Youth Justice Under the Coronavirus

Linking Public Health Protections with the Movement for Youth Decarceration

THE SENTENCING PROJECT
RESEARCH AND ADVOCACY FOR REFORM

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Front cover image:
Giddings State School (TX)
Image is from Google Maps.

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The Sentencing Project works for a fair and effective U.S. criminal justice system by producing groundbreaking research to promote reforms in sentencing policy, address unjust racial disparities and practices, and to advocate for alternatives to incarceration.

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EXECUTIVE SUMMARY

The novel coronavirus, COVID-19, has infected more than 1,800 incarcerated youth and more than 2,500 staff working in the detention centers, residential treatment facilities, and other settings that comprise the deep end of the juvenile justice system. More than six months after the first infections emerged, the emergency is not over.

According to data collected by The Sentencing Project, COVID-19 cases have been reported among incarcerated youth in 35 states, the District of Columbia and Puerto Rico. In five states, more than 100 incarcerated youth have tested positive. Four staff members working in juvenile facilities have died from the virus.

In congregate care settings, this contagious pathogen's spread was inevitable. States and localities have taken steps to mitigate COVID-19's impact, including releasing confined youth, curtailing admissions, limiting visitation and programming, and isolating youth in a manner that mimics solitary confinement. Given the persistent racial and ethnic disparities in juvenile justice, there is little doubt that youth of color are suffering disproportionately from the virus and the changes within facilities that it has brought.

This report summarizes lessons learned through the first months of the pandemic, focusing on system responses, both positive and negative, to slow the virus's spread and to protect the safety and wellbeing of youth in the juvenile justice system while keeping the public informed. Drops in admissions during the pandemic, alongside decisions to release youth at a higher rate than during ordinary times, buttress the long-standing case that youth incarceration is largely unnecessary. Jurisdictions must limit the virus's damage by further reducing the number of incarcerated youth.

RECOMMENDATIONS

Limit incarceration

- Limit admission to facilities to youth who pose an immediate and serious threat to their communities.
- Restrict the use of incarceration only to those youth who cannot be safely treated at home.
- Release post-adjudication youth who are near the end of their treatment.
- Do not move incarcerated youth between facilities.
- Smaller, less crowded facilities are less amenable to spreading COVID-19.

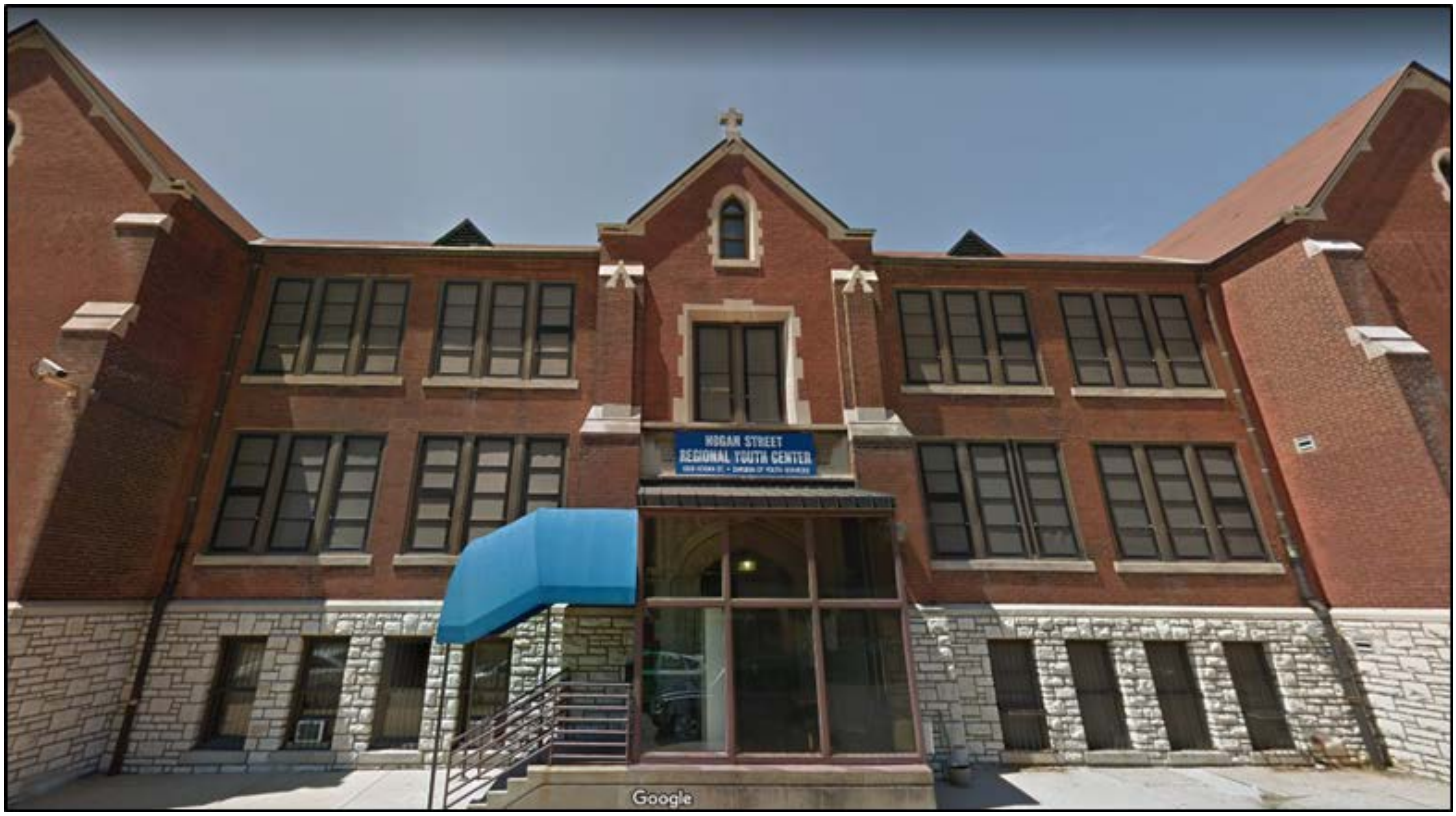
Conditions in facilities

- Ensure frequent communication between incarcerated youth and their families.
- Medical isolation should be supervised by medical personnel, not security personnel.

