

UCLA

UCLA Previously Published Works

Title

Health needs of youth in detention with limited justice involvement

Permalink

<https://escholarship.org/uc/item/8506r590>

Authors

Barnert, Elizabeth

Applegarth, D Michael

Aggarwal, Ektha

et al.

Publication Date

2020-11-01

DOI

10.1016/j.chilyouth.2020.105412

Copyright Information

This work is made available under the terms of a Creative Commons Attribution License, available at <https://creativecommons.org/licenses/by/4.0/>

Peer reviewed



HHS Public Access

Author manuscript

Child Youth Serv Rev. Author manuscript; available in PMC 2021 November 01.

Published in final edited form as:

Child Youth Serv Rev. 2020 November ; 118: . doi:10.1016/j.chilyouth.2020.105412.

Health Needs of Youth in Detention With Limited Justice Involvement

Elizabeth Barnert, MD, MPH, MS¹, D. Michael Applegarth, MSW², Ektha Aggarwal, MSW³, Christopher Bondoc, BA¹, Laura S. Abrams, PhD, MSW²

¹UCLA Department of Pediatrics, 10955 Le Conte Ave, Los Angeles, California

²UCLA Luskin School of Public Affairs, Los Angeles, California

³Office of Diversion and Reentry, Los Angeles County Department of Health Services, Los Angeles, California

Abstract

Although incarcerated youth (i.e., youth sentenced to secure custody) have high health needs, the health of detained youth with limited justice involvement remains poorly understood. Between September 2018 and February 2019, social workers from the Los Angeles County Whole Person Care Juvenile Reentry Aftercare Program (WPC) assessed the health and social needs of youth in pre-trial detention. We partnered with the WPC team to analyze assessments completed by 83 youth participants. Youth were on average 16 years old, most (83%) identified as male, and all were from racial or ethnic minority groups. Participants reported high behavioral health needs, including a high prevalence of prior suicide attempts (16%) and history of substance use (81%). Participants demonstrated a pattern of crisis healthcare utilization. Youth also indicated areas of strength, including personal positive traits, engagement in extracurricular activities, educational achievements, and having multiple sources of social support. The majority of youth (74%) desired vocational training and nearly all (94 %) wanted to return to school after release. Overall, the findings indicate that detained youth with limited involvement in the justice system are a resilient group that have notably higher health risk than same-age peers, signifying a critical opportunity for intervention.

Corresponding author: Elizabeth Barnert, MD, MPH, MS; Assistant Professor, UCLA Department of Pediatrics, 10955 Le Conte Ave, LA, CA 90095; Telephone: (310) 206-1483; ebarnert@mednet.ucla.edu.

Elizabeth Barnert: conceptualization, methodology, formal analysis, data curation, writing original draft, visualization, funding acquisition. **D Michael Applegarth:** software, formal analysis, investigation, data curation, writing- reviewing and editing.

Christopher Bondoc: software, formal analysis, investigation, data curation, writing- reviewing and editing. **Ektha Aggarwal:** intervention delivery (including collecting the assessments), visualization, writing- reviewing and editing. **Laura Abrams:** methodology, validation, formal analysis, writing- reviewing and editing.

Publisher's Disclaimer: This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

Declaration of interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

1. Introduction

The United States (U.S.) incarcerates a larger proportion of its adolescents than any other developed nation. In the U.S., 336 young people per 100,000 youth are incarcerated, with the next highest rate found in South Africa (69 per 100,000), and the lowest rate being reported by Japan (0.1 per 100,000) (Hazel, 2008). Furthermore, incarcerated youth in the U.S. have disproportionately high physical and mental health morbidity compared to non-incarcerated peers (Committee on Adolescence, 2011). Although the health status of incarcerated youth is well documented (Barnert, Perry, & Morris, 2016; Braverman & Morris, 2011), less has been reported on the health of pre-trial detained youth newly admitted to juvenile detention, many of whom have limited prior justice involvement. *Detained youth* refers to youth held in custody under court authority who have not been sentenced to correctional placement (i.e., pre-dispositional trial) (Sickmund, Sladky, Kang, & Puzzanchera, 2019). Many youth in detention are released without any aftercare and reentry planning, leaving them to navigate transitions to the community with limited support (Aalsma, Brown, Holloway, & Ott, 2014).

Limited research has been devoted to better understanding the health and social needs of youth with limited justice involvement. As such, this paper aims to highlight the needs of detained youth by reviewing assessment forms completed with 83 youth in a Los Angeles county detention center. By deepening our understanding of this population, health and correctional practitioners can better meet reentry needs, ideally leading to improved health outcomes and a reduction in future system involvement. This study provides detailed information on the needs and challenges this population faces and increases awareness of service needs for this understudied population.

