"Are those gingerbread cookies for me or my baby?"
(Asked by an adolescent mother of a toddler at a Christmas party for high-risk mothers and their children, 2003)

"My baby is six months now. His dad is in jail. I used to care about him but he's, like, 29 and we've been apart for awhile. The thing that worries me is I got no place to go when I get out of here. My mother's got my boy, but she doesn't want me."
(14-year-old mother in a detention center, 2003)

**"My baby is two now. He's got some brain damage.
I was in here when I had him and he got put in a foster home.
He choked on some food and lost his air.
I've only seen him twice since I had him."**
(16-year-old girl in detention, 1997)

"Can't you help her? She's 16, her baby's two. She's in here for 30 years because she was in the car when her boyfriend hit someone. We try to take care of her but she's a kid."
(38-year-old inmate in a maximum security women's prison asking for assistance for a teen inmate, 1998)

"When I got arrested, the officers slammed me against the hood of the car. I was five months pregnant and lost the baby. I'm really depressed. No one even knows about it in here."
(15-year-old detained girl, 2002)

Are Those Cookies for Me or My Baby? Understanding Detained and Incarcerated Teen Mothers and Their Children

BY LESLIE ACOCA

ABSTRACT

This article describes the barriers to understanding and meeting the needs of detained and incarcerated teen mothers and their children and suggests strategies for overcoming these barriers. The barriers include impaired research access, insufficient programs and services, and improper conditions of confinement. The author presents a blueprint of girl-specific strategies for improving services, such as the administration of a needs-based intake screening and assessment. Exemplary programs from around the nation are cited and their methods described. The article provides a comprehensive plan for systemic change that can be effected by judges, lawyers, program administrators, and other juvenile justice professionals.

INTRODUCTION

The infants and children of adolescent girls detained in juvenile detention centers or incarcerated in adult prisons and jails are among the most vulnerable and least well served children in America. Given the lack of data and information on their exact numbers, health, developmental, and placement status, these children are also among the most invisible. Faced with the immediate needs of hundreds if not thousands of mother-child pairs, members of the judiciary and other juvenile and criminal justice professionals have little guidance on how to meet the best interests of either the teenager or her child. They also have little theoretical support and almost no developmentally appropriate treatment resources for approaching these especially high-risk teen mothers and children as inextricably bound pairs. Given the now well-recognized reality that the health and developmental potential of the child, especially during the first three years of life, is dependent on the quality of the interactions between the caregiver and the child, the lack of these resources in itself constitutes a crisis. Each time a girl 11 to 18 years old who is pregnant or parenting is arrested, restrained, and delivered through the locked doors of a juvenile detention center, county jail, or state prison, the doors close behind her child as well.

One purpose of this article is to describe a context for understanding the risks faced by these mothers and children as part of a larger health crisis facing adolescent girls in the juvenile and criminal justice systems. A second purpose is to describe some of the multiple barriers to successfully understanding and meeting the needs of adolescent mother-child pairs who are involved with the juvenile and criminal justice systems and to suggest strategies for overcoming them. The third is to present guiding principles for the development of services and programs that maximize the health and developmental potential of both teen mothers and their children.

In addition to a review of existing health and justice studies, the research informing this article includes two

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studies on the needs and characteristics of girls in the California and Florida juvenile justice systems (Acoca & Dedel, 1998; Acoca, 2001a). One is a national study of the barriers to providing parenting and substance abuse services to pregnant women in adult correctional facilities where some teen girls are housed (Acoca, 2001b), and the other is an ongoing study co-directed by the Juvenile Law Center of Philadelphia and In Our Daughters' Hands, Inc. of Fairfax, California. The latter project (the Girls Health Screening Project) involves developing a screening instrument to identify the physical health needs of girls in detention centers in different regions of the country. The ultimate goal of the screening is to improve medical assessments and services for girls in the juvenile and criminal justice systems and to contribute to a national database profiling their needs. Once tested in the juvenile justice system, the gender-specific health screening instrument could be used to identify the health needs of girls in the child welfare system as well.

PART ONE: A Brief Overview of the Health and Reproductive Issues of Girls in the Juvenile and Criminal Justice Systems

Historic Trends

Several historic trends are converging to jeopardize the health of adolescent girls in the juvenile and criminal justice systems and that of the next generation, their children.

First, girls are now the fastest growing segment of the juvenile justice system across the United States, even as overall rates of juvenile offending are declining (Snyder, 2002). Due to the increase in the waiver and transfer of juveniles into the criminal justice system, especially in states such as Florida, adolescent girls, some of whom are mothers, are also being held in adult jails and prisons.

In practical terms, this means that the juvenile justice system, designed to address the characteristics and needs of the still larger population of young males, is now struggling to address those of a burgeoning and historically unprecedented number of girls and young women—the vast majority of whom are minorities with low incomes and limited access to health care—pouring in from the point of arrest, through detention and court processing, and into placement.

Second, while the intensity of certain economic and social risk factors (for multiple health and mental health problems as well as delinquency) such as child poverty and teen pregnancy appears to be decreasing, a close inspection of national data trends reveals a two-tier reality. These general improvements have left behind significant numbers of poor and minority youth, especially girls. For example, while teen birth rates declined nationally across all racial and economic groups between 1991 and 1998, birth rates in 1998 remained significantly higher among Hispanic and African American girls than among white girls. Since approximately two-thirds of girls in the juvenile justice system in the United States are young women of color, this variance in the pregnancy rates among girls from different racial backgrounds has special resonance (Acoca, 2001a).

Third, there is what the National Institute of Health is calling an epidemic in the prevalence of certain sexually transmitted diseases in the general population, especially among teenagers and young adults (Eng & Butler, 1997). Because of their higher incidence of victimization and risky behaviors, detained and incarcerated girls are among those at highest risk both for STDs and pregnancy.