Testing and reporting

- Facilities should implement widespread testing among youth and staff to determine the spread of the virus.
- States should publish the number of tests with positive and negative results among youth and staff in all their facilities, whether managed by the state, its counties, or contract providers.
- The Office of Juvenile Justice and Delinquency Prevention (OJJDP) should publish data compiled by the states.
- States and OJJDP should publish current data on population counts in all facilities.
- States and OJJDP should publish current data on population counts by race and ethnicity.

INTRODUCTION



The Hogan Street Regional Youth Center, a 36-bed facility in St. Louis has had 23 youths test positive for COVID19. *Image from Google Maps.*

The Hogan Street Regional Youth Center in St. Louis is one of dozens of secure facilities in Missouri following the lauded "Missouri Model," an approach built on smaller facilities that emphasize rehabilitation over punishment.[1] As with many facilities that comprise the deep end of the juvenile justice system, Hogan Street's ambiguous name masks its purpose. Located in a former Catholic church, nestled into a residential neighborhood, its 36 beds[2] define it as a medium-sized residential facility. It houses teenagers who have been adjudicated delinquent in a juvenile court proceeding, the system's equivalent to conviction in criminal court, for roughly 15 months of treatment.[3] As an early response to the coronavirus, Missouri's Division of Youth Services suspended visits on March 13, 2020.[4]

Ten days later, on March 23, 2020, a youth living there tested positive for COVID-19, the first of 1,805 known positive diagnoses among incarcerated young people across 35 states, the District of Columbia, and Puerto Rico. The state announced that the infected young person would be isolated to prevent an outbreak.[5]

Nevertheless, by mid-June, 18 of the 28 youth at the facility (all of them African American), along with 14 staff members, tested positive for the virus.[6] By the end of the month, 23 youth and 15 out of roughly 50 employees[7] tested positive. Protesters, led by area clergy and joined by union representatives, demanded immediate release of all 28 Hogan Street youth. "We're not asking today, we're demanding," Kristian Blackmon

told the *St. Louis American*.[8] Advocates in 36 states have done the same.[9]

As of September 23, 2020, people in 13 of Missouri's state-run juvenile facilities — 50 youth and 41 staff members — have tested positive for COVID-19.[10]

Similar patterns of infection have erupted across the country, but public information on the scope of the novel coronavirus's spread, the kind that motivated protesters in St. Louis, is not always available. Some states and counties have been testing aggressively and reporting the results; the current number of cases at Hogan Street is known because Missouri's Department of Social Services created a website to alert the public to their existence. In other jurisdictions, the incidence of the virus is hidden by either inadequate testing or inadequate reporting. Untold numbers of COVID-19 cases among incarcerated youth and facility staff are blocked from public view.

The immediate toll has been immense. Incarcerated youth, along with their families, report feeling scared and alone, deprived of information, and cut off from their loved ones. The traumatic experiences of many incarcerated youth during the pandemic may inflict long-lasting harm on an already vulnerable population. This harm continues to be exacerbated by decisions to sharply curtail or eliminate visitation and contacts by families as well as programming and activities for confined youth. The use of isolation that mimics the punishment of solitary confinement rather than medical treatment is a common response, despite the known harms it inflicts on young people.

The virus has killed four staff members working in juvenile justice facilities in the United States. More than 2,500 other infected staff members returned home at the end of their shifts to bring the virus to their families and communities.

Jurisdictions have taken varied steps to slow the spread of the virus. As noted above, most jurisdictions have curtailed visitation and programming. Some have reduced the number of confined youths, either by intentional decisions to shrink populations or as a result of declining referrals to the juvenile courts. For years, advocates and experts have argued against the over-reliance on incarceration,[11] and these population declines in juvenile facilities can point to a new normal with still fewer youth in placement. And still, the virus spreads.

The emergency is not over, and there is more work to be done. Facilities' use of isolation, restrictions on visitation, and interruptions to education and counseling may have slowed the spread of the virus, but only at the expense of the rehabilitative mission of juvenile facilities. More than ever, incarceration should be reserved only for those youth who pose an immediate and serious threat to their communities.

Given the persistent racial and ethnic disparities in juvenile justice, there is little doubt that youth of color are suffering disproportionately from the virus and the changes within facilities that the virus has brought. On a typical day, African American youth are more than four times as likely as their white peers to be incarcerated.[12] As such, the hundreds of youth infected by COVID-19 are more likely to be African American, though scant racial and ethnic data on infections have been shared.

Drops in admissions during the pandemic, buttress the long-standing case that youth incarceration is largely unnecessary.

This report summarizes lessons learned through the first months of the pandemic, focusing on system responses, both positive and negative, to slow the virus's spread and to protect the safety and wellbeing of youth in the juvenile justice system while keeping the public informed. Drops in admissions during the pandemic, alongside decisions to release youth at a higher rate than during ordinary times, buttress the long-standing case that youth incarceration is largely unnecessary. Jurisdictions must now limit the virus's damage by further reducing the number of incarcerated youth. It is also essential to keep the public informed about the scope of COVID-19 by rigorously updating data on infections among youth and staff and publicly disseminating that data.

GROWTH OF THE VIRUS

THE DATA

As of September 23, 1,805 youth in 35 states, Puerto Rico and the District of Columbia have tested positive for COVID-19. Five states report more than 100 infections among youth: Florida, Texas, California, Tennessee, and Arizona (See Figure 1).[13] However, it is important to note that all of these states, except Arizona, have posted information about youth infections on government-run websites. Outbreaks in Arizona were revealed by local media, in one case following a failed effort to cover up the outbreak at the Mingus Mountain Academy.[14]

Twenty-seven facilities have reported at least 20 positive tests among incarcerated youths. Twenty-one of the facilities listed below house post-adjudicated youth (the system's equivalent of youth with a conviction); six others are detention centers, all of them in large urban areas such as Atlanta, Chicago, Columbus (Ohio), Houston, Los Angeles, and San Antonio (see Table 1).