2. Literature Review

2.1 Health of Incarcerated Youth

While this paper focuses on the needs of youth with limited justice involvement, it is beneficial to first review what is known about the larger population of incarcerated youth. Incarcerated youth in the U.S. experience higher prevalence rates of physical and mental health challenges compared to their non-incarcerated peers (Committee on Adolescence, 2011). For example, compared to non-incarcerated girls and boys, rates of chlamydia are approximately four times higher among incarcerated adolescent girls (13.5% in incarcerated adolescent females versus 3.3% in non-incarcerated U.S. adolescent females) and ten times higher among incarcerated adolescent males (6.7% versus 0.7%, respectively).

Mortality risk is also high. An eight-year longitudinal study of justice-involved youth found that the youths' risk of early violent death was four-fold their general adolescent peers, even years after incarceration, with homicide and suicide leading causes of death. In fact, homicide accounted for 90% of deaths and, at 887 deaths per 100,000 person-years, African American male youth had the highest observed mortality rate (Teplin, McClelland, Abram, & Mileusnic, 2005). For those who survive, health sequelae of incarceration may persist into adulthood (Barnert et al., 2017; Heard-Garris et al., 2018; Schnittker & John, 2007). For example, incarceration during adolescence has been associated with worse physical and

mental health, include worse self-reported general health and higher rates of functional limitations, depression, and anxiety (Barnert et al., 2017; Heard-Garris et al., 2018).

Many youth involved in the U.S. juvenile justice system belong to racial or ethnic minority groups and come from low-income families (Sickmund et al., 2019), both of which can lead to health disparities and barriers to care once released (Lau, Lin, & Flores, 2012). Specifically, for 2018, the arrest rate for all juvenile offenses for racial/ethnic minority youth was estimated to be 3,365 per 100,000 compared to 1,793 per 100,000 for white youth. The racial disparity is particularly noticeable when examining arrest rates for African American youth, which was estimated to be 4,618 per 100,000 (Sickmund et al., 2019). Similar patterns are observed when examining juvenile residential placement rates. In 2017, African American youth had the highest placement rate compared to other racial and ethnicity groups in all but six states. The placement ratio for racial minority youth compared to white youth was 2.4 to 1 (Sickmund et al., 2019). Thus, youth involved in the U.S. juvenile justice system are disproportionately subject to racism and out of home placement removals and as such, face significant and intersecting health inequities that merit attention.

2.2 Youth with Limited Justice Involvement.

The health of youth with limited involvement in the justice system is important to consider. As stated above, the detained youth population is larger than the incarcerated youth population, yet the latter group receives more research attention. Newly detained youth may have unaddressed or under-addressed health needs that could be treated by community-based or detention-based health facilities, if identified (Barnert et al., 2016). Yet the variation regarding depth of exposure to the justice system is often overlooked in the literature. Some youth may have only one contact with law enforcement while others go on to experience deeper system involvement. On average, compared to youth in correctional placement (i.e., incarcerated youth), the detained youth population includes youth experiencing their first detention and many may be sent home after a short stay; thus, the detained youth population as a whole is likely younger, lower risk, and at an earlier stage of justice involvement than youth sentenced to correctional placement. Intervention approaches should be modeled to meet the needs of detained youth using a developmentally appropriate approach.

The limited literature on the health status of detained youth demonstrated that 40% of youth at intake to juvenile detention presented with urgent medical needs requiring immediate attention (Hein et al., 1980). These youth also demonstrate a high prevalence of psychiatric disorders. In a random sample of 1,829 youth in pre-trial detention or serving sentences shorter than 30 days, two-thirds of males and three-fourths of females met criteria for one or more psychiatric disorders (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Rates of substance use disorders among detained youth are particularly high, as demonstrated in (Teplin et al., 2002), which found that 51% of males and 47% of female youth met the criteria for a substance use disorder. While these seminal studies provide valuable insight into the health needs of detained youth, they are also dated and lack a comprehensive view of youths' current health needs and strengths. Furthermore, the literature has yet to describe the health of youth with limited involvement in the justice system. Earlier interventions for

detained youth with less system involvement may be key for preventing cycles of repeat incarceration and escalation of health or mental health challenges (Barnert et al., 2014).

As such, this study sought to understand the health needs of detained youth without histories of correctional placement, hereafter referred to as “limited-involvement youth.” The current study takes a broad view of health that includes health symptoms, diagnoses, and care utilization, as well as social supports and youths’ perceived strengths. Our intention was to contribute to the adolescent health literature regarding the health of limited-involvement youth while also informing potential intervention efforts. We therefore measured the health, healthcare utilization, and social needs of detained youth with limited justice involvement.

3. Method

3.1 Approach

For this study, we used a cross-sectional survey design in partnership with Los Angeles County Whole Person Care (WPC), a program funded through a Medicaid waiver and delivered through Los Angeles County Departments of Health Services and Probation. The intervention targeted detained youth without a prior correctional placement (i.e., limited-involvement youth). In order to summarize youths’ health and social needs, our study team obtained permission from WPC and the Los Angeles County Department of Probation to review de-identified youth assessment forms collected by the WPC team. The institutional review boards of our university and the Los Angeles County Health Agency approved all study procedures.