These diseases identified by the NIH, which result from unprotected sex, include chlamydial infection, syphilis, gonorrhea, hepatitis B virus, and many other infections, such as human papillomavirus. The Institute points out that 25% of the 12 million new STD cases in the United States annually are among adolescents, and that girls are the most vulnerable for anatomical as well as social and behavioral reasons. This crisis is deepened by the fact that at least one quarter of adolescents have no health insurance (Eng & Butler, 1997).

Recent studies conducted by Moscicki et al. (2001), show astoundingly high (40%) rates of human papillomavirus infection among young women in the general population. The occurrence of chlamydia infections in girls in the general population has been reported to range between 6% and 8% and is associated with inconsistent condom use (Noell et al., 2001; Shafer et al., 2002); and hepatitis B and C viruses have been reported in girls who are sexually active and engaging in risky behaviors such as self-injected drug use (Noell et al., 2001).

Exposure to violence, a more hidden public health threat, is also contributing to the rise in risky behaviors

among girls that can result in their infection with STDs. A recent study of more than 500 girls under 18 seeking contraception at an outpatient clinic revealed that girls who had witnessed violence were more than two to three times more likely than girls who had not witnessed violence to use alcohol or drugs before sex and have sex with partners who had multiple other partners. Girls who had themselves experienced violence were two to four times more likely than girls who had neither seen nor experienced it to report early initiation of sexual experiences, multiple sexual partners including strangers, and test positive for sexually transmitted diseases. (Berenson, Wiemann, & McCombs, 2001).

Sexually transmitted diseases and pregnancy are significant problems for detained girls because a majority are sexually active, are not consistent in their use of condoms and birth control, and have histories of being violently victimized. Studies of detained girls have found that more than 85% are sexually active while fewer than 50% report use of condoms or contraception (Kingree, Braithwaite, & Woodring, 2000; Morris et al., 1995). Additionally, preliminary findings from a review of the medical case files of 328 girls being held in detention indicated higher rates of HIV infection than would be expected in the general population (Acoca & Lexcen, 2004). Increasing their vulnerability to risky sexual behaviors, studies of girls in the juvenile justice system reveal that the vast majority have experienced sexual, physical, and/or emotional victimization at some point in their lives (Acoca, 2001a; Acoca & Dedel, 1998). Two large sample studies indicate that between 24% and 27% of detained girls report a history of STDs, and 29% report having been pregnant during their lifetimes (Acoca, 2001a; Acoca & Dedel, 1998).

Recent anecdotal reports to the author by juvenile justice professionals in multiple jurisdictions across the country also indicate that pregnant detained girls may be concurrently experiencing a range of health conditions other than STDs, such as tuberculosis, asthma, and mental health disorders for which they are taking psychotropic medications. These health factors, in addition to stressors related to conditions of confinement experienced by detained and incarcerated girls, could compromise their pregnancies, the health of their children, and their ability to parent.

Health: A Primary Challenge

Nowhere is the challenge of identifying and meeting the needs of the growing population of girls in the juvenile justice system greater than in the area of physical and behavioral health. A major finding of one of the largest and most detailed studies ever conducted on girl offenders entitled *No Place to Hide: Girls in the California Juvenile Justice System* (Acoca & Dedel, 1998), which included the official profiles of 1,000 girls and structured interviews of 200 girls in detention facilities, was the following:

> The vast majority (88%) of girls in the juvenile justice system are experiencing one or more serious health and/or mental health disorders. These problems…may well eclipse other juvenile justice related issues within the next decade. Prominent among the physical health disorders reported by girls were: asthma (39%), yeast infections (29%), STDs (27%), and traumatic head injuries (15%). Due to the high reported prevalence of STDs, histories of early and unprotected sex, with multiple partners, entrenched substance abuse (including intravenous use), poverty, violent victimization and their minority status, this population of girls can be assumed to be at highest risk of contracting HIV/AIDS, all forms of hepatitis, as well as other infectious and communicable diseases. The prevalence of mental health disorders were also reportedly very high. Over half (53%) of the girls interviewed said they needed psychological treatment; 24% had seriously considered suicide and 21% had been hospitalized in a psychiatric facility on one or more occasions (Acoca & Dedel, 1998, p. 10).

Additionally, 29% of the girls had been pregnant one or more times and 16% had been pregnant while incarcerated. The average age for the delivery (inside or outside of correctional settings) of their first child was 14. Of those girls who had been pregnant while in custody, 23% miscarried and 29% had been placed in physical restraints (shackled at the wrists and ankles).

After delivery, girls reported that care of their infants was most often assumed by the maternal grandmother (25%) or by the child's father (21%). Several of the young

mothers reported that these same fathers had been abusive to them during their pregnancies and/or had serious substance abuse problems. Approximately 13% of girls reported that their children were living in foster homes.

Perhaps most critical to the health and developmental potential of the children of girl offenders interviewed was the reported severance of the mother-infant bond during the early months of the infants' lives. Eighty-three percent of detained teenaged mothers reported that they had been separated from their infants within three months of delivery.

Incarcerated pregnant girls interviewed for the study reported that they were often hungry and had not been given prenatal vitamins. Interviewers observed that pregnant girls were physically constricted due to ill-fitting correctional clothing and having to sleep on thin mattresses placed directly on cell floors or on slightly raised cement slabs. Further, a majority of the girls who had given birth while in custody reported that they had received no prenatal or parenting classes. Because no obstetrical facilities were available on site, girls in labor were transported to local hospitals to give birth. Upon delivery, most young mothers were separated from their newborns within hours or days of delivery and then returned to correctional facilities with no or limited medical or psychological support services.

While the data excerpted above offer only the barest outline of the health challenges faced by girl offenders, they represent one of the few health profiles to be included in major studies of the general characteristics and needs of this population.

