



VULNERABLE WOMEN AND GIRLS

AT THE INTERSECTION OF SEXUAL VIOLENCE, ADDICTION, CHILD WELFARE AND THE CRIMINAL JUSTICE SYSTEMS

Women and girls suffer from physical and sexual violence, alone and in silence. The silent suffering of being violated, often by family, friends or other trusted persons, dims self-esteem and cuts down women and girls' conceptions of who they can become and what kind of relationships they deserve. In vulnerable communities, these hurt women and girls are too often relegated to the criminal justice system—and not the mental health or treatment services that other victims of sexual violence are generally afforded access to.

A strong correlation therefore exists for vulnerable women between physical and sexual violence and addiction. Women drug abusers are four times more likely to possess a history of sexual violence and trauma, than women who do not use drugs. The pathway to addiction for women at the margins is distinctly tied to how women suffer from violence done to their bodies, and are left to endure those injuries in silence and without help.

This pathway to addiction is especially difficult for vulnerable mothers. There are few family-based treatment programs for mothers and their children to enter together, as a whole family. Many low-income addicted mothers endure the difficult fate of losing their children to the foster care system, and entering into the criminal justice system for non-violent drug related convictions. Presently, most women behind bars for non-violent drug felonies are mothers to minor children.

These mothers behind bars report histories of extreme sexual violence and trauma prior to their incarceration, upwards to 90 percent in states such as New York and California. In prison, women are not afforded opportunities for treatment and healing. Instead, the prison system too often subjects them to more violence. In federal correctional facilities 70 percent of the guards are men and there are numerous incidents of male guards subjecting women to rape, sexual assault, sexual extortion, groping during body searches, and watching women undress in the shower.

At the same time, there are unprecedented numbers of girls entering the juvenile justice system for non-violent convictions. Most are subject to detention for the gendered offenses of prostitution or running away from abusive homes. Many of the girls are already in the foster care system, they have cycled through numerous placements, endured sexual violence in their foster care homes, and reside in group homes or even lock-down facilities due to a lack of available foster-care placements.

Improving the lives of vulnerable women and girls requires comprehensive reforms to child welfare, criminal justice, housing and health policies. Specifically, the **Rebecca Project urges the new administration to consider the following recommendations to make better the lives of vulnerable mothers and girls:**

- **Reauthorize the Pregnant and Parenting Program (PPW) at \$350 million (or \$70 million per year) as part of the overall reauthorization for the Substance Abuse Mental Health Services Administration (SAMHSA).**



- Restructure federal child welfare financing to support family substance abuse treatment services.
- Implement a narrowly tailored waiver of the one-strike policy for mothers and their children.
- Pursue an alternative sentencing to maternal incarceration initiative for non-violent mother offenders.
- End the practice of shackling pregnant offenders during labor, delivery, and post-delivery in state prisons and jails.
- Develop alternative sentencing programs for girls who come to the attention of the juvenile justice system.
- Amend the federal Trafficking Victims Protection Act to ensure that sexually exploited girls born in this country are accorded the same protection and services granted to international victims.

MOTHERING AT THE MARGINS

Too many low-income mothers are dislocated from systems of support, especially mothers struggling with issues of violence, trauma, and untreated addiction. Many of these mothers want to be good mothers to their children but lack access to the mental health and treatment services to surmount their trauma and addiction. Many of these mothers and children are consequently lost to the child welfare and criminal justice systems. But there are significant reforms that can be made to give mothers at the margins the support to heal and raise their children with health, stability, and dignity.

Reforming Child Welfare

The absence of family-based treatment, treatment for both mothers and their children, is a child-welfare crisis. Upwards to 80 percent of the families who come to the attention of child welfare agencies are substance abusing.¹ Yet Only 10% of child welfare agencies report that they can successfully find substance abuse programs for mothers and their children who require the treatment in a timely manner. Hence, alcohol and drug-related cases are more likely to result in foster care than are other child welfare cases. The sacred ties between a parent and child are severed because the family did not receive the family-treatment services to heal together.

At present, family treatment represents less than 5% of the overall treatment available—since most treatment services serve only single-adults and prohibit children from the treatment process. Before the emergence of the meth crisis, which is disproportionately impacting mothers with minor children, the Institute of Medicine estimated that approximately 105,000 pregnant women each year need drug treatment, while only 30,000 of these women receive any form of treatment, and

¹ National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up: the Impact of Substance Abuse on State Budgets*. New York, New York: The National Center on Addiction and Substance Abuse, 1998.



very few of these are in programs with a primary focus on special services for pregnant women or families.