Eighteen of the facilities are publicly run, and nine others are private. It is important to note that public facilities and public agencies have been more transparent in sharing data about the number of COVID-19 cases within

Figure 1. Reported COVID-19 cases by state

Map highlighted to show states with at least 10 known cases among incarcerated youth

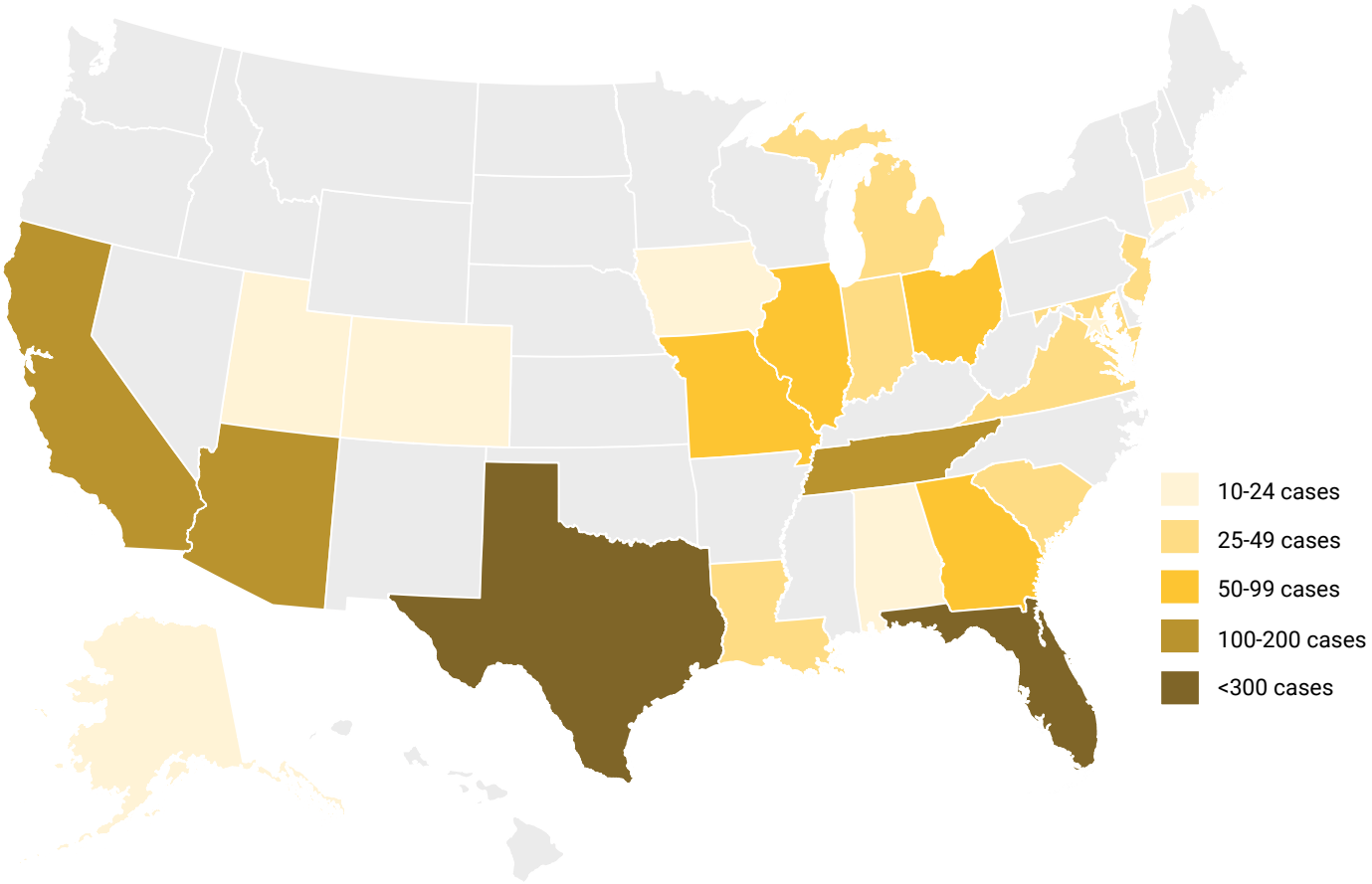


Table 1. Facilities with at least 20 reported cases of COVID-19 among youth[15]

As of September 23, 2020

Facility	Operator	Count	Capacity
Mingus Mountain Academy (Arizona)	Sequel Youth and Family Services	92	142[16]
Giddings State School	Texas Department of Juvenile Justice	89	256[17]
Memphis Youth Academy (Tennessee)	Youth Opportunity Investments, Inc.	54	48[18]
Adobe Mountain School	Arizona Department of Juvenile Corrections	45	459[19]
McLennan County State Juvenile Correctional Facility	Texas Department of Juvenile Justice	43	225[20]
Ventura Youth Correctional Facility	California Department of Corrections and Rehabilitation	42	600[21]
Central Juvenile Hall, Los Angeles (California)	Los Angeles County Probation Department	41	622[22]
Ocala Youth Academy (Florida)	Youth Opportunity Investments, Inc.	40[23]	72[24]
Bon Air Juvenile Correction Center	Virginia Department of Juvenile Justice	34	284[25]
Cook County Juvenile Temporary Detention Center (Illinois)	Circuit Court of Cook County	31	382[26]
Evins Regional Juvenile Center	Texas Department of Juvenile Justice	31	176[27]
Wilder Youth Development Center	Tennessee Department of Children Services	31	120[28]
Standing Tall Music City (Tennessee)	Standing Tall Music City	30	50[29]
Walton Academy for Growth and Change (Florida)	Rites of Passage, Inc.	29	42[30]
Cuyahoga Hills Juvenile Correctional Facility	Ohio Department of Youth Services	29	256[31]
Metro Regional Youth Detention Center	Georgia Department of Juvenile Justice	28	200[32]
Harris County Juvenile Detention (Texas)	Harris County Juvenile Probation Department	28	250[33]
Ron Jackson State Juvenile Correctional Complex	Texas Department of Juvenile Justice	26	268[34]
St. John's Youth Academy (Florida)	Sequel Youth and Family Services	26	72[35]
Pendleton Juvenile Correctional Facility	Indiana Department of Correction	26	391[36]
Bexar County Juvenile Detention Center (Texas)	Bexar County Juvenile Probation	25	278[37]
Wolverine Treatment Center (Michigan)	Wolverine Human Services	25	N/A[38]
Franklin County Juvenile Detention Center (Ohio)	Franklin County Court of Common Pleas	25	132[39]
Okaloosa Youth Academy (Florida)	Gulf Coast Youth Services	23	60[40]
Hogan Street Youth Center	Missouri Department of Social Services	23	36[41]
Palm Beach Youth Academy (Florida)	Sequel Youth and Family Services	22	82[42]
The New Jersey Training School	New Jersey Juvenile Justice Commission	21	300[43]

their institutions. Six of the nine private facilities listed are known to The Sentencing Project because they are in Florida, where the state Department of Juvenile Justice lists COVID-19 cases among youth and staff in almost all the facilities that house justice-involved youth. Other states that widely use privately managed facilities, such as Pennsylvania,[44] do not post such information.