Additionally, while the most recent estimated number of females under 18 years old incarcerated in the United States is 552 in local jails and 112 in state prisons (A. Beck, personal communication, November 2003), an additional 4,200 girls 18 and 19 years old are also being held in adult facilities nationwide. These young women are almost completely invisible from both a statistical and program planning perspective. Moreover, there is no reliable data on how many of them are pregnant or parenting or on the numbers or health of their children.

At the direct service level, a review of the above-mentioned and other current studies on health and parenting programming for detained and incarcerated girls and women revealed that there are no comprehensive, gender-specific, and developmentally-focused medical screening, assessment, and treatment procedures for girls in detention, jail, or prison or at any other point in the juvenile or criminal justice systems. Further, there are no consistent methods for identifying the exact numbers, health, and developmental status or placement needs of the children of girl offenders.

This dearth of research and medical assessment targeting the health needs of girls in the juvenile justice system means that the judiciary and correctional and medical professionals do not have the information to develop appropriate medical resources to meet them. In other words, the multiple, escalating and as yet unquantified health risks facing girls in trouble with the law and their children constitute a medical and social time bomb.

PART TWO: Barriers to and Suggested Strategies for Understanding and Meeting the Needs of Teen Mother-Child Pairs

This section will touch upon some of the critical barriers to identifying and meeting the needs of detained and incarcerated pregnant and parenting girls and their children and will suggest specific strategies for overcoming them. The challenges described here have been selected for their immediacy and because their remedies may be found at least in part through the juvenile and family courts.

Lack of Research Access to Girls; Lack of Focus on Their Infants and Children

Understandably, researchers proposing to conduct physical or mental health related research with adolescent girls in juvenile and adult correctional institutions must undergo a formal review process to ensure that the rights of the girls and the professionals who serve them are protected and that the goal of the research merits the inevitable expense and intrusion upon facility operations. Arguably, adolescent girls, particularly pregnant and parenting girls deprived of their liberty, are among the most vulnerable of populations and thus must be vigorously protected from breaches to their confidentiality and other research-related harms. However, they are also dangerously invisible from a research perspective. Many medical, legal, and juvenile justice professionals and

researchers, including this author, are concerned that research access to girls and their health records is becoming increasingly difficult and in some cases impossible to obtain.

The stringency of the new federal Health Insurance Portability and Accountability Act (HIPAA) regulations, coupled with the lack of familiarity of some members of Institutional Review Boards (entities charged with reviewing and approving proposals to conduct human subjects research) with the characteristics of girl offenders and their conditions of confinement, combine to make obtaining permission to conduct institution-based case file reviews a long and expensive process.

Also of great concern is the increasing difficulty—if not impossibility—of obtaining permission to conduct face-to-face interviews with detained and incarcerated girls. Without the benefit of hearing and recording the girls' personal histories in various domains (home, school, and other institutions and community placements), it is impossible to identify their health needs or those of their children. Illustrating the importance of the interview process, both the California and Florida girls' studies mentioned above showed significant discrepancies between the richness of data gathered from official probation case files and that obtained from face-to-face interviews with the girls. For example, only 23% of the girls' probation case files reviewed indicated histories of abuse or neglect while 65% of girls interviewed reported such victimization (Acoca & Dedel, 1998). The latter is more consistent with the literature on the characteristics of girl offenders and has significant implications for processing and providing services to girls. Given the significant differences between the rates of lifetime pregnancy reported through official case review and interview profiles (8% and 24% respectively in the Florida study), it is possible that the number of girl offenders with pregnancy histories and other reproductive health issues will be underrepresented if interviews are excluded from the research process.

There are currently no consistent procedures for gathering information on the infants and children of detained and incarcerated girls. Intake screenings and assessments for girls generally attempt to determine if the young woman is pregnant or has children, but there is rarely any attempt to gather more comprehensive information on the health or placement of her child. The reality is that in most jurisdictions there is no credible data on the exact number of children of incarcerated teen parents, either male or female, where these children are placed, or what their needs are. Although it is beyond the province of this article, the lack of data currently being gathered on the children of young detained males is also problematic. Typically, the only information researchers, probation officers, or the courts have about the children of juvenile offenders are statements such as those quoted at the beginning of this article.

Finally, there is also a fundamental lack of information mapping the existence or evaluating the effectiveness of the handful of health and parenting programs for adolescent girl offenders and their children. Of particular concern is the absence of outcome data describing the long-term impact of any parenting programs as compared to other types of programming on child participants' development and on the success of family reunification efforts.

Strategies for Supporting Research Access

Judges have in some cases crafted judicial orders that address HIPAA requirements and protect the rights of research subjects while facilitating appropriate access to the official records of understudied populations such as detained girls. Judges may also work with researchers to assist in educating members of Institutional Review Boards and other professionals in the community about the importance of obtaining accurate information on juvenile offenders and their children.

Strategies for Gathering Comprehensive Data on Juveniles Held in Detention and Adult Correctional Facilities

Probation departments, juvenile and adult correctional professionals, child welfare agencies, and the medical community should collaborate on the development of needs-based intake screening and assessment for juvenile girls entering detention, jail, or prison that include their reproductive histories and the status of their children. At a bare minimum, such needs-based assessments must include the following core elements: health needs, mental health and substance abuse related needs, parenting needs, educational and vocational

needs, gang affiliation assessment, and juvenile justice processing needs. Examples of simple tools that could be refined according to the characteristics of girls within individual jurisdictions can be found in the California girls' study referenced throughout this article (Acoca & Dedel, 1998).

Strategies for Obtaining Evaluation Data on Mother-Child Programs Serving Girls in Juvenile and Adult Correctional Facilities

Juvenile and family court judges have the capacity to convene resources to serve adolescent girl offenders and their infants and toddlers. To accomplish this, they can, in collaboration with local maternal and child health and child welfare agencies and departments of probation support the replication and evaluation of promising programs or the development of new ones. When recommending or supporting the development of such services, the judiciary can require that these be formally evaluated, ideally by a credible outside evaluator experienced in measuring the outcomes for girl-specific programs.