Family treatment is the last and best hope for so many drug addicted mothers and their children. When mothers achieve access to family-based treatment services, they are able to find health, healing and stability for themselves and their families. SAMHSA's evaluation of the family treatment programs demonstrates the following indicators and outcomes of success:

- Parental sobriety averaged at 60 percent, at discharge and 6 months post-discharge from treatment.
- Rates of premature delivery, low birth weight, and infant mortality were improved for participating women.
- Significantly reduced alcohol and drug use, as well as decreased criminal behavior.
- Treatment costs were offset three to four times by savings from reduced costs of crime, foster care, Temporary Assistance to Needy Families [TANF], and adverse birth outcomes.

When family treatment costs are compared to the costs of incarcerating a substance abusing mother and placing her children in foster-care, the savings to the state and nation are significant. For example:

- Family treatment costs average between \$14,000 to \$25,000 per family per year depending on the state (for example, in Utah it costs about \$14,000 and in New York treatment is approximately \$25,000).
- The average cost of one child in the foster care system is \$40,000 per year.
- The average cost of state and federal incarceration of a mother is \$30, 000 per year.
- The Department of Justice (2002) concluded that lifetime costs of caring for drug exposed children range from \$750, 000 to 1.4 million per child.

Recommendation: Reauthorize the Pregnant and Parenting Women Program (PPW) to Expand Family Treatment Capacity.

In 1992, Congress authorized P.L 102-321, PHS Act Section 510, to pioneer funding for family-based treatment. The residential women and children (RWC) grants, and residential treatment grant program for pregnant and postpartum women and children (PPW) established a new family-based model of treatment where mothers and their child could achieve treatment together, as a family. The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) awarded \$241,000,000 over a five year period between FY 1993-1997 to create and expand family treatment under the Residential Women and Children and Pregnant and Postpartum Women Demonstration Program. A total of fifty family treatment programs received funding under the RWC/PPW.

Unfortunately, after the demonstration grants expired Congress did not renew its commitment to family-based treatment programs. Despite unprecedented outcomes in family stability, parental sobriety, and child well-being, funding for the RWC/PPW programs dropped to \$10.7 million and by the year 2000 the RWC/PPW authorization received no appropriated funding at all. PPW



funding was not included in the subsequent SAMHSA reauthorization. PPW is currently funded at \$12 million a year.

SAMHSA ‘s imminent reauthorization offers an opportunity to provide \$350 million for family treatment programs, a funding level which allows for a substantial expansion of family treatment capacity, especially in areas hard hit by the meth crisis. A funding level of \$350 million for family treatment (PPW) will create and expand an estimated 90 more family-based treatment programs to serve our most vulnerable families.

Recommendation: Restructure Federal Child Welfare Financing to Support Family Treatment

The primary source of federal funding for child welfare agencies is Title IV-E is the principle source of federal funding for child welfare agencies. Unfortunately, the current structuring of Title IV-4 funding is restricted to supporting the costs of out of placements. Funding is therefore not available for services to prevent families from entering into the foster care system or providing intervention program and supports to keep vulnerable families safe and stable. Restructuring IV-4 funding to be flexible and support prevention services, such as family treatment, enables families to stay together in a context of safety and health.

The evidence-based, successful outcomes of family treatment programs, demonstrate that family treatment is a safe, effective, and healing approach to keeping families together, and preventing their entry into the child welfare system. Since parental substance abuse is the primary reason for out of home placement, it is common sense child welfare policy reform to restructure child welfare financing to support prevention services such as family treatment, which is less costly and provides for more successful outcomes for children than foster care placements.

Please find below a cost-benefit analysis of a California family treatment program and its savings to the Los Angeles child welfare system, and other costs offset from the savings of family treatment.