The Los Angeles County WPC team invited detained youth to participate in voluntary assessments for the purpose of identifying potential transition services needed following release, a new target area for intervention. For youth who elected to participate in the WPC program, a WPC social worker administered the assessment form to youth one-on-one in a private setting while youth were detained at juvenile hall. Appendix A shows the youth assessment form administered by the WPC social workers. The WPC program would then connect youth to a community health worker who would assist youth in engaging in care once released (Wang et al., 2012). The intervention aimed to address the needs of vulnerable youth during the challenging transition period after release from detention, with the goal of improving their social and behavioral determinants of health. Our partnering agencies have explained that, in Los Angeles, youth released from correctional placement receive pre-release aftercare planning and post-release transition services; however, youth released from detention to home do not receive pre-release aftercare planning and are less likely to receive aftercare transition services. Thus, the WPC program was designed to support healthy transitions for youth returning to the community from detention who would otherwise not receive aftercare support. Our study team partnered with WPC program to assist with developing and implementing the intervention, and to analyze the assessment forms in order to provide summary data on the youth.

3.2 Population

The study sample included 83 detained youth who entered Los Angeles County Central Juvenile Hall between September 2018 and February 2019. The Los Angeles juvenile hall population is predominantly comprised of males and youth of color (Herz, Chan, & Lee, 2015). Youth who were at Central Juvenile Hall during the WPC enrollment period (September 2018 – February 2019) who were Medicaid eligible and without any history of correctional placement were invited to participate in the WPC intervention. A dedicated on-site staff member from Probation referred youth to WPC for assessments and transition planning if youth met program eligibility criteria and were deemed unlikely to receive a correctional placement after their adjudication hearing. Probation agreed to notify WPC if youth were sentenced to a correctional placement. None of the detained youth were sentenced to correctional placement, further indicating that this population would likely not receive transition planning. Thus, after their stay at juvenile hall, all participants were either released home on probation or released without probation supervision, which included some individuals who had their charges dropped.

3.3 Data Collection and Analysis

WPC social workers assessed youth at Los Angeles County Central Juvenile Hall between September 2018 and February 2019. At the time of survey administration, participants had been detained for one to three days. The assessments measured youths' health and social needs, and took place in a confidential setting. Social workers emphasized that the assessment was voluntary and that youth could choose to skip questions or stop the assessment at any point. All responses were self-reported by youth and recorded by social workers on a hardcopy form. The survey gathered demographic information and assessed youths' educational status, social supports, physical health, mental health, and substance use. At the end of the assessment, social workers and youth identified areas in need of additional support.

Of the 117 youth invited to complete the voluntary assessment, 34 did not participate. Of those 34 youth, 22 declined, eight transferred to another facility prior to initiating the survey, two were released prior to completing the assessment, and two did not qualify for the intervention due to Medicaid ineligibility. Of the 107 youth available, 83 completed the assessments, leading to a participation rate of 78%.

After the assessment period, our research team obtained hardcopies of the de-identified assessment forms (i.e., with all personal identifiers redacted); see Appendix A. Two research assistants then entered the assessment forms into REDCap, a HIPAA compliant electronic database, hosted at [university name blinded for review] (Harris et al., 2009). Development of the REDCap database and progress or questions about data entry were discussed in weekly team meetings. After completing data entry, the research assistants reentered 20% of the forms to verify accuracy; the data were overall consistent. The study team then imported survey responses into Stata 15 for coding and analysis.

3.4 Coding the Assessment

As seen in Appendix A, participants did not receive any scaling or Likert questions and primarily provided yes or no responses or selected an item from a list of options. For example, participants were asked if they attended school regularly, were experiencing homelessness prior to juvenile hall, needed help getting food upon release, had been hospitalized or visited the emergency room within the past year, or ever attempted suicide. Participants who indicated yes for these types of questions were coded as a “one” and those who responded no were coded as a “zero.” For questions that asked participants to identify family members or peers such as, “who is part of your social support” or “who do you feel safe with,” personal identifying information was redacted such that the research team received de-identified assessment forms. Other questions asked participants to select responses from lists of physical or mental health symptoms, or substances they had previously used. Participants could indicate more than one item on the lists and are coded as such. A few questions were coded into ordinal categories: “what was your highest level of education,” “when did you last use,” and “how often do you use it.”

Relevant open-ended questions were also examined. We reviewed all responses for open-ended questions and then placed participants’ responses into defined categories. For example, participants were asked “what are your strengths” and responses were placed into the following categories: positive personality trait, extracurricular activity, educational performance, social connections, vocational, or none. Participants who listed more than one strength were represented in multiple categories. Lastly, at the end of each assessment, the WPC social worker listed identified needs of the youth. These needs were placed into the following categories: job training, mental health services, obtaining identification, school credit, academic tutoring, food support, physical health services, housing, substance use treatment, transportation, college prep, extracurricular activities, financial support, legal support, and parenting classes. Youth who identified multiple needs were coded as such.