Barriers Related to Juvenile Justice Processing and Juvenile Waiver and Transfer into the Criminal Justice System

Justice by Gender, a 2001 report by the American Bar Association and National Bar Association, outlined some of the unique and troubling aspects of juvenile justice processing for girls. For example, girls are far more likely than boys to be charged with status offenses, such as running away. Called "bootstrapping," this process leads girls into the delinquency system and may increase the likelihood that they will eventually enter the criminal justice system.

According to the ABA/NBA report, this penetration of girls, including pregnant and parenting girls, into the juvenile justice system for minor offenses appears to be the result of apparent bias in routine discretionary decisions made by law enforcement, probation, prosecution, and judges. Violation of valid court orders, contempt, probation and parole revocation, misdemeanor charges for running away, and warrants are among the legal mechanisms driving this phenomenon. Girls are also more likely to be detained for lower level offenses and for technical violations of probation or parole where there is no new offense.

Legal professionals and researchers alike have long observed that the use of detention for girls is often a means of controlling social behaviors that have not been addressed at home, in school, or in the community. In the absence of a safe home or treatment environment for pregnant girl offenders, detention is also sometimes used as a protection of last resort. Naturally, the safety of detention environments for young pregnant women and the lack of alternatives for these young women should be questioned.

While the rates of more serious or person offending among girls have risen compared to those of boys (Snyder, 2002), there is controversy over the interpretation of this trend. Researchers are evaluating if girls are becoming more violent or if families, law enforcement, and the courts are more willing to criminalize adolescent rebellious behaviors. Since many of the person offenses with which girls are charged actually represent mutual combat situations in the girls' home environments, many legal professionals and scholars argue they should be diverted or charged differently. From an intergenerational perspective, if a pregnant or parenting girl is entering the system as the result of conflict with her parents or caregivers, the juvenile and family court system should carefully evaluate the home environment and mobilize resources such as in-home family counseling and domestic violence interventions to interrupt the cycle of family violence.

At every point in their movement through the juvenile justice system, which is primarily designed to address the behaviors and circumstances of the still larger population of young males, girls are disadvantaged by the lack of gender-responsive services and programs. This is also true for the girls who are waived and transferred into the criminal justice system where they are not entitled to the age-appropriate educational and therapeutic services that they would be mandated to receive within the juvenile system. Young mothers in adult facilities may also face prolonged separation from their children due to long sentences and the geographical isolation of women's prisons. The lack of responses and resources for girls has a particularly devastating effect when the young woman being arrested, detained, or incarcerated is pregnant or parenting.

There are, for example, no consistent procedures for

addressing the needs of the infants and young children of girls who are arrested. What happens to the six-month-old infant who is left behind with the girl's mother, teenage boyfriend, or girlfriend when she is picked up by police and detained? If the girl has been in a caregiving relationship with that child, what effect does the interruption of the mother-child relationship have on both the infant's and young mother's health and developmental potential? In the case of pregnant girls whose condition may or may not be visible to arresting officers, what happens to the girl who miscarries, as did the young woman quoted earlier, due to physical arrest procedures or restraint during transport?

Strategies for Addressing the Gender Effect on Girls and Their Children of Juvenile Justice Processing and Movement into the Criminal Justice System

A comprehensive approach to processing issues is beyond the scope of this article; however, law enforcement, judges, probation, child welfare professionals, and community-based providers should receive regularly updated, high quality information and training on the characteristics and needs, including those related to health and reproduction, of girls in and at risk of entering the juvenile justice system. This ongoing educational component should also include the most sophisticated and current information on early childhood development specifically with regard to teen mother-child pairs. The National Council of Juvenile and Family Court Judges could serve as a central distribution point for this type of information regarding girls within the juvenile justice system in collaboration with the National Association of Women Judges for girls within the criminal justice system.

Additionally, a developmentally sound and culturally responsive system of care must be developed for delinquent girls at every point in their involvement from arrest through commitment. This network of services should provide community-based alternatives to detention and placement and waiver into the criminal justice system. Child welfare agencies should collaborate in the development of this system to ensure that infants and children of teen mothers who are arrested and detained have safe and nurturing home environments, consistent caregivers, and regular visitation with their mothers. Guiding principles for the development of this system are included in Part Three of this article.

Barriers Related to Programs and Services

The availability of gender-responsive and developmentally appropriate programs within juvenile and adult correctional institutions and post-release in the community determines whether or not young women will be able to develop the multiple competencies required for successful community re-entry and family reunification and parenting. In the general population, these competencies would include the mastery of vocational, academic, and social skills, and the formation of a pro-social identity within a matrix of family and friends. For girl offenders, whose development, as the literature has established, typically has been interrupted by victimization, substance abuse, educational failure, and poverty, completion of these developmental tasks is much more complex and formidable.

Given their documented alcohol and other drug abuse histories (75% of girls in California detention centers reported regular use of alcohol and drugs [Acoca & Dedel, 1998]), girls must concurrently develop sophisticated recovery skills, basic and remedial academic skills (complicated by the reality that living wage jobs are increasingly linked to the skilled use of computers), and practical living skills. Phrases such as "living skills" assume a different meaning when infused by the real experiences of detained pregnant and parenting girls who will leave "secure" settings with little more than the earrings and jeans they were arrested in. These young women—sometimes held for longer than their offenses warrant for "their own protection" or that of their infants—often return to fragmented or abusive living situations to face the completion of school and treatment programs, the care of infants and young children, and finding a job. They do so despite the lack of concrete supports such as transportation and reliable child care and while coping with the inevitable emotional loss and upheaval caused by the early severance of the mother-child bond.

