational material, detention facility programming, recreational activities, and contact with family.[106]

Nationally representative data suggest the use of isolation and solitary confinement is common in juvenile detention facilities. The JRFC found 47% of juvenile detention centers reported locking youth in a room for 4 or more hours within the previous month.[83] The SYRP found 35% of youth reported being held in isolation or solitary confinement.[53] Of those held in isolation, 55% reported being held for more than 24 hours.[53] These reports may understate the use of juvenile isolation and solitary confinement because they do not include youth in adult facilities.

The negative effects of solitary confinement on adults are well documented and may include anxiety, depression, impaired memory, hallucinations, suicidal thoughts, anger, psychosis, paranoia, heart

palpitations, headaches, abdominal pain, and insomnia.[107] The 2009 "Juvenile Suicide in Confinement: A National Survey" highlights this vulnerability.[108] In this report, the authors examined 110 juvenile suicides occurring between 1995 and 1999 and found 62% of suicide victims had a history of room confinement, and 51% were on room confinement status at the time of their death.

In 2016, the US Department of Justice issued guiding principles on the use of isolation and solitary confinement and recommended against the use of isolation and solitary confinement in juveniles, stating, "In very rare situations, a juvenile may be separated from others as a temporary response to behavior that poses a serious and immediate risk of physical harm to any person. Even in such cases, the placement should be brief, designed as a 'cool down' period, and done only in consultation with a mental health professional."[109] In 2018, Congress passed legislation prohibiting the use of room confinement (except as a temporary response for juveniles who pose a serious and immediate risk to themselves or others) for youth in federal facilities.[110] There are few juveniles in federal detention centers, and nonfederal detention centers are not obligated to adhere to these principles.

Many states have passed legislation aimed at restricting or eliminating juvenile isolation. A 2016 analysis by the Lowenstein Center for the Public Interest found that 29 states or jurisdictions prohibit the use of punitive solitary confinement in juvenile detention facilities, 15 states impose time limits on the use of punitive solitary confinement, and 7 states place no limits to the use of solitary confinement.[111] In 2016, the AAP endorsed the United Nations position and the AACAP policy statement on solitary confinement of juvenile offenders and opposed the use of solitary confinement for juveniles in correctional facilities.

Many organizations have developed tools to reduce the use of isolation in juvenile confinement. The Council of Juvenile Correctional Administrators published a tool kit[112] outlining steps to reduce the use of isolation and recommendations to use alternative behavior management options and responses. These options may include cognitive behavioral therapy, dialectical behavior therapy, collaborative problem solving and trauma-informed care, and de-escalation training for juvenile correctional employees, workers, and/or officers.

Educational Needs

Youth involved with the justice system often present with significant educational challenges. The SYRP[53] found that 24% of youth reported they were not enrolled in school at the time they entered custody, 61% had been expelled or suspended, and 48% reported being below the level expected for their age. Learning disabilities are more common among youth in custody, with reported rates as high as 30%.[53]

Despite increased educational need, available data suggest confined youth receive inadequate educational support. A 2016 report from the US Department of Education Office for Civil Rights[113] found the number of hours and days of educational programming varies widely between facilities, teachers working in confinement facilities are more likely to be absent, and confinement facilities are less likely to offer essential math and science courses. The US Department of Education and Department of Justice developed guiding principles for the provision of high-quality education in juvenile justice secure settings.[114]

In multiple studies, authors have documented that youth with intellectual and developmental disabilities are overrepresented in the juvenile justice system. Although there is variance between sites, the estimated national average prevalence of intellectual and developmental disabilities in confined youth is 33%.[115] Confined youth with intellectual and developmental disabilities have the same rights under the Individuals with Disabilities Education Act as nonconfined youth and are entitled to individualized education programs and special education services.[115] The National Center on Criminal Justice and Disability provides recommendations for preventing involvement of adolescents with intellectual and developmental disabilities in the justice system and improving the delivery of special education services for confined youth.[116]

JUVENILE JUSTICE REFORM AND OPPORTUNITIES FOR ADVOCACY

Community-Based Interventions and Alternatives to Youth Confinement

Over the last 2 decades, advances in social, developmental, and neurologic sciences have transformed our understanding of health and well-being across the life course. It is recognized that trauma, adversity, and ACEs are associated with a maladaptive stress response, changes in brain architecture, and poor physical, mental, and behavioral health outcomes.[23,26] Advances in neuroscience and neuroimaging have demonstrated numerous structural and functional changes in the brain occur during the period of adolescence.[117] These changes may be associated with impulsive, risk-taking, and reward-seeking behaviors that may make adolescents more likely to interact with the justice system.