4. Results

4.1 Demographics

The age of respondents ranged from 13 to 18 years of age, with an average age of 15.9. On average, youth reported 14.6 years old as their age of first arrest, with no prior arrests or detention stays leading to correctional placement. Consistent with the demographics of the Los Angeles County juvenile justice population, most respondents identified as male (84%) and described their race/ethnicity as Hispanic (55%) or African American (33%). All youth identified as a racial or ethnic minority. Several youth reported having a learning disability (13%), and a higher proportion reported an individualized education plan (36%). Additionally, 25% of youth reported that they did not regularly attend school. Reasons for irregular school attendance included being on the run, bullying, safety concerns, family circumstances, or simply not wanting to attend. See Table 1 for a summary of participants’ demographic characteristics.

4.2 Reasons for Detention

Our research team was not provided the reason for detainment on record with the court; however, youth responded to an open-ended question asking, “why do you think you got in trouble.” Participants responses were grouped into the following categories: theft (29%), gun-related issues (11%), general reports of a probation violation (11%), assault (10%), negative peer influences (8%) (typically defined by youth as “hanging out with the wrong people”), drugs (7%), receiving a new warrant (6%), youth citing an error in decision-making (5%), youth saying they “don’t know” (4%), other reasons (11%) (e.g., tagging, boredom, looking like the suspect, lying, etc.), and two youth not responding. Percentages add up to over 100% as five youth (6%) listed more than one reason for getting in trouble. When asked “have your actions affected anyone,” 41% responded their family, 36% said “no one”, 10% identified themselves, 10% said their friends, 6% said a “victim”, and 4% did not respond. As with the previous question, five youth indicated more than one of the response categories.

4.3 Physical and Mental Health

Youth reported a low prevalence of physical health issues; 66% reported no known history of any health conditions. Participants who reported ever having a physical health condition most commonly reported asthma (11%), allergies (7%), and heart issues (5%). Twelve percent of youth indicated a health condition in the “other” category, with the most severe being two reports of gunshot wounds. Other health conditions listed in the other category included responses such as “pain in my stomach,” “testicular cyst,” “broken fingers,” “migraines” and other conditions. Single reports of diabetes, liver disease, seizures, and an open wound were also recorded.

Fifty-nine percent of youth identified a doctor or clinic in the community where they received physical healthcare and 33% identified a community provider where they received mental health services. Regarding hospital utilization, 23% of participants reported an emergency room visit within the last year, and 21% reported a hospitalization during the previous year. Many participants reported a mental health diagnosis (29%), with 16% reporting a suicide attempt. Table 2 provides an overview of general health information for participants.

Among the 24 participants with a mental health diagnosis, the most common diagnoses they reported included attention deficit hyperactive disorder (67%), followed by depression (17%), anxiety (13%), and bipolar disorder (8%). Appendix B provides a complete list of identified mental health diagnoses. Participants were also asked about challenges related to mental health (Table 3). About two-thirds of the youth reported struggling with a mental health issue. The most frequently reported mental health challenges included: anger (35%), sadness (28%), and mood swings (12%). Additionally, nearly one-fourth of participants (24%) reported that a mental health issue interfered with daily activities. Of the 24% (n=20) who reported that their mental health condition created a barrier to daily activities, 17 responded to the follow-up questions asking: if they had received past treatment for it, previously taken medication for it, or were currently taking medication for it. Of the 17

respondents, 10 reported prior mental health treatment, eight had previously received medication, and two were currently taking medication.

4.4 Substance Use

The majority of youth (81%) reported using some type of illicit substance in their lifetime (see Table 4). The substances with the highest lifetime prevalence of use were marijuana (74%), followed by alcohol (25%), and then tranquilizers (11%). In this sample, “Xanax” was the only type of tranquilizer reported by the youth. Of the 71 youth who reported lifetime illicit substance use, 79% reported using within the month leading up to detention, and 56% reported using in the week prior to their arrival at juvenile hall. When asked how frequently they used substances, 41% reported daily, 34% reported weekly, 7% at least monthly, 4% less than monthly or quit, and 14% did not respond.

4.5 Identified Needs

Youth frequently indicated a need for vocational training (74%). Furthermore, 72% of youth indicated they were not employed before going to detention. Of the 22 youth who had been employed, 45% stated they could return to their job once released. Social workers conducting assessments identified that nearly half of participants needed mental health services (42%). Other commonly reported needs included help obtaining state identification (37%), support with school credit recovery (24%), and academic tutoring (18%). Furthermore, social workers stated that youth needed assistance with issues related to food support, physical health, housing, and substance use. Table 5 includes a list of the identified health and social needs.

4.6 Social Support and Identified Strengths

During the assessment, youth identified individuals in their social support system. Sixty-four percent of youth identified an immediate family member as part of their social support system, specifically mother (49%), father (25%), and sibling (21%). Less frequently than family members, youth identified friends (16%) and romantic partners (12%). Appendix C provides a complete list of the identified social supports. When asked to name individuals they felt safe with, nearly 70% of youth identified at least one person, with 20% of youth naming two or more individuals. However, 7% of youth reported not feeling safe with anyone. Youth most frequently identified mothers and fathers as safe individuals.