Lack of Services for Dually Diagnosed Girls

While there are a few notable exceptions, the overall paucity documented in many studies of adequate substance abuse, parenting, health, and mental health pro-

grams for girls in juvenile and adult correctional facilities is remarkable. Since the health and well-being of teen mothers in detention, prison, or jail is inextricably bound with that of their children, these gaps have a devastating intergenerational impact.

An example of one of the most glaring of these service gaps, given the profile of girl offenders, is the almost complete absence of intensive programs either within locked facilities or in the community for dually diagnosed girls (those with co-occurring psychiatric and substance abuse problems). Where such programs do exist, they often are geared more toward boys than girls, which may compromise the programs' capacity to respond to girls' histories of victimization, or may simply be too small to accommodate the number of girls who need them. Further, few if any of these programs are equipped to serve pregnant or parenting girls or address the needs of their children.

Lack of Developmentally Focused Mother-Child Services

Clearly, one of the most obvious mismatches between the unique needs of girl offenders, their children, and the mission of most correctional systems is the dearth of services specifically for pregnant and parenting girls. The central task of correctional facilities is not child development but containment of youthful offenders. While there are approximately five prison- and jail-based nurseries for adult women offenders across the country, we know of none for girls in secure settings. Additionally, visitation policies conducive to strengthening the mother-child relationship are inconsistent or nonexistent for girls in juvenile facilities. Consequently, it is very difficult to provide hands-on developmentally sequenced counseling (that which addresses the unique tasks related to each phase of early childhood development, e.g., zero to three months, three to six months, etc.), and support for mother-child pairs. Further, most parenting curricula for offenders do not specifically address early childhood phases and may not even take into account the developmental differences associated with teen mothers.

Among the existing program options to be considered are the following: community-based mother-child programs where mothers live at home and receive intensive in-home and program-based services (such as the Mother-Infant Program and Child Haven Program in California described in this article as representing the highest caliber of developmentally sequenced interventions for multiple risk mother-infant pairs); residential mother-infant and child programs where girl offenders can be placed directly as an alternative to correctional facilities; and therapeutic foster homes where skilled foster parents can provide parenting support and guidance in a safe, homelike environment.

Pregnant and parenting participants interviewed for studies referenced here were particularly concerned that, due to the lack of on-site obstetrical services, girls in labor must be transported outside correctional facilities to community hospitals to deliver their infants. As recently as 2003, some girls reported that they were shackled during transport, even on the way to the hospital for delivery, raising the risk of precipitous births. Reportedly, some postpartum girls were returned to detention soon after delivery without being fully recovered and were thereafter denied adequate medical supervision.

Girls also reported that in most cases their newborns were removed from their care within hours or, at most, days of delivery. This early severance of the mother-child relationship is primarily due to the fact that there are few community-based dispositional alternatives for pregnant and parenting girl offenders, even those who are nonviolent and pose little risk to their communities.

Limitations Due to the Holding of Adolescent Parenting Girls in Jails and Prisons

As stated in Part One of this article, roughly 5,000 adolescent girls (including 18- and 19-year-olds) are being held in adult jails and state prisons. None are currently being held in federal prisons. As an unanticipated part of its national study of parenting and substance abuse services for adult women prison and jail inmates, researchers interviewed four girls between the ages of 15 and 17 and several other young women who were 18 and 19 who were being held in maximum security adult prisons (Acoca, 2001a). The research team was struck by the vivid physical and behavioral differences between these very young girls, who were smaller, quieter, and

more tentative, and their adult counterparts. (A majority of adult female state prison inmates are over 30 years old [Greenfield & Snell, 2002].) Moreover, although some of these young girls exhibited the mementos of childhood such as frilly cotton socks worn with their regulation shoes, they were serving adult sentences of nine to 40 years and all reported that they were already mothers. All had also reported being separated from their infants and children and had received few if any visits from their children. None of the existing parenting services addressed the developmentally unique parenting needs of this population of young women who all face not only the forfeiture of their adolescence and the rights to education and health care accorded other children and youth, but also the permanent loss of their children. Prison administrators, program staff, adult inmates, and the adolescent girls interviewed joined together in calling for developmentally targeted physical health, mental health, and parenting services for this growing but still invisible population.

Lack of General Health and Medical Services

Beyond the scarcity of adequate perinatal and developmentally-targeted parenting services, the overall absence of adequate medical and psychological services for girl inmates emerged as a dominant theme from the interviews conducted during past studies and from the observations of the researchers. These inadequacies affected every aspect of health care, and undermined directly or indirectly the delivery of all other categories of services.

Girls in several institutions reported that there were often inadequate services for immediate problems such as scabies and lice, chronic health disorders such as asthma, infectious diseases such as tuberculosis, severe dental disease, and a variety of other health conditions. There were no negative air pressure rooms (which should be used to contain the spread of active tuberculosis) in any of the juvenile facilities visited even though a small percentage of girls self-reported a history of exposure or positive tests (Acoca & Lexcen, 2004).

Even when such services did exist, access to them was impaired, in some cases, by the sick call process that requires girls to submit in writing their medical complaints to the facility staff who may or may not be able to respond to them in a timely manner. Both juvenile and adult facility administrators were concerned that the "outsourcing" of correctional medical services to for-profit medical corporations might decrease the availability of medical services even further. Lastly, some girls reported that if they are diagnosed as having a medical or dental problem and are awaiting treatment, their medical status can preclude their access to parenting, substance abuse, and other programs. In some cases, girls may be placed in medical isolation within detention and adult facilities for a broad range of health-related conditions including the flu, pregnancy, and psychiatric problems (Acoca & Lexcen, 2004).

