Treating Youths in the Juvenile Justice System

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KEYWORDS

• Juvenile justice • Detained girls • Sexual risk-taking • STIs • Juvenile detention

KEY POINTS

- Juvenile justice-involved youths reside primarily in the community and receive health care from community providers.
- Adolescents involved with the correctional system report more high-risk sexual behaviors that lead to disproportionate rates of negative health outcomes.
- Pediatric providers are uniquely positioned to identify and address high-risk sexual behaviors and comorbid substance abuse and mental health issues in this underserved population.

Approximately 70,800 US youths were housed in more than 2500 juvenile justice (JJ) residential placement facilities nationwide according to the most recent statistics from the Office of Juvenile Justice and Delinquency Prevention.[1,2] Despite 25 years of movement away from juvenile incarceration toward decriminalization and diversion to community-based programs, the United States still incarcerates a higher percentage of youths than any other developed country.[3] However, most of the 2 million juveniles arrested and processed by the courts are remanded to community programs or probation.[4] Higher rates of risky sexual and substance use behaviors reported by JJ-involved youths, compared with noninvolved peers, present the community with public health risks. High rates of recidivism mean that there is often a revolving door through which many JJ-involved youths shuttle between detention and home communities. One-fifth of youths remanded to JJ residential placements were returned to the community in less than 2 weeks, and many return to detention repeatedly.[1,5,6]

Pediatricians are in a unique position to address factors that place children at risk for entry into the JJ system and to provide continuity of care, screening, and treatment of detained youths when they return to community care. Pediatric providers are also positioned to be powerful advocates for social policy changes and funding to remediate the social determinants of health (poverty, family dysfunction, substance and child abuse, and depression), which are predictors of JJ involvement.[7]

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Higher rates of sexually transmitted infections (STIs), including chlamydia, gonorrhea, syphilis, and human immunodeficiency virus (HIV), have been reported in both juveniles and adults entering correctional facilities and also in those returning to community settings. Reported rates underestimate the problem, because the lack of available testing and treatment in many juvenile facilities leads to underreporting.[8] The risk behaviors in which adolescents engage are clearly recognized as the root cause of such health outcomes.[9] Because risky sexual behaviors themselves are correlated with early death, disability, and socioeconomic challenges, they have long been recognized as a public health priority.[10] Recent national surveys of high school youths indicate that today's adolescents are reporting less frequent sexual intercourse encounters, fewer sexual partners, less substance use before sex, and increased condom and other contraceptive use.[10] However, in the JJ population, these decreases are not being seen. It is essential to address not only the sexual risk behaviors and their consequences in this population but also the individual, family, and sociodemographic factors that contributed to those behaviors.

SEXUAL RISK PERSISTS DURING AND AFTER ANY JUSTICE SYSTEM CONTACT

A longitudinal study of 1829 youths detained between 1995 and 1998 in Chicago's Cook County Juvenile Detention Center aimed to identify HIV/STI risk behaviors at baseline and again at follow-up 3.5 to 4.5 years later.[11] More than 60% engaged in 10 or more sexual risk behaviors at baseline and approximately two-thirds persisted or increased that pattern at follow-up. Of youths who reported unprotected vaginal sex at baseline, more than 50% of boys and almost 70% of girls maintained this behavior 3 to 4 years later. Having unprotected sex while drunk or high was reported at follow-up by 75% of boys and 60% of girls. More than half the study subjects had a substance use disorder at baseline, increasing at follow-up to greater than 80% use. At the time of that study, injection drug use was uncommon at both baseline and follow-up. Given that the epidemiology of HIV has shifted toward increased heterosexual transmission, accounting for one-third of current AIDS cases, up from 4% in early HIV reporting, this population is at high risk for HIV/AIDS.[12,13] Most of these behaviors were more prevalent among youths who were arrested and returned to the community, compared with those who were incarcerated, so community health providers must be part of the solution, developing comfort in communicating with high-risk youths and in using motivational interviewing to change behaviors.

Increased STI/HIV risks follow not only detention or incarceration, but also any encounters with the justice system. Police encounters or arrests may be a proxy for other factors that predict increased STI/HIV risk. A retrospective cohort study of adults and juveniles having had any contact with the Marion County, Indiana justice system looked at STI occurrence and HIV incidence rates in the year following arrest or incarceration, compared with the county's nonoffender rates.[14,15] Offender rates were higher in general, but rates for chlamydia (2968 per 100,000) and gonorrhea (2305 per 100,000) were higher than for syphilis (278 per 100,000) and HIV (61 per 100,000). Rates were up to 2.8 times higher in women than in men and 6.9 times higher in blacks than in whites. Chlamydia and gonorrhea rates were highest among 15 to 19 year olds. Incident HIV was highest in 20 to 44 year olds, suggesting likely exposure during adolescence. Interestingly, those arrested, but not detained, had higher annual rates of testing positive for these STIs in follow-up compared with those who were incarcerated, presumably because sexual activity in jail and prison is prohibited.[14]