Participants also identified areas of strength through open-ended response. Nearly half (49%) reported a positive trait such as a strong work ethic, kindness, or resiliency. Many youth indicated their participation in extracurricular or recreational activities (22%), such as sports or music. Participants also reported educational achievements (18%), social connections (12%), and vocational skills (6%) as areas of strength. Finally, while the majority of youth identified at least one strength, 11% reported having no strengths, and one youth did not respond. Most participants (94%) indicated they wanted to return to school following their release.

5. Discussion

Overall, findings demonstrate high health and social needs among the detained youth with limited justice involvement, as well as strengths that indicate resilience, as evidenced by a strong desire to obtain vocational training, continue their educational pursuits, and many viewed themselves as having positive attributes. Self-reported mental health and substance use treatment needs seem to exceed the youths' physical health needs. Findings suggest that coordinated attention to the health, mental health, service needs, and assets of youth with limited justice involvement is warranted, especially when considering areas of foci for intervention.

5.1 Physical Health

Consistent with prior studies on justice-involved youth in the community, results suggest that the detained youth perceive themselves as physically healthy overall, yet they also report frequent use of high-cost healthcare utilization such as emergency room visits and hospital stays (Barnert et al., 2019). By providing preventive care, referrals, and other resources, professionals can likely reduce youths' high-cost healthcare utilization and help maintain their overall physical health (Musich, Wang, Hawkins, & Klemes, 2016).

5.2 Behavioral Health

In contrast to physical health, participants conveyed high mental health needs. Although the majority of youth reported struggling with a mental health challenge in their lifetime, only half of the participants received treatment. One in four youth reported that current mental health issues were severe enough to create barriers to daily activities. These findings suggest a need to assist youth with limited justice involvement in obtaining treatment and support for mental health. Of note, the sample reported a strikingly high lifetime prevalence of suicide attempts. While high, the prevalence of suicide attempts observed in our sample aligns with existing studies. Youth in juvenile detention centers have a lifetime prevalence of suicide attempts between 11% and 27% (Stokes, McCoy, Abram, Byck, & Teplin, 2015). Our sample fell within this range, with 16% of respondents reporting a previous suicide attempt. In comparison, in 2017, 7% of same-age youth without any justice involvement attempted suicide (Centers for Disease Control and Prevention, 2018). Although rates of suicide attempts are alarmingly high amongst all U.S. youth, the rate observed in our sample was more than double that of nonjustice-involved peers, indicating an urgent need for intervention.

Likely interrelated with high mental health needs, substance use rates in our sample far exceeded those of same-age peers without justice involvement. Participants in our sample reported noticeably lower use of alcohol and tobacco compared to national data from the National Institute of Health (NIH) Monitoring the Future Study. However, compared to the national prevalence of lifetime substance use among 10th graders in the U.S., as reported in the NIH national data, our sample demonstrated considerably higher prevalence of marijuana use, as well as higher use of cocaine or crack (National Institute on Drug Abuse, 2019). The importance of granting access to substance use treatment cannot be understated, especially for adolescents closely monitored by law enforcement at high risk of re-

incarceration. Tailored, evidence-based community treatment interventions exist for youth post-incarceration and have shown mixed evidence of improving vocational outcomes and reducing recidivism (L Abrams & Snyder, 2010; Burns, Schoenwald, Burchard, Faw, & Santos, 2000; Henggeler, Cunningham, Pickrel, Schoenwald, & Brondino, 1996). Extending prevention and intervention services as early as possible could likely benefit youth. WPC social workers identified that 15% of the youth in our sample needed substance use treatment upon release. These results highlight this population's clear need for support and likely still underestimate the true severity of this need.

5.3 Social Supports and Strengths

Participants viewed family members as their primary sources of support and safety. While individual youths' relationships with their families may vary, the finding overall suggests the value of professionals providing support and resources to the youth alongside their families. The findings align with previous work demonstrating the pivotal role of parent engagement in overcoming youths' barriers to care during reentry after incarceration and support the value of family-focused interventions after detention (Barnert et al., 2019; Martinez & Abrams, 2013).

In addition to strong family support systems, many youth identified personal traits such as resiliency and kindness as strengths, attributes often underappreciated among youth with incarceration histories (Todis, Bullis, Waintrup, Schultz, & D'Ambrosio, 2001). Identified strengths can serve as anchoring points for youth, caregivers, and service providers as they work together to address youths' health and social needs. Additionally, a large portion of youth desired vocational training and nearly all youth wanted to return to school. Rather than give up on justice-involved youth because of the environmental challenges they face, professionals can instead leverage youths' inner motivation to assist them in changing their health behaviors and reducing justice system involvement. Identifying youths' strengths and inner motivation to envision and then build a better future can also nurture positive relationships, leading to long-term growth and positive social engagement that has ripple effects across the life course (Abrams & Aguilar, 2005; Fortune, 2018).