Large for-profit private providers, such Sequel Youth and Family Services (operator of Mingus Mountain Academy, St. Johns Youth Academy, and Palm Beach Youth Academy) and Youth Opportunity Investments, Inc. (operator of the Memphis Youth Academy and the Ocala Youth Academy), operate dozens of facilities, and do not share information about COVID cases on their respective websites. Government agencies have often issued press releases with some details (such as counts) about the outbreaks in their facilities; Sequel and Youth Opportunity Investments have failed to do the same.

The data shown in Table 1, collected by The Sentencing Project, show a preponderance of outbreaks in large facilities, but it is hard to draw robust conclusions. On one hand, it makes sense that larger facilities would see more cases simply due to their larger population base. A 250-bed facility presents more opportunities for the virus to flourish than a 25-bed facility. On the other hand, larger facilities are more often publicly run facilities, and public facilities have been more likely to report their data than private facilities.

What is clear is that these data should be collected and reported by the federal government, specifically the Office of Juvenile Justice and Delinquency Prevention (OJJDP), to allow for a more thorough review and sound conclusions. Instead, OJJDP has relied on The Sentencing Project to collect and report the incidence of COVID-19.[45]

Because visitation has been curtailed, one of the main pathways for the virus to enter facilities is when staff are infected. Because testing is not comprehensive — either inside or outside facilities — it is beyond the scope of this paper to determine whether contagious staff or contagious youth are more likely to spread the disease. Nevertheless, staff cases are even more common than cases among incarcerated youth. Thirty-three states and the District of Columbia have had more cases among staff than youth, while only nine states and Puerto Rico have had more cases among youth than staff.

Four people working in youth facilities have died from COVID-19.

Patricia George, age 67, worked in the Crossroads Juvenile Center in Brooklyn, New York, and died in early April.[46]

Kenneth Moore, age 52, worked for the District of Columbia's Department of Youth Rehabilitative Services at the New Beginnings facility in Laurel, MD, and the Youth Services Center in the District, and died on April 1.[47]

Sean Wilson, age 43, worked at the Giddings State School in Texas, and died on June 28.[48]

Keith Green, age 54, worked at the Jerry J. Esmond Juvenile Justice Center in Galveston, Texas, and died on July 29.[49]

LIMITATIONS TO THE DATA

The data presented above are sharply limited by a lack of testing and a lack of reporting. As a result, the presence of states with high numbers of cases might reflect more testing and reporting, rather than a higher incidence of infections. While proactive testing and reporting may bring unwanted attention to a state's struggle with the virus in juvenile facilities, it can also limit the spread. That said, large numbers of tests will not invariably result in large numbers of positive diagnoses. After four youths tested positive in mid-June, North Carolina offered testing to all confined youth and staff and found zero additional cases among them.[50] A handful of positive cases among staff at large facilities in Rhode Island[51] and Nebraska[52] preceded additional testing that found fewer than five more cases among youths in each large facility. Maine is regularly testing all the youths at Long Creek Juvenile Facility, and has found one case out of 152 tests as of September 23.[53]

The Sentencing Project's tracking of COVID-19 cases in juvenile facilities reflects known cases. This effort is hampered by inadequate testing and inconsistent reporting, and could be better managed by the federal

Office of Juvenile Justice and Delinquency Prevention. Nevertheless, there are states that have been more transparent through regularly updated user-friendly websites. The District of Columbia and Louisiana were among the first jurisdictions to provide regular counts of the youth and staff in their facilities to test positive for COVID-19. Unfortunately, even those locales' reporting was flawed. The District of Columbia posts totals for its Department of Youth and Rehabilitative Services (DYRS) without specifying which of the two DYRS facilities have witnessed the cases.[54] Louisiana posts counts only among four state-run youth prisons, not the other facilities that are part of its juvenile justice system despite the Louisiana Office of Juvenile Justice's (OJJ) knowledge and willingness to share that information with the *Washington Post*.[55]

Few states provide demographic data about youth who have tested positive. (Setting aside important considerations about non-binary youth, gender can occasionally be derived from the simple fact that some facilities house only males or only females.)

There are positive examples of states and localities that have informed the public about the scope of COVID-19 in their facilities.

- First, states should publish data among all the youth and staff in its facilities, both public and private. Maryland's Department of Juvenile Services provide these data.
- Second, states should seek and share data from the county-run facilities. Tennessee's Department of Children's Services (DCS) provides these data, though DCS aggregates all the cases among the 17 detention centers it licenses.
- Third, states should list the negative test results and population counts as well as the positive diagnoses. Doing so assures the public that the facility knows the scope of the problem. Ohio's Department of Youth Services provides these data.
- Fourth, states should post demographic information about all their incarcerated youth and the youths who have tested positive. No state provides this information, though Tennessee's DCS posts demographic information (race and gender) regarding those youth who have been tested.

THE NEED FOR COMPREHENSIVE TESTING

On June 28, the Texas Juvenile Justice Department (TJJD) announced that Sean Wilson, an employee of Giddings State School, died from the coronavirus. To that point, 17 youth in TJJD facilities and 30 employees had tested positive for COVID-19, and TJJD announced it would test all TJJD employees and youth in its six state-run facilities, finding 165 cases among roughly 1,700 staff and 189 among roughly 700 youth once testing was completed in early August.[56]

Such comprehensive testing also took place in New Jersey, Maine, North Carolina, and Maryland, revealing far fewer previously unknown cases. Massive testing is the only path to ensuring that the virus can be found in congregate care settings. The disease is often asymptomatic, and even those youth who show symptoms have reasons to keep them secret, fearing the use of solitary confinement as a containment tool.