SHIELDS FOR FAMILIES, INC. – LOS ANGELES, CA

Since the Shields for Families family treatment program’s implementation in 1994, outcome data has been closely monitored. During the initial stages of the program (1994-1999), Exodus was part of a national evaluation through the Center for Substance Abuse Treatment, in addition to a local evaluation through SHIELDS. National evaluation results established the program as a best practice model for the federal government in 2001. **Evaluation outcomes of the program over the past five years (2002-2007) for mothers and their children conducted through SHIELDS Research Division include:**

- **An 81.2% completion rate (national average = 25%).**
- **Family reunification rates of 85%.**
- **An average of 646 days in treatment (national average = less than 90 days).**
- **All clients obtained a high school diploma.**



- Increase in parental knowledge of child development and parenting skills with parents scoring an average of 90% on post-test scores.
- Over 200 parents received completion certificates for parenting and child development classes.
- Success in achieving low rates of Very Low Birth Weight among infants born to enrolled mothers (average= 4.5% over the last six years, 0% in the last year).
- High rates of entry into prenatal care (average=67% over the last six years, 72% in past year).
- Immunization rates among enrolled children averaged 80% in the past 5 years.
- Of a total of 264 infants who were born in the program in the past 6 years, less than 6% had positive toxicology screens.

In the past 5 years, a total of 236 children (95%) have received at least 1 developmental screening. Overall, 85% of children received scores that fell within the normal range of development, and 15% of children were identified with potential delays and referred for additional assessment and specialized services. **Evaluation outcomes of the child development component include:**

- 60% of participants improved attitudes towards school and education;
- 75% of participants improved grades in math and English;
- 77% of participants improved self esteem and self confidence;
- 77% of participants improved cultural awareness/identity and community mobilization skills;
- 80% of participants improved awareness of substance abuse related issues and made a commitment to live drug free.

Shields for Families saves the child welfare system \$25,280,000.00 annually.

Foster Care Dollars Saved Annually		
Thru up front assessments (collaboration w/ child welfare)		\$25 million
	14 open cases per year at \$20,000	
Thru reunification	=	\$280,000
		\$25,280,000.00

Housing for Mothers and Families at the Margins

The Housing Opportunity Program Extension Act of 1996 gives broad discretion to Public Housing Authorities (hereinafter referred to as “PHAs”), as it arguably should, to evict tenants connected with drug-related behavior. Congress developed the “one strike” provision as part of this Act, and HUD strengthened this rule by creating a regulatory policy for its enforcement. HUD’s most far-reaching effort, giving wide discretion to the PHAs, involves the promotion of applicant screening procedures. HUD encourages PHAs to screen all applicants’ criminal records as well as to develop their own eligibility criteria. To ensure that all housing authorities screen



applicants, HUD's "One Strike Guide" states that PHA ratings and funding are directly related to whether or not the PHAs are "adopting and implementing effective applicant screening."²

HUD encourages PHAs to consider applications for residence by persons with such criminal histories on a case-by-case basis, focusing on the concrete evidence of the seriousness and recentness of criminal activity as the best indicators of tenant suitability.³ PHAs are also advised to take into account the extent of criminal activity and any additional factors that might suggest a likelihood of favorable conduct in the future, such as evidence of rehabilitation.⁴ In practice, however, PHAs have implemented stringent exclusionary policies, denying project-based public housing to over 46,000 applicants in 2002.⁵ This figure represents only a fraction of applicants rejected because of their criminal records and excludes those who are denied Section 8 housing assistance since HUD does not require PHAs to report Section 8 denials of housing.

Denied access to public housing has inimically impacted low-income mothers who achieved sobriety as a result of their participation in family-based treatment programs and seek to stabilize their families.

Since the passage of mandatory sentencing laws, the fastest growing prison population is women with non-violent drug felony convictions. And most of these women are mothers: in State prison, 65.3% of incarcerated women are mothers to minor children and 58.8% are mothers to minor children in Federal prison. The majority of the women are also untreated addicts. According to BJS, 89% of incarcerated women reported using drugs on a regular basis at the time of the offense.

The "one strike" policy on eligibility for public housing has created an unintended and disproportional impact on mothers due to the increasing numbers of mothers behind bars for non-violent drug felonies. Incarcerated mothers who reenter the community, seek to achieve sobriety in family-based treatment programs, and hope to stabilize their families, ought to be given a chance to create a better life for themselves and their children.