5.4 Service Needs

Many newly detained youth indicated service needs that reflect those of the incarcerated youth population. Common and addressable service needs included job training, mental health services, assistance with obtaining legal identification, education, food support, and housing. Increasingly, reentry planning processes exist that support youth during community reentry after incarceration, a period described as difficult, disorienting, and an opportunity for positive change (L Abrams & Snyder, 2010; Altschuler & Brash, 2004). Similar to youth with deeper levels of justice involvement, it is important to identify and address the unmet health and social service needs of youth exiting detention. It is concerning that in Los Angeles and beyond, there is no systematic approach for assisting limited-involvement youth in meeting their service needs upon release. Failing to meet these needs signifies a missed opportunity to improve the trajectories of highly vulnerable youth. In contrast, meeting services needs early in the pathway of correctional system involvement can minimize repeat exposures to the justice system and maximize chances of success, contributing to important

decarceration efforts underway (Barnert et al., 2017; Epperson & Pettus-Davis, 2017). Meeting the service needs of recently detained youth is likely a worthy investment for a healthy society, one that can improve the health and wellness of youth and their families during adolescence and help better prepare youth to progress into adulthood.

5.5 Study Limitations

Our study approach introduces some limitations. Although all youth who met intervention criteria were invited to participate in the assessments, the respondents only included 83 Medicaid-eligible individuals with no prior history of correctional placement. As a result, the reported health and social needs likely *underestimate* the needs of detained youth. Furthermore, youth with better health may have been more likely to agree to voluntary assessments. Although surveys were not designed for research purposes, assessments were conducted in a rigorous, systematic fashion. Furthermore, the lead author contributed to the development of the assessment forms via her role on the Los Angeles WPC steering community. Additionally, all items were self-reported and health records were not reviewed; thus, the data are subject to self-reporting bias. Even so, the data are useful in describing the health and social needs of the surveyed youth and may give insight into the needs of other youth with limited justice system involvement.

6. Conclusion

Detained youth with limited justice involvement are an understudied group with potentially critical intervention needs. Overall, the findings indicate that the detained youth surveyed have markedly higher health and social needs than same-age peers with no prior justice involvement. Thus, these limited-involvement youth fall within a potentially influential intervention period in which county agencies and community service providers can provide support that meet youths' health and social service needs and assists in curtailing future system involvement. Findings suggest the importance of coordinated efforts between correctional and healthcare officials, community personnel, and the youth and their families to support the health and social wellbeing of limited-involvement youth. Practitioners, researchers, and policymakers attentive to the critical opportunity for promoting the health and wellbeing of detained limited-involvement youth as they return to the community have the opportunity to potentially impact life trajectories of a vulnerable and resilient group of young people.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments:

We thank our study partners at Whole Person Care-LA at the Los Angeles County Departments of Health Services and Probation.

Funding: This work was supported by the National Institutes of Health – National Institute on Drug Abuse [UL1TR000124] and the California Community Foundation [BAPP-16-125450].

Appendix B

Mental Health Diagnoses

	N	%
ADHD	16	66.7
Depression	4	16.7
Anxiety	3	12.5
Bipolar	2	8.3
Anger Issues	1	4.2
OCD	1	4.2
Behavioral Issues	1	4.2
Learning Disability	1	4.2
Mood Disorder/Split Personality	1	4.2
PTSD	1	4.2
Missing	1	4.2

Note. This table only includes the 24 youth who had been diagnosed with a mental health condition. Some youth reported more than one diagnosis. Percentages represent the prevalence for each condition out of the 24 youth. ADHD stands for attention deficit hyperactivity disorder. OCD stands for obsessive compulsive disorder. PTSD stands for post-traumatic stress disorder.

Appendix C

Youth Social Supports

	N	%
Mother	41	49.4
Father	21	25.3
Sibling	17	20.5
Peer	13	15.7
Grandparent	10	12.0
Romantic Partner	10	12.0
No One	7	8.4
Aunt or Uncle	6	7.2
Other Family	4	4.8
Cousin	3	3.6
Counselor	3	3.6
Other	3	3.6
Gang	2	2.4
Missing	4	4.8

Note. Youth could mark more than one individual; the percentage for each item is from the total sample. Other Family contains general references to family (e.g., “my family,” “family”). Other category contains responses of “wrap around services,” “sponsor/boxing coach,” and an unidentified individual.