RECOMMENDATIONS

1. **Facilities should implement widespread testing among youth and staff to determine the spread of the virus.** The virus is often asymptomatic, meaning that looking for high fevers or coughs is insufficient to diagnose possible COVID-19 cases.
2. **States should report data on the scope of COVID-19 in their juvenile justice facilities, including positive and negative test results by facility.** The results should be published in easily accessible formats to inform the public, particularly the families of incarcerated youth.
3. **The Office of Juvenile Justice and Delinquency Prevention should collect and publish data compiled by the states.**

BENEFITS OF PAST REFORMS

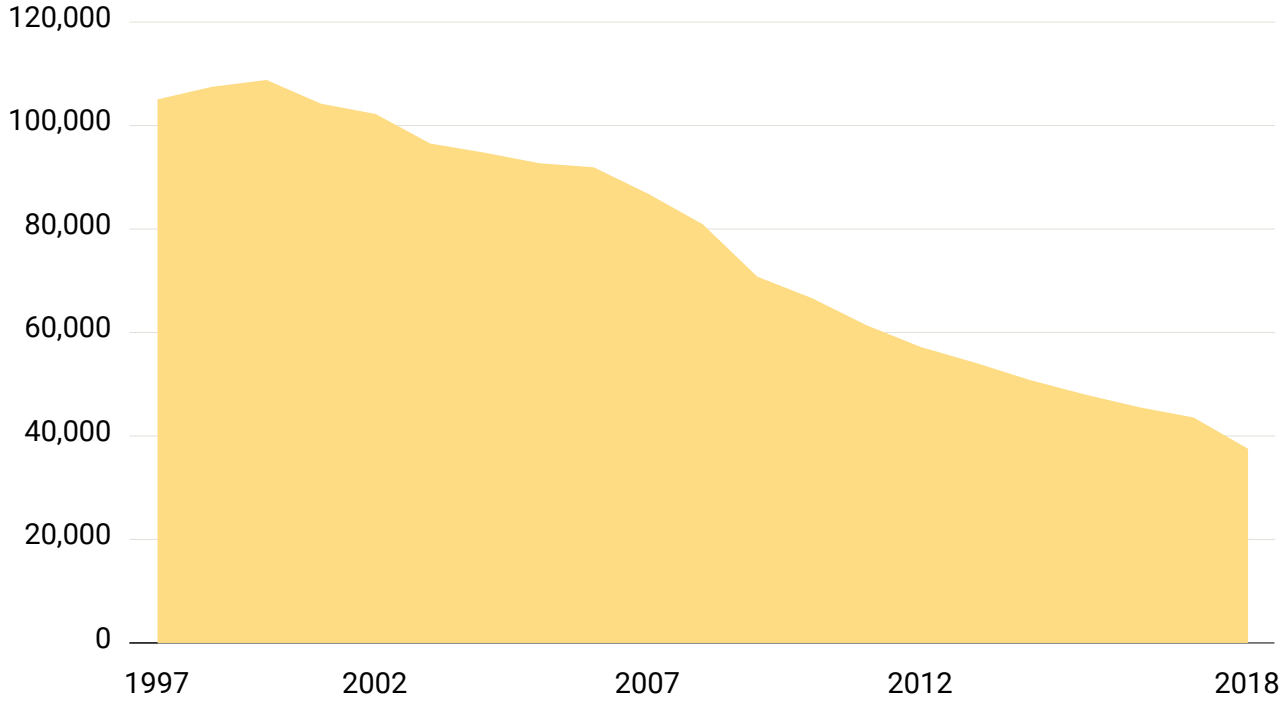
The significant changes to the juvenile justice system since the year 2000 have resulted in states incarcerating fewer youth and doing so in facilities that are smaller and less crowded. Commensurate with declines in juvenile offending dating to the start of the century, there are now fewer incarcerated youth than there have been in decades. As of October 2018, the date of the last national one-day count, there were 37,529 youths housed in 1,510 juvenile justice facilities around the country, a 65 percent drop from 2000, when the one-day count revealed 108,802 youths in 3,047 facilities (See: Figure 2).[57]

By comparison, more than two million Americans are housed in adult prisons and jails (including 3,400 people under 18 in prisons[59] and 735 people under 18 in jails[60]), and there have been more than 132,000 cases of COVID-19 among incarcerated people in prison alone.[61] The smaller population and lower crowding in youth facilities has benefited youth and staff alike and provides lessons for the criminal justice system.

Other data show that the system is smaller and less crowded than it has been in years. As of October 2000, 257 facilities were over capacity, housing more than

Figure 2. Youth in residential placement

One-day count, 1997-2018



Sources: Puzzanchera, C., Hockenberry, S., Sladky, T.J., and Kang, W. (2020). "Juvenile Residential Facility Census Databook" and Sickmund, M., Sladky, T.J., Kang, W., & Puzzanchera, C. (2019). "Easy Access to the Census of Juveniles in Residential Placement."

21,000 youths. As of October 2018, just 11 facilities were overcapacity, home to approximately 500 youths. In 2000, 57 percent of facilities were under capacity, compared to 82 percent in 2018. Moreover, there are just 68 facilities with at least 100 beds as of 2018, a 74 percent decline from 2000, when 264 such large facilities existed.[62]

As such, many juvenile justice systems have been better equipped to deal with the problems of congregate living and the spread of COVID-19 than they would have been had the number of incarcerated youth not been reduced substantially before the pandemic. Large, crowded facilities are destined to be breeding grounds for viruses.

In California's Bay Area, detention had already fallen sharply from its peak 20 years ago, and has fallen in half again during the pandemic. San Francisco's juvenile hall, designed to hold 150 youths, held fewer than 15 youths for most of August — overseen by 90 staff members.[63]

Youth First reports that declining populations during the pandemic (along with budget pressures stemming from the pandemic) caused nearly a dozen remaining facilities to be closed.[64] It seems likely that having fewer large and crowded facilities helped make this crisis smaller than it otherwise would have been. This partial success not only justifies past reforms that closed large youth prisons and sought alternatives to incarceration, but points to a further need to close more youth facilities and promote alternatives to incarceration that keep kids safely in the community with their families.

The most obvious solution to slow the spread of COVID-19 in congregate care facilities is by limiting the number of people there each day.

STEPS TO SLOW THE SPREAD OF THE VIRUS

EXPERT GUIDANCE

Public health experts responded to the inevitability of the virus's spread in congregate care settings, including the facilities that comprise the deep end of the juvenile justice system. In March, the Centers for Disease Control and Prevention issued guidance (subsequently updated) for correctional and detention facilities because such facilities present "unique challenges for control of COVID-19 transmission among incarcerated/detained persons, staff, and visitors." Social distancing and cleanliness were essential ingredients, even if the virus's presence was not yet apparent. "Because many individuals infected with COVID-19 do not display symptoms," according to the CDC, "the virus could be present in facilities before cases are identified. Both good hygiene practices and social distancing are critical in preventing further transmission."[65] However, from the outset, the CDC ignored calls from public health experts to decarcerate.[66]

The American Academy of Pediatrics (AAP) issued guidance of its own. "Detention facilities may struggle to ensure social distancing and may experience supply chain disruptions in obtaining soap, hand sanitizer, personal protective equipment, and cleaning supplies. Collectively, these factors increase the risk of COVID-19 transmission among confined youth."[67] According to the AAP's guidance, juvenile justice agencies should "Release youth who can be safely cared for in their home communities." This recommendation echoed the advice of more than 30 current and former juvenile corrections administrators, comprising Youth Corrections Leaders for Justice,[68] current and former prosecutors comprising Fair and Just Prosecution,[69] and Physicians for Criminal Justice Reform[70] who also called for more releases.