This evolving knowledge has contributed to the development and

implementation of community-based alternatives to incarceration that are more appropriate for the unique developmental needs of justice-involved youth. Numerous reports have highlighted shortcomings associated with the incarceration of juveniles in the United States. The Annie E. Casey Foundation's *No Place For Kids: The Case for Reducing Juvenile Incarceration* argues that juvenile incarceration is dangerous (documented cases of physical and sexual abuse), ineffective (does not decrease involvement in delinquent behaviors), unnecessary (only 26% of youth confined in residential facilities committed a violent offense), obsolete (community-based alternatives have been demonstrated to reduce recidivism), wasteful (in 2008, an estimated $5 billion was spent on juvenile incarceration), and inadequate (deficient in mental health treatment, substance use treatment, educational programming, and transitional support and often retraumatizes youth).[118]

Many jurisdictions responded to these concerns by implementing reforms (diversion programs, mentor programs, implementation of the Juvenile Detention Alternatives Initiative, etc)[118,119] aimed at reducing the rate of juvenile incarceration and improving outcomes for justice-involved youth. The Juvenile Detention Alternatives Initiative is one available resource and tool that provides training and technical assistance to jurisdictions interested in reforming their juvenile justice systems. Examples of community-based alternatives to detention and secure confinement include day and evening reporting centers (providing youth with supervision and programming during the day and/or evening), electronic monitoring, home- or community-based detention, and intensive family treatment models such as multisystemic therapy, functional family therapy, and multidimensional foster care.[118,119]

The Office of Juvenile Justice and Delinquency Prevention[120] advocates for a comprehensive strategy of supporting the adolescent's family and engaging core institutions, such as schools, businesses, and religious organizations, to help develop mature and responsible youth. The strategy of delinquency prevention is the most effective approach while recognizing the need for graduated sanctions to protect the community. The best prevention involves targeting risk factors for delinquency, such as ACEs, childhood trauma, 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.[17,29,118–120]

Overall, there is growing evidence that for many youth, community-based alternatives to incarceration are more effective options than confinement.[118,119] This evidence and overall reductions in youth crime have contributed to significant decreases in the rate of juvenile confinement in the United States.

Juvenile Transfer Laws

Juvenile transfer laws govern the relocation of juvenile cases to adult court. Current juvenile transfer laws were created largely as a result of state legislative actions during the 1980s and 1990s, triggered by a rise in youth crime and intense media focus on juvenile crime during that period.[121] States responded by enacting legislation that automatically placed juveniles in the jurisdiction of the adult court for certain offenses or gave prosecutors discretion to place juveniles in adult court. Although juvenile crime rates have steadily decreased since the mid-1990s, many of the juvenile transfer laws of this era remain in effect.[121]

Although legislators enacted these laws as a deterrent to juvenile crime, evidence suggests that juvenile transfer laws have little or no effect on general juvenile crime rates.[122] Additionally, compared with youth in the juvenile court system, recidivism rates were higher for juveniles with cases in adult criminal court. Recidivism rates were higher particularly for violent offenders.[122] Proposed explanations for increased recidivism rates among youth tried in criminal court include the stigma of having a felony criminal record, less focus on rehabilitation in the adult criminal justice system, and sense of resentment among youth tried and punished as adults.[122]

Currently, all states have transfer laws that allow juvenile offenders to be prosecuted in adult court. The 4 types of transfer laws[7] are as follows:

- statutory exclusion: specific crimes are automatically transferred to adult court;
- judicially controlled transfer: all juvenile cases begin in juvenile court and must be transferred to adult court by the juvenile court;
- prosecutorial discretion: also known as "direct file," prosecutors may choose to file in adult or juvenile court; and
- once an adult, always an adult: once a juvenile has been prosecuted in adult court, all future cases go to adult court.

