Juvenile Incarceration and Health

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ABSTRACT

Addressing the health status and needs of incarcerated youth represents an issue at the nexus of juvenile justice reform and health care reform. Incarcerated youth face disproportionately higher morbidity and higher mortality compared to the general adolescent population. Dental health, reproductive health, and mental health needs are particularly high, likely as a result of lower access to care, engagement in high-risk behaviors, and underlying health disparities. Violence exposure and injury also contribute to the health disparities seen in this population. Further, juvenile incarceration itself is an important determinant of health. Juvenile incarceration likely correlates with worse health and social functioning across the life course. Correctional health care facilities allow time for providers to address the unmet physical and mental health needs seen in this population. Yet substantial challenges to care delivery in detention facilities exist and quality of care in detention facilities varies widely. Community-based pediatricians can serve a vital role in ensuring continuity of care in the postdetention period and linking youth to services that can potentially prevent juvenile offending. Pediatricians who succeed in understanding and addressing the underlying social contexts of their patients' lives can have tremendous impact in improving the life trajectories of these vulnerable youth. Opportunities exist in clinical care, research, medical education, policy, and advocacy for pediatricians to lead change and improve the health status of youth involved in the juvenile justice system.

KEYWORDS: adolescent health; juvenile incarceration; juvenile offenders; underserved populations

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IMPROVING THE HEALTH of incarcerated youth represents an issue at the intersection of juvenile justice reform and health care reform. Currently, bipartisan support for promoting the health of youth involved in the juvenile justice system is creating a policy window that coincides with public readiness to address the epidemic of juvenile incarceration.[1] The juvenile justice system, established in the 1900s to protect, guide, and offer treatment in the "best interest" of the child, has increasingly taken a punitive approach toward delinquent youth. This trend heightened in the 1980s and 1990s, when many punitive statutes were enacted.[2,3] Largely in response to the get-tough approach of this era, juvenile justice reformists have increasingly advocated for decriminalization and diversion of nonviolent juvenile offenders to community-based treatments and other alternatives to incarceration, arguing that institutionalization harms youth and is costly.[2,3] Many politicians, law enforcement personnel, legal advocates, and business leaders have begun to make changes on behalf of these vulnerable youth. It is important that pediatricians also embrace the population of justice-involved youth as doing so signifies an opportunity to promote the health of highly vulnerable children. To empower and guide pediatricians in responding to juvenile incarceration, we address 5 fundamental questions: 1) What type of youth are incarcerated and how does the process work? 2) What are the health needs of incarcerated youth? 3) What are the roles of community and academic pediatricians in preventing incarceration and in caring for justice-involved youths? 4) What is the state of health care in juvenile detention facilities? 5) What are the clinical, research, medical education, policy, and advocacy priorities for promoting the health of youth involved in the juvenile justice system?

INCARCERATED YOUTH AND THE JUVENILE JUSTICE SYSTEM

DEMOGRAPHICS

With 2 million youth arrested annually in the United States and 60,000 detained, justice-involved youth represent a large, high-risk, vulnerable population largely hidden from public view.[4,5] The rate of youth confinement peaked in 1995. It has steadily declined since then, mainly as a result of lower arrest rates and to changes in local and state approaches toward nonviolent youth offenders.[6] Nevertheless, the United States still incarcerates a higher proportion of youths than any other developed country.[6]

Significant disparities by race/ethnicity and class exist. African American adolescents are 5 times more likely and Latino and American Indian youth 3 times more likely to be incarcerated compared to white adolescents.[4] In 2003, black youth comprised 38% of all detained youth.[5] Incarcerated youth often come from highly disadvantaged backgrounds. These youth often have high rates of exposure to adverse childhood experiences (ACEs) and limited financial resources.[7] Many live in high-crime neighborhoods. This increases incarceration risk and creates a socioeconomic disparity that is accentuated for black and Hispanic youth.[8,9] These inequities perpetuate cycles of mass incarceration seen in many disadvantaged communities.[9] Each time a youth is incarcerated, he or she has a higher risk of recidivism. Within 3 years of release, 75% of adolescents are rearrested.[6]