Other organizations have weighed in. The National Governors Association called for releasing more youth and reducing admissions.[71] The Council of Juvenile Corrections Administrators posted documents with common virus-related questions and current practices from governments agencies, including releasing more incarcerated youth, on its website.[72]

The CDC recommends limitation of transfers among facilities, a step many agencies follow by keeping youth in their local detention facilities instead of moving them to long-term secure placement. But the more obvious and effective solution, urged by advocates, current and former administrators, and the AAP, is to limit admissions and expedite releases.

DECISIONS TO RELEASE MORE YOUTH

Despite the long-term progress decreasing youth incarceration, many youths who pose no threat to public safety as well as those charged with low-level offenses remain incarcerated on a typical day. Some localities, bolstering the case for further decarceration, reduced their incarcerated populations as a proactive response to the oncoming pandemic. Colorado Governor Jared Polis[73] and Michigan Governor Gretchen Whitmer[74] issued executive orders to release more youth as a strategy to reduce infections. Leaders in Georgia,[75] Massachusetts,[76] and elsewhere released dozens of youth to limit their exposure to the virus.

Juvenile defenders have sued state governments to force the release of more youth to stem the damage from COVID-19. Lawsuits have been brought against the states of Alabama,[77] Pennsylvania,[78] Louisiana,[79] and Texas[80] to force the release of more youth, all of them

unsuccessful. On the other hand, Maryland's Department of Juvenile Services released 200 incarcerated youth at the end of April as a response to state court orders there.[81]

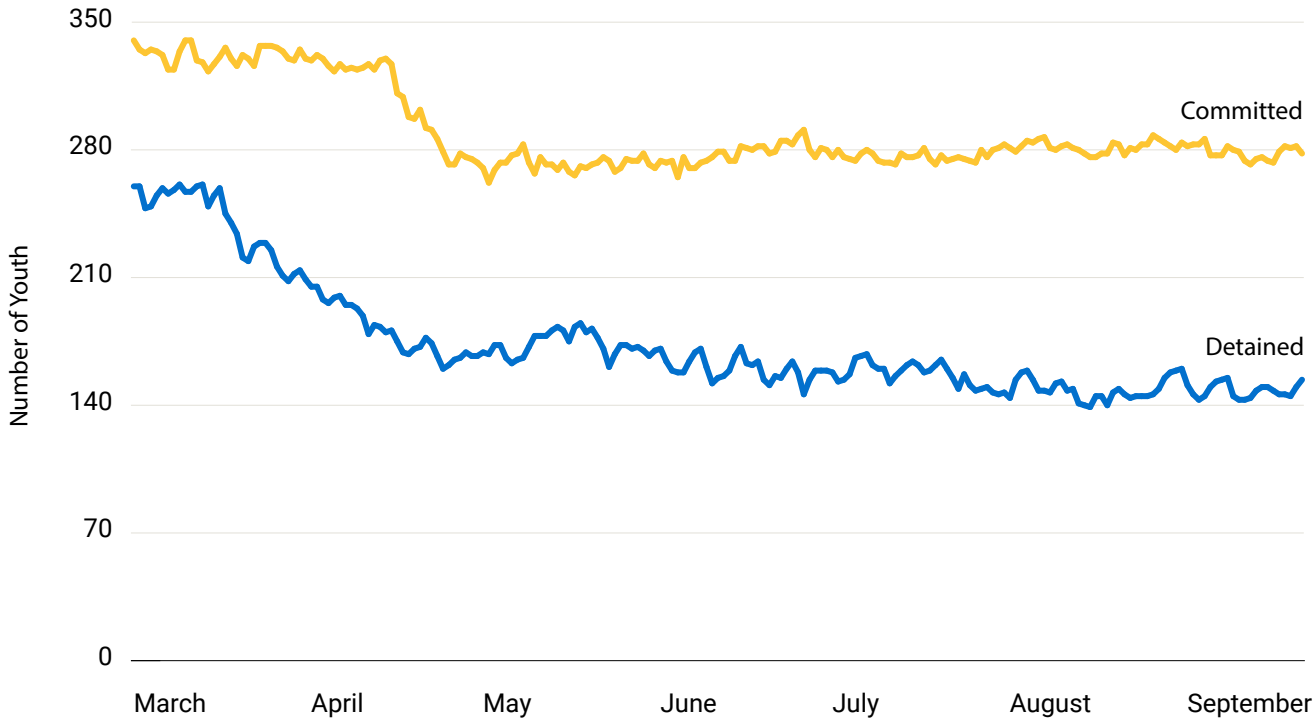
By suspending the Colorado parole board's decision-making power to release youth, and leaving the decision in the hands of the Department of Youth Services, Colorado decreased the number of incarcerated youth from 600 on March 1 to 439 on May 1, including a 35 percent decrease in detained youth (See Figure 3).[82] In Michigan, Governor Whitmer strongly encouraged release from local detention centers unless there is a "substantial and immediate safety risk to others." Very few of the youth held in Michigan detention centers can be considered a threat to public safety due to pending or adjudicated charges or other factors;[83] there was an opportunity to release many youths. States around the country still detain youth — as Michigan did before the pandemic — who could be safely returned to the community.