Juveniles prosecuted in adult court may be confined in adult detention facilities. Juveniles in adult prisons report learning more criminal behavior from adult inmates, fear of victimization, and being least likely to say they would not reoffend. Juveniles in adult facilities, compared with those in 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.[123]

Reform efforts have focused on changing the ways in which juveniles may be transferred to adult court. Advocates argue that statutory exclusion and prosecutorial discretion may limit the juvenile court's ability to provide the most appropriate sanctions for youth. There is also concern that prosecutors may use the threat of adult sanctions to coerce youth to accept plea bargains to avoid longer sentences. Several states have successfully enacted legislation limiting the transfer of juveniles to adult court.[123] For example, in 2012, Colorado enacted legislation limiting juvenile transfer to adult court, allowing for judicial review for all juvenile cases and adding juvenile sentencing provisions to convictions in adult court. In the 5 years after this legislation, Colorado saw a 78% reduction in direct file cases and a 99% reduction in adult jailing of juveniles.[124]

Life Without Parole and Death Penalty

Over the last 15 years, the US Supreme Court issued several decisions limiting extreme sentences for juvenile offenders declaring unconstitutional capital punishment of individuals who committed crimes as a juvenile (under age 18)[125] and abolishing mandatory life without parole sentences for crimes committed as a juvenile; however, it is still permissible to impose life without parole sentences for juveniles after judicial consideration of individual case circumstances.[126] The United States is the only country in the world that sentences juveniles to life without the possibility of parole.[127] Extensive advocacy efforts, including litigation, media campaigns, and legislative advocacy are underway with goals of abolishing juvenile sentences of life without parole in the United States.[128]

Minimum Age of Juvenile Court Jurisdiction

The minimum age of juvenile court jurisdiction is the youngest age at which a child may be referred to a juvenile court for a delinquent act. At the time this policy was written, only 21 states had a minimum age standard, varying from 6 to 11 years of age.[129] In 2017, approximately 29 779 children younger than 12 years were referred to juvenile court, and 3375 were held in detention.[130] Article 40 of the United Nations Convention on the Rights of the Child decrees governments establish "a minimum age below which children shall be presumed not to have the capacity to infringe the penal law"[131] and specified that this age be no younger than 12 years.[132] Many advocates have called for the establishment of state and/or federal laws that set the minimum age of criminal responsibility at no younger than 12 years.[133]

Fines and Fees in the Juvenile Justice System

Juvenile courts throughout the country regularly impose costs that may include court costs, fees for a public defender, probation supervision fees, child support to the state, cost of Global Positioning System monitoring, cost for participation in diversion programs, health care costs, and fines.[134] Low socioeconomic status is a well-established risk factor for involvement with the juvenile justice system, and imposition of such costs may place an undue burden on justice-involved youth and their families.[17] Furthermore, inability or failure to pay these costs may lead to significant consequences for justice-involved youth, including civil judgment, extension of probation, violation of probation, incarceration, suspension of driver's license, ineligibility for expungement, and imposition of additional fees.[135]

Access to Legal Representation

Children and adolescents accused of crimes have a constitutional right to legal counsel regardless of their ability to pay.[136] However, youth may encounter many barriers to obtaining adequate legal representation. An analysis by the National Juvenile Defender Center[137] found the following:

- only 11 states have a presumption that youth are automatically eligible for an attorney irrespective of financial status;
- no states guarantee lawyers for youth during interrogation; and
- 43 states allow youth to waive their right to a lawyer without first consulting a lawyer.

Youth without adequate access to legal representation throughout their involvement in the justice system may not fully understand their rights and may be influenced to make decisions that are not in their best interest. Recommendations made by the National Juvenile Defender Center[137] include making all youth eligible for a publicly funded juvenile defender, appointing youth a lawyer before interrogation and well in advance of the first court hearing, and prohibiting waiver of counsel until youth have the chance to consult with a lawyer.

Empowerment of Justice-Involved Youth

Decades of research have been conducted on risk factors for juvenile delinquency, protective factors, and outcomes for justice-involved youth; however, until recently, the voices of justice-involved youth have been largely absent from juvenile justice research and policy.[138] Justice-involved youth are the experts of their lived experience and have unique insight into the strengths and weaknesses of the juvenile justice system. Justice-involved youth have

demonstrated that when given the opportunity, they can provide both insight into the root causes of juvenile delinquency and offer recommendations for improvement of the juvenile justice system.[138,139]

RECOMMENDATIONS

The following recommendations are provided for caring and advocating for justice-involved youth and their families.