N = 83

References

- Aalsma MC, Brown JR, Holloway ED, & Ott MA (2014). Connection to mental health care upon community reentry for detained youth: a qualitative study. *BMC Public Health*, 14, 117. doi:10.1186/1471-2458-14-117 [PubMed: 24499325]
- Abrams L, & Aguilar J (2005). Negative trends, possible selves, and behavior change: A qualitative study of juvenile offenders in residential treatment. *Qualitative Social Work*, 4(2), 175–196.
- Abrams L, & Snyder S (2010). Youth offender reentry: Models for intervention and directions for future inquiry. *Child and Youth Services Review* 32(12), 1878–1795.
- Altschuler DM, & Brash R (2004). Adolescent and Teenage Offenders Confronting the Challenges and Opportunities of Reentry. *Youth Violence and Juvenile Justice*, 2(1), 72–87.
- Barnert ES, Dudovitz R, Nelson BB, Coker TR, Biely C, Li N, & Chung PJ (2017). How Does Incarcerating Young People Affect Their Adult Health Outcomes? *Pediatrics*, 139(2). doi:10.1542/peds.2016-2624
- Barnert ES, Lopez N, Pettway B, Keshav N, Abrams LS, Zima B, & Chung PJ (2019). The Role of Parent Engagement in Overcoming Barriers to Care for Youth Returning Home After Incarceration. *Journal of Community Health*. 45(2), 329–337. doi:10.1007/s10900-019-00747-1
- Barnert ES, Perry R, Azzi VF, Shetgiri R, Ryan G, Dudovitz R, ... Chung PJ (2014). Incarcerated Youths' Perspectives on Protective Factors and Risk Factors for Juvenile Offending: A Qualitative Analysis. *American Journal of Public Health*, 105(7), 1365–1371. doi:10.2105/AJPH.2014.302228 [PubMed: 25521878]
- Barnert ES, Perry R, & Morris RE (2016). Juvenile Incarceration and Health. *Academic Pediatrics*, 16(2), 99–109. doi:10.1016/j.acap.2015.09.004 [PubMed: 26548359]
- Braverman P, & Morris R (2011). The health of youth in the juvenile justice system In Sherman F & Jacobs F (Eds.), *Juvenile Justice - Advancing Research, Policy, and Practice* (pp. 44–67). Hoboken: Wiley.
- Burns B, Schoenwald S, Burchard J, Faw L, & Santos A (2000). Comprehensive Community-Based Interventions for Youth with Severe Emotional Disorders: Multisystemic Therapy and the Wraparound Process. *Journal of Child and Family Studies*, 9(3), 238–314.
- Centers for Disease Control and Prevention. (2018). Youth risk behavior survey data summary and trends report 2007–2017. Retrieved from <https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trendsreport.pdf>.
- Committee on Adolescence. (2011). Health care for youth in the juvenile justice system. *Pediatrics*, 128(6), 1219–1235. doi:10.1542/peds.2011-1757 [PubMed: 22123883]
- Epperson M, & Pettus-Davis C (Eds.). (2017). *Smart decarceration: Achieving criminal justice transformation in the 21st century*. Oxford, England: Oxford University Press.
- Fortune C-A (2018). The good lives model: A strength-based approach for youth offenders. *Aggression and Violent Behavior*, 38(1), 21–30.
- Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, & Conde JG (2009). Research electronic data capture (REDCap)--a metadata-driven methodology and workflow process for providing translational research informatics support. *Journal of Biomedical Informatics*, 42(2), 377–381. doi:10.1016/j.jbi.2008.08.010 [PubMed: 18929686]
- Hazel N (2008). Cross-national comparison of youth justice. In. Salford, UK: University of Salford.
- Heard-Garris N, Winkelman TNA, Choi H, Miller AK, Kan K, Schlafer R, & Davis MM (2018). Health Care Use and Health Behaviors Among Young Adults With History of Parental Incarceration. *Pediatrics*, 142(3). doi:10.1542/peds.2017-4314
- Hein K, Cohen MI, Litt IF, Schonberg SK, Meyer MR, Marks A, & Sheehy AJ (1980). Juvenile detention: another boundary issue for physicians. *Pediatrics*, 66(2), 239–245. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/7402808> [PubMed: 7402808]
- Henggeler SW, Cunningham PB, Pickrel SG, Schoenwald SK, & Brondino MJ (1996). Multisystemic therapy: an effective violence prevention approach for serious juvenile offenders. *J Adolesc*, 19(1), 47–61. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/9245264> [PubMed: 9245264]
- Herz D, Chan K, & Lee S (2015). *The Los Angeles County Juvenile Probation Outcomes Study*. Los Angeles: Advancement Project.