The Annie E. Casey Foundation surveyed the sites that are part of its Juvenile Detention Alternative Initiative (JDAI), a wide array of detention centers, though not a representative sample, finding that population counts at the JDAI sites declined by 24 percent in March,[84] and continued to fall in May.[85]

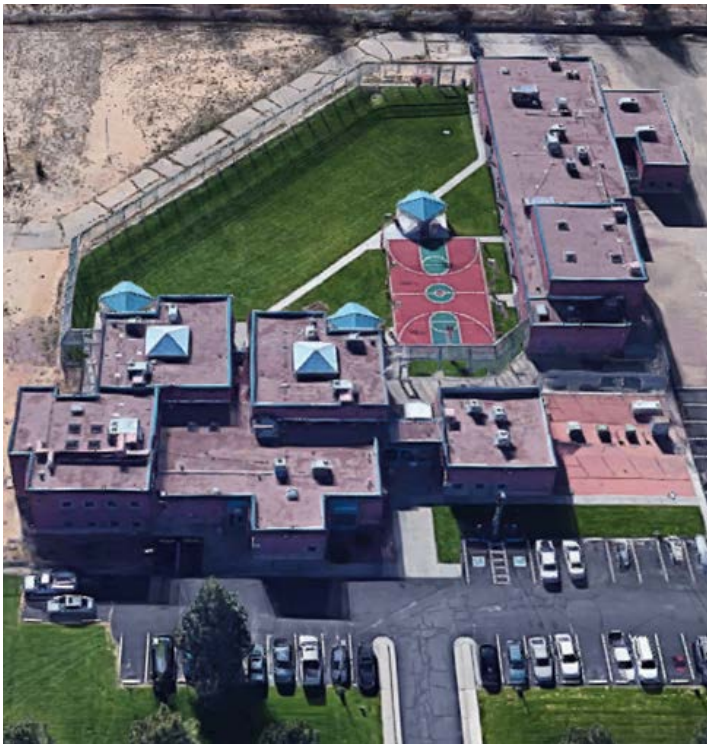
Mostly, this was due to reduced admissions and not proactive releases. Many youth held in detention are there for very short stints, revealing that detention is often unnecessary. Thus, much detention of youth is unnecessary and likely to reflect administrative convenience or intransigence rather than a necessity for public safety.

Reducing populations among committed youth, who are sentenced either to complete treatment or for a set period of time, has been less common but necessary in response to the pandemic. For example, Colorado Governor Polis's executive order had an impact, dropping committed populations in the state by 20 percent, from 340 on March 1 to 270 on May 1.[86] Not surprisingly, the number of youth in Colorado known to have tested positive for COVID-19 is well below the national average. (Moreover, Colorado has been transparent with its COVID-19 data, so its infection count is more complete than elsewhere.)

Figure 3. Colorado youth placement, March-September 2020



Source: Colorado Division of Youth Services.



The Pueblo Youth Services Center, a 27-bed facility in Pueblo, Colorado, has had four youths test positive for COVID-19. *Image from Google Maps.*

Colorado's initial response shouldn't be confused with the normal population churn in facilities. Since the initial releases, the committed population in Colorado has fluctuated between a low of 262 and a high of 291, but generally holding between 270 and 280 youths. Such modest day-by-day changes mostly reflect the irregular patterns of admissions and releases.

Another tactic to reduce the spread of the coronavirus in facilities is to stop admissions in the state-run post-adjudication facilities, a tactic recommended by the CDC, and one that had been successful in California.[87] In that state, adjudicated youth continued to be held in county-run facilities after commitment to a state-run post-adjudication facility was ordered. Through July 3, only three youths in California's three state-run facilities had tested positive for COVID-19. California then opted to allow intakes at its state-run facility in Ventura, and 20 cases emerged through July. The decision was reversed at the beginning of August.[88]

REDUCED ADMISSIONS

Many of the releases from juvenile facilities took place in March and April, but populations have continued to fall mostly due to reductions in admissions. For Annie E. Casey Foundation's Juvenile Detention Alternative Initiative sites, there were roughly 200 admissions per day in January and February, but roughly 100 per day in April and May.[89] Georgia's Clayton County limited admissions to youth charged with violent or gun felonies, and the detention population fell from 15 to fewer than four on most days.[90] In the District of Columbia, youth cannot be taken into custody unless they present a risk of harm to themselves or others.[91]

While the JDAI sites are not a representative sample, it is likely that reduced admissions have taken place elsewhere, as well.

RACIAL AND ETHNIC DISPARITIES

The juvenile justice system is rife with racial and ethnic disparities, and the declines in detention have been no exception. African American youth are more than four times as likely as their white peers to be incarcerated, a ratio that holds true across a range of offenses.[92] Racial and ethnic disparities, already large at initial contact with law enforcement, generally grow at each point of contact with the rest of the justice system.

The extent to which racial and ethnic disparities pervade COVID-related releases is mostly unknown at this time. Juvenile Court Statistics, reviewing outcomes in juvenile courts nationally, is released annually. These data show that youth of color are treated more harshly at most stages of the juvenile justice system, but the courts' data are not separated by state.[93] Another set of data, Census of Juveniles in Residential Placement (CRJP), show racial and ethnic disparities in incarceration, including state-by-state, but are only published every other year.[94] The most recent CJRP, for 2017, was released in November 2019. In short, comprehensive, real-time demographic data about released youth do not exist.

Surveying its Juvenile Detention Alternative Initiative (JDAI) sites, the Annie E. Casey Foundation found the release rate for white youth has been twice as high as their African American peers during the pandemic.[95] This is a recurrent, persistent problem in juvenile justice as reforms have predominantly benefited white youth. Youth incarceration rates for all youth fell from 2001 to 2017, but the rate of declines were fastest among white youth.[96,97] It is not surprising to see these patterns continue during the pandemic. In order to immediately address racial disparities in the context of pandemic response, all states and jurisdictions should report releases by race and identify and correct for racial disparities in such releases.

RECOMMENDATIONS

1. **States should publish current data on detained and committed youth by race and ethnicity.** Despite the fact the facilities are always aware of their exact population counts, nationwide data lags years behind. To understand the scope of the virus and jurisdictions' responses to it, states should publish weekly population reports showing daily populations with additional demographic information such as race, ethnicity, and gender of incarcerated youth.
2. **Because smaller, less crowded facilities are less amenable to spreading covid-19, jurisdictions should:**
    - **Restrict the use of incarceration only to those youth who cannot be safely treated in the community.**
    - **Limit admissions to facilities to youth who are immediate and serious threats to their communities and who cannot be safely housed in a less restrictive setting.**
    - **Restrict the use of detention.**
    - **Release post-adjudication youth who are near the end of their treatment.**
    - **Release post-adjudication youth who can be served in the community.**
3. **Do not move incarcerated youth between facilities.**

IMPACT OF COVID-19 ON YOUTH AND FACILITIES

LIMITS TO VISITATION

To limit the virus's entrance into facilities, jurisdictions have restricted visitation. A typical example took place in Louisiana, where the Office of Juvenile Justice announced the end of in-person visits in March. For families and incarcerated youth, this was a heartbreaking change.