Finally, the lack of intensive mental health services for adolescent girls with severe psychiatric disorders has been identified as one of the most significant and pressing problems facing the juvenile justice system nationally. A study of detained youth in Cook County, Illinois, between 1995 and 1998 revealed that girls had higher rates of psychiatric disorders than boys. Nearly three-quarters of girls met diagnostic criteria for one or more psychiatric problems including high rates of depression and anxiety (Teplin et al., 2002). Recent interviews with detained girls revealed that many, including pregnant girls, are taking one or more psychotropic medications which may or may not be adequately supervised by physicians or psychiatrists (Acoca, 2004). Institutional administrators interviewed in past studies expressed concern that the as yet unevaluated impact of managed care on the correctional health care system will diminish the already limited availability of mental as well as physical health services for incarcerated women and girls (Acoca, 2001a).

Program Limitations Due to Conditions of Confinement

The physical environment of detention, jail, and prison facilities generally cannot offer sufficient fresh air, sunlight, freedom from overcrowding, or physical privacy to protect the health of either girls or boys, but places young pregnant women at increased risk. Additionally, the training of probation and correctional staff often does not include gender-specific information on how to understand and work with girl offenders. Even more limited is training that teaches staff how to supervise and work with pregnant and parenting girls.

Consequently, young pregnant women may be housed in dark, sealed, and overcrowded facilities with other girls with colds, flu, or even more serious diseases such as tuberculosis. Their access to comfortable clothes, bedding, and extra food may be limited and their concerns and worries about their health and that of their babies may be ignored or misinterpreted by staff who have not been prepared to address them. Moreover, many facilities simply do not have counseling or supervision staff who are trained to address the emotional pain experienced by parenting girls who have been separated from their children (Acoca & Dedel, 1998).

Lack of Pre-release or Aftercare Services

Another area of nearly universal agreement between girls in detention and facility treatment and administrative staff was the critical lack of both pre-release and aftercare services for all girl offenders, but particularly for pregnant and parenting girls. Focus groups conducted with detained girls in 2002 and 2003 revealed that their fears about having no home environment to return to after their release, no money, no transportation, and limited access to health, counseling services, and child care were paramount. Girls and professionals alike encouraged researchers to recognize that parenting services cannot exist outside a more extensive matrix of health and mental health services including early childhood developmental assessments and interventions that transcend institutional walls and extend into girls' home communities and families. Of particular concern is the observation that even the new national focus on the development of aftercare services for adolescents in the juvenile justice system is addressing only the needs of the larger population of young male offenders and failing to address or even recognize the needs of girl offenders and their children.

Strategies for Addressing the Dearth of Girl-Specific and Mother-Child Services for Girls in the Juvenile Justice System

The first step in the development of these services is to create accurate, current profiles of the characteristics and needs of girl offenders, their flow through the juvenile justice system, and the status and placement of their children. The second step is the design of a continuum of girl-specific services that provide developmentally targeted programs for pre-adolescent and adolescent girls who are in or at risk of entering the juvenile justice system. A recommended blueprint for this system of care (found in Acoca & Dedel, 1998, Chapter 2, Part III) is outlined below. Although there are only a handful of screening and assessment instruments and programs nationally that are specifically designed to address the needs of adolescent girls and their children, examples of relevant tools and services are noted under each component of the suggested blueprint.

1. Comprehensive needs-based screening and assessment including health, education, mental health, substance abuse, parenting and juvenile justice system processing and advocacy. In addition to the instruments described in the California Girls' Study, Cook County, Illinois, has developed a girl-specific risk and needs assessment for girls in its juvenile justice system. Further, the girls' health screening tool currently being designed by In Our Daughters' Hands, Inc. and the Juvenile Law Center will be tested in 2004 and 2005 and will be disseminated to juvenile justice systems nationally once its reliability and validity have been determined.

2. Girl-specific, in-home, family and school-based prevention and early intervention services for at-risk girls and girls who have entered the juvenile justice system. The Commonweal Children's Program in Bolinas, California, provides intensive, early intervention, and school-based services to this population of girls.

3. Girl-specific diversion programs. Examples of these programs include the following: intensive alcohol and drug education for girls, community service and alternatives to gangs, violence prevention and victim awareness, and girls' wilderness ventures. The San Diego, California, Department of Juvenile Probation has developed some models for these categories of service, particularly in the area of providing community alternatives to gang membership for girls and boys. In the area of girl-specific wilderness experiences designed to raise levels of self-esteem and competency in girls, the Team Program in Larkspur, California, part of the Marin County Department of Education, is a national leader.

4. Dispositional alternatives (including multiple types of intervention and treatment) for girls 12-18 who have entered the juvenile justice system. The PACE Program for Girls of Jacksonville, Florida, functions in more than 20 Florida counties to effectively build girls' academic and social skills, prevent girls' reoffending, and serve as the hub for an array of family and community services.

Examples of girl-specific residential substance abuse and mental health disorders are extremely limited. This is a critical gap given the depth of the substance abuse problems revealed by girls in the juvenile justice system, the relationship of this problem to girls' offending, and the deleterious effects of alcohol and drug use on pregnant and parenting girls and their children. Two examples of small residential drug treatment programs serving this population are the Star Program in Santa Cruz, California, which operates on the grounds of the Santa Cruz Juvenile Detention Center and the Threshold for Change Program in Novato, California, which was designed and implemented by the author.

5. Secure residential and detention services. The Girls' Rehabilitation Program in San Diego, California, which operates within a wing of the San Diego Juvenile Detention Center, offers an array of mental health, parenting, and educational services. Again, examples of this type of service are rare.

6. Ongoing care (as opposed to aftercare). This category of service is almost completely lacking for girls who are leaving detention and placement or who are completing community supervision. The Fit Program in Baltimore, Maryland, provides girl-specific probation services and attempts to link girls to community services that transcend their involvement with the juvenile justice system. Additionally, the Juvenile Rights Advocacy Project of the Boston Law School is currently collaborating with the author to develop a girls' health advocacy project. This program will ultimately assess the health and mental health needs of girls in the Boston juvenile justice system and then advocate for relevant services in the community as the girls move through and out of that system. Since many of the young women offenders in the Boston system are pregnant or parenting, it is hoped that this program will develop a particular emphasis on the delivery of appropriate health and developmental services for both the girls and their children.