Family treatment programs have consistently demonstrated successful outcomes in family sobriety and reunification. According to research from the Substance Abuse and Mental Health Administration (SAMHSA) conducted in 1998, 2001, and again in 2003, family treatment programs reached successful outcomes, with 60 percent of families achieving sobriety at the end of treatment and six months after completion of treatment. Family treatment programs have sought to alleviate barriers for families in order to help parents secure their sobriety and become self-sufficient. A fundamental barrier to family stability, according to family treatment directors across the country, is the "one strike" housing policy. The "one strike" policy has rendered many mothers, in recovery from their drug addiction as a result of family treatment, homeless—because

² HUD Notice PIH 96-16 (HA), April 12, 1996 and attached "one strike" guidelines: HUD, "One Strike and You're Out Screening and Eviction Guidelines for Public Housing Authorities," April 12, 1996.

³ Housing Opportunity Program Extension Act of 1996, Pub. L. No. 104-120, 110 Stat. 834 (1996)

⁴ *Ibid.*, § 9(c)

⁵ Office of Litigation, U.S. Department of Housing and Urban Development, December 22, 2003. Figured based on data given to HUD by PHAs.



they possess a drug felony conviction. Other parents are homeless and unable to reunify with their children because they cannot prove to the judge an ability to stabilize their family in a home.

Recommendation: Implementation of Narrowly-Tailored Waiver for Parents in Recovery

Neither Congress nor HUD intended the “one strike” policy to unnecessarily burden families by punishing parents who have successfully completed family-based drug treatment programs, and are no longer engaging in the illegal use of a controlled substance or abuse of alcohol. A narrowly-tailored waiver that lifts the exclusion of persons with drug and drug-related felony convictions from eligibility for public housing, as it applies to this specific population of parents in recovery, would increase the success of these families, not only in terms of gaining housing, but contribute to the overall re-stabilization of their lives. HUD could implement this narrowly-tailored waiver as a directive and/or demonstration project.

Mothers Behind Bars

Twenty-five years ago, the presence of women—especially mothers—was an aberration in the criminal justice system. However, following the introduction of mandatory sentencing to the federal drug laws in the mid 1980s, the number of women in prison has risen 400%.⁶ The percentage of females incarcerated for drug offenses now surpasses that of males. *And most of these women are mothers.*

The most recent statistics indicate that drugs are responsible for the incarceration of 34 percent of state prisoners who are female and 72 percent of federal female prisoners.⁷ Indeed, drug related offenses accounted for 65 percent of the increase in the female prison population between 1996 and 1999.⁸ Many of these mothers then represent a displaced population that should be in the public health system, but instead are displaced into the criminal justice apparatus, at more cost and worse outcomes to them and our federal and state governments.

When mothers are placed behind bars for untreated addiction, their children are either placed in foster care or kinship care. During the period of incarceration, it is a struggle for incarcerated mothers to maintain an abiding connection to their children. Women's prisons are often located in rural areas far from the cities in which the majority of inmates lived, making it difficult to maintain contact with their children and jeopardizing the prospects of successful reunification. A national study found that more than half of the children of women prisoners did not visit their mothers while they were in prison. Over 60 percent of the children who did not visit lived more than 100 miles from the prison where their mothers were incarcerated.⁹ Incarcerated mothers with children in foster care are often unable to meet court-mandated family reunification requirements for contact and visitation with their children, and consequently lose their parental rights.

When these mothers are in prison, they receive little or no opportunity for healing from the disease of addiction. Effective programs for both male and female offenders are limited, but programs explicitly designed and implemented for women, especially mothers, are nearly non-

⁶ Bureau of Justice Statistics., U.S.Dep't of Justice, ncj 175688, Women Offenders 1(Lawrence A. Greenfield&Tracy L. Snell eds.,1999)

⁷ Bureau of Justice Statistics., U.S.Dep't of Justice, ncj 175688, Women Offenders 1(Lawrence A. Greenfield&Tracy L. Snell eds.,1999) at 7.

⁸ Women in Prison, BJS, (1994).

⁹ Id.



existent. Despite the growing numbers of female inmates, Morash and Byrnum found in a nationwide study that few services addressed women's distinct needs and experiences. Specifically lacking were services for mothers and pregnant women.¹⁰ The treatment programs that existed lacked comprehensiveness, and counselors did not focus on the women's histories of physical and sexual victimization that led to their drug abuse.¹¹

The dearth of adequate services for women and mothering offenders is not limited to incarceration settings, but impacts women at every point in their involvement with the criminal justice system. Pre-trial diversion and release services, court-sentenced alternatives and re-entry programs for women and mothering offenders are restricted in number, size, and effectiveness.¹²

Recommendation: Alternative Sentencing to Family-based, Treatment-based, Community-based Programs for Mothers with Non-violent Felony Convictions.