Gina Womack, executive director of Families and Friends of Louisiana's Incarcerated Children, told a reporter that the lack of information, as well as the state's low prioritization of system-involved youth reminded her of a prior disaster. "It seems like there's really no plan in place of the outbreak in the youth facilities," Womack said, "and it seems as if Katrina never happened."[98] As word of the outbreak spread in those facilities, Nicole Hingle, whose son was incarcerated at Louisiana's Bridge City Center for Youth, told NBC News, "This is one of the worst things I've ever had to go through. I just sit by the phone and I wait and I pray, and I wait and I pray, and that's all I can do as a mom. I wait for my son to call, and I just pray that my worst fear doesn't come to reality."[99]

One alternative, implemented in Utah, is to expand video visitation and ensure that it is truly free to families. However, the lack of adequate technology on both sides of the call can be a daunting barrier to implementation. "These are typically the most underserved families in really challenging circumstances," Utah Juvenile Justice Services Director Brett Peterson told the *Salt Lake Tribune*, noting they may lack high-speed internet connections required for video calls. The Department assists with buying equipment for families and with technical support. Peterson plans to continue the program after the pandemic ends.[100]

DISRUPTING PROGRAMMING

Ending visits has not only harmed youth's connection to their families, but has disrupted the programming that is an essential piece of the juvenile justice system's rehabilitative mission. The juvenile system strives to distinguish itself from adult corrections by valuing rehabilitation over punishment; ending such programming blurs that difference. Chris Rodgers, a county board member in Omaha, noted that programming was "taking a hit" because of limits to visitors at the detention center there.[101] An outbreak at the Baltimore City Juvenile Justice Center, where roughly 60 percent of the youth are 16-years old and younger,[102] paused classes.[103] A mother in the Florida panhandle said her son was unable to start his rehabilitation programming because of the state's response, and cannot be released until he finishes that treatment.[104] Education at Oregon's MacLaren Youth Correctional Facility stopped for months this summer, restarting more than a month after the last youth there tested positive.[105]

It is not just the infected youth who suffer. In Ohio, single cases of staff testing positive have placed full facilities into quarantine.[106] In Oregon, a new case among staff at the MacLaren facility placed one living unit in quarantine for two weeks, marking the end of their in-person visits.[107]

These are just a handful of the countless examples showing how current visitation policies interfere with daily life in the juvenile justice system. These limitations on movement, both for youth inside the facilities and for the people who would provide programming, have sharply limited basic activities.

ISOLATION

Facilities have been inconsistent in following the guidance issued by the CDC. Seventeen year old "Denise," who was arrested at her Alabama school and detained after an incident involving a cell phone in class, said that "It was impossible to do social distancing in such a small cabin for 10 people.... Social distancing wasn't really enforced by the group leaders. They didn't really take steps to protect us from COVID-19."[108] Another teenager, in Baltimore, said "I was trying to stay six feet away from people, but we really can't in there — it's tight," the teenager told the *New York Times*. "And then I was thinking: It doesn't even matter. Everybody was breathing the same air."[109]

Ordinarily, incarcerated youth live near other incarcerated youth. They eat, sleep, learn and recreate near each other. Yet people in all walks of life suspected of carrying the virus are urged to quarantine pending test results and after attaining a positive diagnosis. Steps taken to medically isolate youth have mimicked solitary confinement, considered torture or cruel, inhumane and degrading treatment for children under international human rights law and standards.[110]

In Maryland, youth are given an hour a day to shower or exercise before returning to their cells. Jenny Egan, chief attorney in the juvenile division for the Maryland Office of the Public Defender in Baltimore, notes that many of her clients have mental illnesses and cognitive limitations that are exacerbated by isolation. Nevertheless, the state isolates youth who test positive for COVID-19 for roughly 10 days.[111]

"Medical isolation means that a person needs to stay physically separated from others," Maryland Department of Juvenile Services spokesman Eric Solomon told radio station WYPR. "For youth, they remain in their room and have access to a bathroom with a shower. If they are well enough and if cleared by the medical director, they are also allowed to go outside."[112] In Maryland as well as Colorado, the fact that the door is unlocked distinguishes the medical isolation from solitary confinement.[113]

AMEND, a project of the University of California, San Francisco and its Medical Center, recommends several factors to distinguish medical isolation from solitary confinement in practice and not merely in name. Medical isolation, they note, is designed to stop the spread of disease, whereas solitary confinement is a form of punishment. The most essential of these differences is to ensure that a decision to isolate is made by medical professionals.[114]

UNDER-STAFFED FACILITIES

Even before the pandemic, many facilities struggled to maintain full staffing. Under present conditions, staff shortages have worsened, threatening the safety of youth and staff alike. In New York[115] and Louisiana,[116] youth riots have been blamed on staffing issues,[117] though certainly such events also occur without the virus present. With fewer staff, there is another reason to fear for the safety of incarcerated youth. Advocates in Florida fear that facilities there, which have often been the site of sexual abuse, are particularly incapable of preventing abuse during the pandemic, and that youth are less likely to report its occurence.[118]

RECOMMENDATIONS

1. **Medical isolation should be supervised by medical personnel, not security personnel and should be clearly delineated from solitary confinement or any other form of punitive isolation.** Separating youth who have tested positive, or youth who are awaiting test results, from the rest of the population is necessary to slowing the virus's spread. However, separation should not be a form of punishment. Living conditions for youth in medical isolation should approximate conditions in the general population as much as possible, including access to outdoor exercise and programming.
2. **Any youth subject to medical isolation should be monitored by medical and mental health staff at least daily.**
3. **Ensure frequent communication between incarcerated youth and their families.**

CONCLUSION

The actions of some state and local governments provide templates for other localities to follow. It has long been known that too many youth are incarcerated for too long, with many youths better suited to non-justice system remedies for their misbehavior and challenges. During the COVID-19 era, some jurisdictions have opted to release more youth, with the real possibility of permanent changes to their respective juvenile justice systems once the emergency has passed. Declining populations, both via active choices and as residue of declining arrests during the pandemic, have closed nine state-run facilities, according to the Youth First Initiative.[119] The states and counties that have reduced their populations provide a roadmap for a smaller, focused use of incarceration in limited circumstances.

The emergency is not over. More youth can be released, with a need to focus on youth of color.

Nevertheless, there is far more to be done. More youth can be released, with a need to focus on youth of color. Racial disparities in release existed in reforms prior to the pandemic and initial data indicates that racial disparities continue to exist in releases undertaken in order to address the pandemic in facilities now. Those who are released require meaningful, well-funded plans that offer the services that are not presently being provided inside the facilities.

Lastly, jurisdictions need to find and track the virus in their facilities and report what they find to the public. Absent federal leadership, states and counties will be forced to do this on their own.

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