7. Prevention and early intervention services for pregnant and parenting teens and their children zero to three years old. The Child Haven Program in Fairfield, California, and the Infant-Parent Program at the University of California, San Francisco, San Francisco General Hospital, offer comprehensive services for teen mother-child pairs including some teen mothers who are or have been in detention or placement. The core elements of these programs include the following: intensive home visiting by family and infant-parent therapists flexibly configured to meet the needs of the girls and their children; developmental assessments and developmentally sequenced groups for mother-child pairs (including groups for monolingual Spanish-speaking mothers); and concrete supports including funds for food, formula, transportation, and shelter.

PART THREE: Guiding Principles for Programs and Services for Girl Offenders and Their Children

The juvenile and family court must be provided with suggested definitions of the terms "girl-specific," "gender-responsive," and "family-focused" in order to assist in the development of programs serving adolescent girls and their children. For this reason, this section begins with a brief description of the underlying or guiding principles that should inform all services for girl offenders and their families. These principles emerged from the focus group and individual and professional interviews of the three studies directed by the author and observation of promising in-custody and community-based programs serving women and girl offenders.

The following approaches are essential to the development of authentically gender-responsive programs. The literature is abundantly clear in its criticism of the "add girls and stir" approach. Simply functioning in all-girl environments, hanging pictures of accomplished women on the walls, and labeling services as "girl-specific" do not qualify services as gender-responsive. In addition to providing physically and emotionally safe program environments—a key guiding principle—programs must actively

promote the development of multiple and interrelated competencies. Chief among these are parenting skills, recovery skills, academic and vocational skills, health maintenance skills, and practical living skills. These are essential to girls' capacity to initiate drug-free lifestyles and maintain themselves economically, socially, and as parents. Both the juvenile and criminal justice systems programs must also attend to the unique developmental tasks and characteristics of adolescent girl offenders and their children. While a young woman may have been convicted of committing an offense deemed to be "adult" by nature of its seriousness, she herself remains developmentally a child. Effective substance abuse, parenting, and other programs serving girls must explicitly address the child behind the offense.

1. Provide physically and emotionally safe correctional and program environments.

The number one guiding principle, because all other elements of effective programming depend on it, is the provision of physically and psychologically safe correctional and program environments. The challenges to the creation of this safety are myriad. Among those touched upon in the literature and in the last section are threats to girls' health due to the physical environment of detention centers, jails, and prisons, inappropriate interactions between staff and girls, and security procedures that jeopardize the health of pregnant girls. Paramount in eliminating these hazards to the safety of detained and incarcerated girls and their children is articulating and actively enforcing the promotion of girls' and children's safety as part of the institution's mission. Protections that specifically address the unique health, reproductive, parenting, and developmental needs of adolescent girls must be included in the administrative, personnel, and program policies of every institution and at the state department of corrections level.

Programs that include infants and children either on a residential or visiting basis must make the best interests of the child—protecting and promoting the child's physical safety and healthy development—their number one priority. Any conflicts with established correctional policies must be resolved in favor of child protection. Moreover, clear and articulated procedures for ensuring that girls who consent to participate in research interviews have their anonymity and confidentiality completely protected must also be in place. Again, conflicts with standard correctional practices must be addressed.

2. Promote staff training.

The staff culture communicates more to girls than any formal treatment group. Administrators must recruit both custody and program staff who are appropriate in their demeanor, able to exercise professional boundaries, and responsive to the characteristics and needs of girl offenders and their children. This is especially important because many correctional and probation staff, particularly those who have gained their professional experience working with boys, report that they dislike working with girls because they experience girls as more demanding and their needs as more complex. Girl-specific training curricula that are appropriate to each professional level (administrative, custody, and treatment) and that address the challenges faced by male correctional staff who supervise young females, should be delivered as a regular component of staff orientation and at regular intervals thereafter. This training should deliver an understanding of adolescent girls' unique developmental pathways and of the challenges confronting teen mothers and their children. Successful completion of this training should be linked to job retention and advancement.

Currently the abovementioned PACE Program for Girls offers, on a contractual basis, a comprehensive gender-specific training curricula for correctional and other professionals working with girls in the juvenile justice system. However, there should be a national effort to build a core curriculum integrating current research and best practice information from programs and universities across the nation that would be a required component of staff training for every professional working directly with girls or in a policy or administrative position making decisions regarding girls.

Further, juvenile correctional institutions and the programs within them must provide structured opportunities for staff to become aware of and discuss their experiences of gender identity and how these experiences and biases apply to the girls they are supervising.

3. Focus on the family.

A family-focused approach that incorporates a multi-

generational perspective should be integrated into all categories of programming (e.g., substance abuse, health, vocational, etc.) at every point in girls' involvement with the juvenile or criminal justice systems, from arrest through aftercare. "Family-focused" in this context means using a variety of concrete strategies (such as letter writing, storybook readings on tape, phone calls, and supervised visitation) to help girls understand and improve their relationships with their children and family members while separated and providing developmentally sequenced interventions for adolescent girls who are being reunited with their infants and children. Different categories of service, such as substance abuse treatment, must include a component that addresses girls' health, including reproductive health, and when appropriate, parental roles. Additionally, services for girls must address other key family and extended family relationships, including grandparents, parents, aunts, uncles, siblings, spouses, partners, close friends, and children's caregivers. Although there is some controversy over the involvement of their children's fathers in programming, greater attention should be paid to forging linkages, when appropriate and safe, between children and their fathers. Finally, institutional policies, procedures, and practices should be designed to actively promote rather than hinder family linkages. Restrictive or inhumane visitation policies should be rescinded.