A mothering initiative should be introduced that supports the development of competitive grants for states to develop alternative sentencing programs for mothers with non-violent felony convictions that are not step-down, lock-down programs but community-based, family-based, and treatment-based. At the federal level, the mothering initiative will expand grants to the Bureau of Prisons to implement alternative sentencing programs that are community-based, family-based, and treatment-based for mothers with non-violent felony convictions.

Recommendation: End the Practice of Shackling Mothers During Labor, Delivery, and Post-delivery.

Jails and prisons use restraints on women in labor and delivery as a matter of course regardless of whether a woman has a history of violence (*which only a minority have*), regardless of whether she has ever absconded or attempted to escape, and regardless of her state of consciousness.

Only 3 states have legislation regulating the use of restraints on pregnant women: California, Illinois and Vermont. In the other 47 other states, and the District of Columbia, no such laws exist. Eight Correctional Departments have no formal written policy governing the use of restraints on pregnant women. AZ, HI, IN, IA, ME, NH, NJ and NC. Only five state departments of corrections and the District of Columbia have written policies stipulating that no restraints are to be used on inmates during labor and birth: CT, FL, RI, WA, WY and DC.

The American College of Obstetricians and Gynecologists (ACOG) released a statement in June 2007, supporting the an end to the practice of shackling mothers in labor and delivery as “physical restraints have interfered with the ability of physicians to safely practice medicine by reducing their ability to assess and evaluate the physical condition of the mother and fetus, and have similarly made the labor and delivery process more difficult than it needs to be; thus, overall, putting the health and lives of the women and unborn children at risk.”

On October 31, 2007, the Federal Bureau of Prisons (BOP) released new post-order language that discourages the use of metal waist restraints on pregnant offenders and prohibits the placing of

¹⁰ See generally, Merry Morash et al., Findings from the National Study of Innovative and Promising Programs for Women Offenders 40-46 (Dec.1995).

¹¹ Leslie Acoca, Natl. Council on Crime and Delinq. The Robert Wood Johnson Foundation, Barriers to the Adoption of Harm Reducing Gender-Specific Substance Abuseand Parenting Programs for Incarcerated Mother, spring 2000.

¹² *Id.*



pregnant women in a face down, four-point restraint. The BOP post-order also prohibits placing of pregnant women in restraint belts that directly constrict the area of pregnancy.

http://www.aclu.org/pdfs/prison/bop_policy_escorted_trips_p5538_05.pdf

The US Marshals have pursued similar reforms to the use of restraints on pregnant offenders. Recently, USMS Policy 9.1 (Restraining Devices) section (D)(3) was revised in October 2007 to prohibit the use of restraints on pregnant offenders during labor, delivery, and immediate post delivery and to use on pregnant women generally restraints that do not constrict the direct area of pregnancy.

The new administration has an opportunity to extend these exemplary federal reforms to the state prisons and jails, and finally ending the draconian practice of shackling incarcerated mothers during labor, delivery and post-delivery. We urge the President to issue an Executive Order directing that the policy of the BOP be extended to all state and local jails, prisons, juvenile justice systems, and ICE facilities.

VULNERABLE GIRLS

Girls behind bars share narratives of repeated physical and sexual violence. In a study conducted by the Oregon Social Learning Center, chronically delinquent girls reported their first sexual encounter at the age of 6.¹³ Another study on delinquent girls revealed that in California, 81 percent of chronically delinquent girls reported being physically abused and 56 percent were sexually abused.¹⁴

Sexual or physical violence is more central to girls' pathways to detention than it is for boys. For example, the Oregon Social Learning Study found that while 3 percent of delinquent boys experienced physical abuse, 77.8 percent of the girls were abused.¹⁵ The prevalence of girls' experiences of sexual and physical trauma plays out in their mental health status. Girls are more likely than boys to be diagnosed with more than one mental health disorder and suffer from higher rates of psychiatric disorders and depression.¹⁶

During the years 1990-2000, girls' detention jumped by 50 percent, compared to a 4 percent increase for boys.¹⁷ While the rate of incarceration for girls outpaces that of boys, girls are not being arrested for violent crimes. The overriding reasons for girls' arrests are for the gendered offenses of running away or prostitution.¹⁸ Many girls charged with runaway offenses are escaping from homes where there is sexual and or physical violence directed at them. Girls engaged in prostitution are often already victims of violence, and they comprise the majority of youth detained for prostitution.