Delivery of Care

- Confined youth should receive the same level and standards of medical, oral, mental health, and substance use care as nonconfined youth accessing care in their communities. Pediatricians should ensure that confidential health care is practiced in accordance with state and local laws, even in correction health clinics.
- All juvenile correctional facilities should adopt and comply with the NCCHC's "Standards for Health Services in Juvenile Detention and Confinement Facilities."
- Facilities should provide youth who are confined for more than 1 week comprehensive preventive services, including a comprehensive history and physical examination; mental health and substance use screening; dental screening; vision screening; pregnancy screening with options counseling; the full range of contraception, including emergency contraception; vaccines; STI and/or HIV testing; adequate pregnancy care; and management of chronic health conditions. Care should be affirming and appropriate for all youth, including those who identify as LGBTQ.
- Consistent with NCCHC recommendations, transgender youth who received hormone therapy before incarceration should have therapy continued without interruption, absent urgent medical reasons to cease treatment.
- All juvenile facilities should implement a comprehensive suicide prevention program that includes ongoing suicide risk assessment.
- Whenever possible, the pediatrician from the medical home should be notified when an adolescent is admitted and discharged from a detention facility. In cases in which confined youth do not have a pediatrician, efforts should be made to establish care in a medical home.
- Strict limits should be placed on the use of restraints for pregnant and hospitalized adolescents.
- Incarcerated youth should maintain eligibility for their existing health insurance benefits. If insurance eligibility is terminated or suspended during confinement, it should be reinstated before release. Eligible uninsured youth should be enrolled in Medicaid while incarcerated.
- Legislation repealing the Medicaid inmate exclusion policy should be supported, thus allowing Medicaid coverage for incarcerated children and adolescents.

Developmentally Appropriate Confinement Facilities

- Children and adolescents should be detained or incarcerated only in facilities with developmentally appropriate programs with staff who are trained to deal with their unique mental health, social, educational, recreational, and supervisory needs and should not be detained in adult facilities.
- Detention facilities and juvenile justice systems should implement a trauma-informed approach that responds to the needs of justice-involved youth and their families.
- Consistent with recommendations of the US Department of Education and Department of Justice, education in confinement facilities should be provided in "a safe, healthy facility-wide climate that prioritizes education, provides the conditions for learning, and encourages the necessary behavioral and social support services that address the individual needs of all youths, including those with disabilities and English learners."[114]
- Use of isolation and solitary confinement for children and adolescents should be prohibited.
- Because of documented cases of systemic and recurring maltreatment of confined youth, jurisdictions should establish independent oversight entities for youth confinement facilities.
- Confinement facilities should recognize and respond to the unique needs of justice-involved female youth, LGBTQ youth, and youth with chronic medical, mental health, and developmental needs.

Advocacy and Juvenile Justice Reform

Many opportunities exist for pediatricians to advocate for juvenile justice reform. Pediatricians can work with the AAP chapter in their state, justice-involved youth and their families, the juvenile justice sections of their state judiciary and bar, state and local governmental officials, detention facilities, and community organizations serving justice-involved youth. Although key issues may vary between jurisdictions, priority targets for juvenile justice reform may include the following recommendations:

- Incarceration of adolescents is a last resort and only for offenders who have committed serious crimes and cannot be safely placed in a community-based program.
- Support research and advocacy efforts aimed at eliminating racial and ethnic disparities within the justice system. Research and

advocacy efforts should include an examination of racial and/or ethnic bias throughout the justice system and focus on delinquency prevention by mitigating the impact of interpersonal and structural racism.

- Support legislation that establishes a minimum age of (at least) 12 years for criminal responsibility under which a person may not be charged with a crime.
- Support legislation abolishing sentencing of adolescents to life without the possibility of parole.
- Support legislation reducing and/or eliminating the imposition of fees and fines for justice-involved youth and their families.
- Support legislation ensuring all justice-involved youth receive adequate and timely legal representation.
- Advocate for adolescents to be prosecuted in the juvenile justice system. Transfer to the adult court should occur only after judicial review. A youth's mental health status and exposure to trauma, adversity, and ACEs should be considered as mitigating factors.
- Advocate for research to identify risk factors for involvement with the justice system, protective factors, outcomes for incarcerated youth, and effectiveness of community-based alternatives to incarceration and use resulting data to make evidence-based juvenile justice policy reforms.
- Engage justice-involved youth and families as advocates for juvenile delinquency prevention and juvenile justice reform.

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ABBREVIATIONS

AACAP: American Academy of Child and Adolescent Psychiatry
AAP: American Academy of Pediatrics
ACE: adverse childhood experience
ACOG: American College of Obstetricians and Gynecologists
ED: emergency department
JJDPA: Juvenile Justice Delinquency and Prevention Act
JRFC: Juvenile Residential Facility Census
LGBTQ: lesbian, gay, bisexual, transgender, and queer and/or questioning
NCCHC: National Commission on Correctional Health Care
PCP: primary care provider
STI: sexually transmitted infection
SYRP: Survey of Youth in Residential Placement

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