Detention Process

Youth enter the juvenile justice system upon arrest or through referrals to the juvenile courts made by parents, schools, or probation officers. In 2012, approximately 5% of juvenile arrests were for violent crimes, including murder, forcible rape, and aggravated assault; 22% were for nonviolent property crimes such as theft or arson; and the majority of other crimes were for low-level, nonviolent offenses such as alcohol or marijuana use.[10] Through zero-tolerance school policies, infractions such as truancy are more likely to lead to suspension, expulsion, and arrest. This approach is under scrutiny for exacerbating the school-to-prison pipeline, whereby disadvantaged and minority youth are systematically transitioned from the educational system to the criminal justice system.[9] Proposed reforms include moving toward decriminalization and diversion for low-level, nonviolent offenders, with an emphasis on community-based supervision and treatment, when appropriate.[3]

In the current system, after arrest, youth await a court hearing. While awaiting trial, they are placed in detention or, if determined safe by police, may be returned home. A youth who is found guilty will be handled by one of several options: he or she is placed on house arrest; is ordered to serve time in a residential facility, such as a juvenile hall, camp, ranch, or group home; or is diverted to management outside of the court system (eg, to community-based treatment programs). Once released to home, youth remain on probation and under court supervision for a court-specified period of time.[11]

Costs of Juvenile Incarceration

US taxpayers spent $5 billion in 2008 to confine youth in the juvenile justice system.[12] The average direct cost to states of confining a single young person is estimated at $241 per day. The average length of stay for a youth in confinement typically ranges between 3 and 4 months.[13] Following from this, the average cost for confinement is approximately $21,690 to $28,120 per youth per stay. Indirect costs must also be considered. In one report, economists estimate the indirect long-term costs of juvenile incarceration to US taxpayers at $8 to $21 billion per year when considering the cost of recidivism (including later involvement in the adult criminal justice system); unemployment and lost future earnings; lost future government tax revenue; additional health care expenditures in Medicare and Medicaid; and cost of sequelae of sexual assaults that may occur during confinement.[14] Incarceration among adult men has been shown to reduce hourly wages by 11% and annual earnings by 40%.[15] In contrast, the monetary benefit to society of saving a single high-risk 14-year-old from a life of crime is estimated at $2.6 to $5.3 million.[16]

Health and Juvenile Incarceration

Health and Incarceration Across the Life Course

Complex relationships exist between juvenile incarceration and health. The racial/ethnic and socioeconomic disparities present in the juvenile justice system may partially explain the worse health status seen among incarcerated youth compared to the general adolescent population.[17] Minority youth face significant health inequities that may be exacerbated by the immediate and long-term health consequences of incarceration.[19] For example, high rates of unmet mental health needs among minority youth may increase incarceration risk, lead to an exacerbation of symptoms during incarceration, and alter youths' ability to socially reintegrate after confinement.[8,17] Given the relatively high prevalence of incarceration among youth of color, the health of young black and Hispanic boys has become inextricably linked with the cycles of mass incarceration prevalent in many of their communities.[9]

Incarceration may have some health benefits, mainly because individuals have access to care while in detention and are separated from dangerous environments. However, juvenile incarceration is associated with poor adult health outcomes, including substance use, early mortality, and worse social functioning.[19] Recent studies suggest strong causal associations between youth incarceration and adult health outcomes, including worse general health and higher rates of functional limitations.[18,20,21] Proposed mechanisms include heightened exposures to infectious diseases, trauma in detention facilities, and social barriers present after detention related to social stigma and social isolation.[19] Racial/ethnic disparities in access to health care and the high prevalence of minority youth in the juvenile justice system may reinforce the relationship between juvenile incarceration and health. The school-to-prison pipeline creates disparities in the educational and juvenile justice systems that likely have detrimental effects on health.[22]

Risks for juvenile incarceration may begin as early as gestation and act across an individual's entire life.[23] Many of these risks relate to experiences of childhood adversity. As many as 93% of youth entering the juvenile justice system report having experienced at least 1 circumstance in their lives that could be considered an ACE.[7] Individuals exposed to a high burden of ACEs, namely abuse, neglect, and household dysfunction, may adopt