¹³ Chamberlain, P. (January 24-26, 2002), *The Multidimensional Treatment Foster Care Model: Research and Community-Based Services*. Presented at 2nd National Training Conference on Juvenile Detention Reform. Portland, Oregon: Annie E. Casey Foundation.

¹⁴ Acoca L., and Dedel, K., *No Place to Hide: Understanding and Meeting the Needs of Girls in the California Juvenile Justice System*, San Francisco, Ca.: National Council on Crime and Delinquency, 1998.

¹⁵ Chamberlain, 2002.

¹⁶ National Child Traumatic Stress Network Juvenile Justice Working Group. *Trauma Among Girls in the Juvenile Justice System*. 2004

¹⁷ Sickmund, M. Sladky, T.J., and Kang, W., *Census of Juveniles in Residential Placement Datebook*, 2004.

¹⁸ Snyder, H. (2004). *Juvenile Arrests 2002*. Washington, DC Office of Juvenile Justice and Delinquency Prevention. OJJDP Statistical Briefing Book.



Girls are also disproportionately detained for technical violations and status offenses. In 2001, girls were twice as likely as boys to be detained on the basis of technical violations and status offenses.¹⁹ Generally, girls are detained for non-serious reasons such as probation violations, warrants, or minor offenses. Another emerging trend is that girls are being detained due to domestic violence in the home.²⁰

When girls are detained, they are placed in detention centers originally structured and operated for boys. The traditional methods of asserting authority and order, isolation approaches, and severe discipline characterizing juvenile detention are inappropriate for girls given their distinct pathways into the juvenile justice system. Often, girls in detention are subject to isolation and restraints—practices which are especially injurious to victims of sexual and physical trauma.²¹ Detention units are also riddled with problems of overcrowding and a dearth in basic services such that girls receive minimal access to mental health screening and treatment. Moreover, detention is not safe. Girls in detention report being physically and sexually assaulted by male staff.

Girls involved in the juvenile justice system require opportunities to heal from the profound trauma that has disfigured their lives and their hopes. Rather than be placed in detention for running away or prostitution, they require a safe place to heal. Unfortunately, there are few community-based, therapeutic, gender-specific programs for girls in detention. Girls are rarely afforded the opportunity to be alternatively sentenced or referred to community-based and gender-specific programs, since few exist. Only a handful of cities are developing alternatives to detention for girls, with an emphasis on healing from violence and trauma.²²

Gender-specific and effective programs honor the relational identities of girls and provide therapeutic, safe, and strength-based interventions to address the imprint of gendered violence on their development. Cities such as Philadelphia, San Francisco, and Boston have stitched together either collaborative relationships to provide girls gender-responsive programs or assembled a continuum of care. Each city has revamped its approach to girls in detention to be gender-responsive, comprehensive, safe, and both community and family-based. In Boston and San Francisco, the juvenile justice systems have formed collaborative relationships with community-based organizations to provide individual plans for girl offenders as an alternative to detention which recognizes the sacred ties to community, and addresses the girls' needs from a strength-based assessment. In Philadelphia, the Department of Human Services spearheaded an across systems continuum of home-based alternatives to detention, reducing the number of girls in detention to fewer than ten. The continuum includes the critical response to girls' mental health needs and braids together the justice and dependency systems as points of entry for vulnerable girls to receive comprehensive services.

¹⁹ Sickmund, Sladky, and Kang, 2004.

²⁰ Francine T. Sherman. *Pathways to Juvenile Justice Reform: Detention Reform and Girls, Challenges and Solutions*. Baltimore, Md. Annie E. Casey Foundation, 2005.

²¹ *Id.*

²² *Id.*



Recommendation: Alternatives to Detention for Girls

It is imperative that the next administration address the specific condition of girls behind bars and create opportunities for health, healing and wholeness for vulnerable girls. An initiative for alternative sentencing to strength-based, therapeutic, and trauma-sensitive programs for girls involved in the juvenile justice system should be pursued.

Recommendation: Reform the Trafficking Victims Protection Act

The new administration should additionally address the dangerous intersectionality that vulnerable girls experience between poverty, sexual violence, and relegation to the criminal justice system through reforming the federal Trafficking Victims Protection Act. The legislation ought to be amended to ensure that sexually exploited girls born in the US are accorded the same protections and services afforded to international victims.