4. Provide access to core programming and services.

The literature on girl offenders highlights the importance of delivering a constellation of core services that includes physical health, mental health (with a special emphasis on girls' histories of victimization and trauma), education, and vocational programming. Every girl entering detention or other correctional facility should receive a gender-specific health and mental health screening, a comprehensive assessment and, where appropriate, treatment and/or intervention in these core areas. The infants and children of girl offenders should also be medically, psychologically, developmentally, and educationally screened, assessed, and treated. These core services enable substance abuse and parenting programs to accurately profile the needs of detained girls, configure and match service delivery to girls' needs, maximize the participants' potential for success, and ensure the safety of adolescnt mothers and children. Suggested elements of these core services are included in the blueprint section of this article, beginning on page 74.

5. Provide developmentally appropriate and sequenced interventions for adolescent girls, adult and teen mothers, and their children.

Parenting programs in locked settings that house girls must offer program components that specifically address the girls' unique developmental characteristics and needs. Another developmental issue, one that affects women of all ages, is the very definition of parenting services. In the service model recommended here, the unit of service is the mother-child pair, and the goal of parenting programs is to maximize the child's developmental potential by fostering respectful interactions between the mother and child. This is accomplished through the hands-on provision of developmentally sequenced (tailored to each unique and defined stage of infancy and childhood) interventions that assist the mother and child together. When mothers and children are separated due to detention or incarceration, the information delivered in parenting classes must still be developmentally appropriate and geared toward giving mothers the skills to actively improve their relationships with infants and young children

6. Provide culturally responsive programming.

As stated earlier, the majority of girl offenders are young women of color. Not only is it important to integrate racial and ethnic differences into the approach of every program, it is also critical to consider differences in the expectations, stereotypes, and interpersonal relationships of women from different socio-economic backgrounds; from urban and rural environments; and from heterosexual and lesbian lifestyles. It is also important to consider the immigration status of the woman and her family, e.g., whether she or they have recently arrived from another country or are first- or second-generation immigrants. Girls who are separated from family members who are in other countries may have special needs and face extraordinary stress due to this type of family fragmentation. Additionally, programs must be able to serve girls who do not speak English. Ideally,

some members of the custody staff, in addition to program staff, should be bilingual.

Finally, gender-competent programs for young women must include a perspective on the status of women, gender roles, images, and mores present in American culture at large. Since women's offending usually emerges from a context of poverty and layers of discrimination linked to class, minority status, appearance, and other factors, helping women decode how these barriers have affected them personally can provide insight, understanding, and pathways to positive behavioral change.

7. Provide concrete supports for programming.

Effective parenting and other programs for girls must include a broad spectrum of practical supports that may not be included under the traditional rubric of "juvenile justice system interventions." These should be configured during pre-release planning based on the individual life circumstances of the girl and the resources available to her and her family upon her release. As indicated above, such supports and services include a safe and drug-free home, transportation, child care, medical, psychological and substance abuse treatment, and, when appropriate, income maintenance and legal advocacy.

8. Formally evaluate programs and services, and implement research-based programming whenever possible.

A rigorous evaluation component should be an integral part of the design and implementation of parenting programs for girl offenders and their children. These evaluations must include both quantitative and qualitative strategies (including the experiences of young women program participants) and outcome measures that go beyond recidivism to include the long-term impact of intensive programming on child development and women's health. The results of credible program evaluations should be used to improve services and as the basis for the funding and design of new and/or expanded services.

As has been stated, few existing programs have the resources and the technical capability to conduct formal outcome evaluations. Moreover, most of the organizations that have traditionally provided juvenile justice research and program evaluation have little or no expertise in measuring the effectiveness of programming for girls. However, as local, state, and federal funding agencies increasingly require evaluation strategies for new programs, and as the pool of researchers developing gender-responsive evaluations grows, this situation is bound to improve.

Next Steps

First, legal and other professionals should refer to and, whenever possible, visit effective girl-specific parenting programs when considering the implementation of gender-responsive parenting and other programs. Reading or listening to presentations about girl-specific program models cannot replace the experience of visiting actual parenting classes provided to groups of pregnant girls detained in San Diego County or to an individual teen mother with a fragile infant being served by a Child Haven psychologist in the Solano County Neonatal Intensive Care Unit. Although these are considered model programs, and such programs are rare, examples of services that serve girls in the juvenile justice system exist in many larger jurisdictions, and most are open to visitation by interested professionals.

Second, judicial organizations should assume a leadership role in convening resources that specifically address the characteristics and needs of girl offenders, their children, and families. Research featuring this information should be included in judicial training curricula and juvenile justice conferences. Further, initiatives and publications in the area of juvenile justice should explicitly include strategies to improve the health and developmental potential of girls and their children rather than generic approaches to "youth" or "delinquency." Ultimately, gender-specific programming must also address the parenting needs of young male offenders and their children as well.

Third, the judiciary, prosecutors, defense attorneys, and legislators should collaborate in examining and altering the recent trend of girls entering the juvenile and criminal justice systems at a time when overall rates of offending are declining. Finally, the extreme lack of community-based prevention services, alternatives to incarceration, and physical and mental health services, especially for pregnant and parenting teens, must be examined with the spotlight that the legal profession

and elected policymakers have the power to train on this still-hidden population.

Conclusion

The quotation from the girl who did not know which child the cookies were for—herself or her baby—illustrates the developmental crossroads that many teen mother-child pairs must face. If we take the high road, this young woman will receive the developmentally appropriate services described in this article that will support her health and her relationship with her baby, thus giving both children a chance to claim their futures. If this young mother-child pair is ignored and forced to take the low road through denial of services, two more generations will be at risk of losing their lifetime potential to develop health, competence, and freedom from the juvenile and criminal justice systems.

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