- Lau M, Lin H, & Flores G (2012). Racial/Ethnic Disparities in Health and Health Care among US Adolescents. *Health Services Research*, 47(5), 2031–2059. doi:10.1111/j.1475-6773.2012.01394.x [PubMed: 22417169]
- Martinez DJ, & Abrams LS (2013). Informal social support among returning young offenders: a metasynthesis of the literature. *International Journal of Offender Therapy and Comparative Criminology*, 57(2), 169–190. doi:10.1177/0306624X11428203 [PubMed: 22094597]
- Musich S, Wang S, Hawkins K, & Klemes A (2016). The Impact of Personalized Preventive Care on Health Care Quality, Utilization, and Expenditures. *Population Health Management*, 19(6), 389–397. doi:10.1089/pop.2015.0171 [PubMed: 26871762]
- National Institute on Drug Abuse. (2019). Monitoring the Future 2018 Survey Results. Retrieved from <https://www.drugabuse.gov/drug-topics/trends-statistics/infographics/monitoring-future-2018-survey-results>.
- Schnittker J, & John A (2007). Enduring stigma: the long-term effects of incarceration on health. *Journal of Health and Social Behavior*, 48(2), 115–130. [PubMed: 17583269]
- Sickmund M, Sladky T, Kang W, & Puzanchera C (2019). Easy Access to Juvenile Court Statistics: 1997–2017. Retrieved from <https://www.ojjdp.gov/ojstatbb/ezajcs/>.
- Stokes ML, McCoy KP, Abram KM, Byck GR, & Teplin LA (2015). Suicidal Ideation and Behavior in Youth in the Juvenile Justice System: A Review of the Literature. *Journal of Correctional Health Care*, 21(3), 222–242. [PubMed: 26084946]
- Teplin LA, Abram KM, McClelland GM, Dulcan MK, & Mericle AA (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry*, 59(12), 1133–1143. doi:10.1001/archpsyc.59.12.1133 [PubMed: 12470130]
- Teplin LA, McClelland GM, Abram KM, & Mileusnic D (2005). Early violent death among delinquent youth: A prospective longitudinal study. *Pediatrics*, 115(6), 1586–1593. doi:10.1542/peds.2004-1459 [PubMed: 15930220]
- Todis B, Bullis M, Waintrup M, Schultz R, & D'Ambrosio R (2001). Overcoming the odds: Qualitative examination of resilience among formerly incarcerated adolescents. *Exceptional Children*, 68(1), 119–139.
- Wang EA, Hong CS, Shavit S, Sanders R, Kessel E, & Kushel MB (2012). Engaging individuals recently released from prison into primary care: a randomized trial. *American Journal of Public Health*, 102(9), e22–29. doi:10.2105/AJPH.2012.300894

Highlights

- Detained youth with limited justice involvement had high behavioral health needs
- 16% had prior suicide attempts and 81% reported histories of substance use
- Detained youth also had multiple strengths, social support, and desired to succeed

Table 1

Demographic Information

	N	Mean or %
Average Age	83	15.9
Age at First Arrest *	82	14.6
Sex		
Female	12	14.5%
Male	70	84.3%
Missing	1	1.2%
Race/Ethnicity		
Hispanic	46	55.4%
African American	27	32.5%
Native American	2	2.4%
Multiracial	7	8.4%
Missing	1	1.2%
Education Level		
8 th	2	2.4
9 th	14	16.9
10 th	18	21.7
11 th	24	28.9
12 th	21	25.3
Missing	4	4.8
Have IEP		
Yes	30	36.1
No	35	42.2
Don't Know	12	14.5
Missing	6	7.2
Attend School Regularly		
Yes	58	69.9
No	21	25.3
Missing	4	4.8
Homeless Prior to JH		
Yes	5	6.0
No	77	92.8
Missing	1	1.2

Note. IEP stands for Individual Education Plan. JH stands for Juvenile Hall.

* One youth did not report their age.

N=83

Table 2**Medical Information**

	N	%
Identified a Healthcare Provider		
Yes	49	59
No	31	37.3
Missing	3	3.6
ER Visit Past Year		
Yes	19	22.9
No	54	65.1
Missing	10	12.1
Hospitalized Past Year		
Yes	17	20.5
No	59	71.1
Missing	7	8.4
Has MH Diagnosis		
Yes	24	28.9
No	52	63.9
Missing	6	7.2
Ever Attempted Suicide		
Yes	13	15.7
No	68	81.9
Missing	2	2.4
MH Community Provider Listed		
Yes	27	32.5
No	47	56.6
Missing	9	10.8

Note. ER stands for Emergency Room; MH stands for Mental Health.

N=83

Table 3

Prevalence of Ever Experiencing Mental Health Challenges

	N	%
None	29	34.9
Anger	29	34.9
Sadness	23	27.7
Mood Swings	10	12.0
Anxiety	7	8.4
Suicidal Ideation	7	8.4
Flashbacks or Nightmares	6	7.2
ADHD Symptoms	5	6
Other	3	3.6
Seeing or Hearing Things	3	3.6
Trauma	2	2.4
Sleep Issues	2	2.4
Hurting Themselves	2	2.4
Grief	1	1.2
Missing	3	3.6

Note. “Other” category contains responses of “family issues,” “split personality,” and “hold lot inside.” Youth could mark more than one symptom or challenge; percentages for each item is from the total sample. ADHD stands for attention deficit hyperactivity disorder.

N=83

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 4

Type of Illicit Substance Ever Used by Youth

Substance	Juvenile Sample Ever Used		National Prevalence For 10 th Grades Ever Used
	N	%	%
Marijuana	61	73.5	34.0
Alcohol	21	25.3	43.1
Tranquilizers*	9	10.8	5.7
Cocaine/Crack*	6	7.2	3.4
Meth	3	3.6	0.7
Tobacco	2	2.4	14.2
Opioid*	1	1.2	2.0
Ecstasy	1	1.2	3.2
Helium	1	1.2	-
PCP	1	1.2	-
None	12	14.5	-
Missing	4	4.8	-

Note. Tranquilizers reported in this sample were exclusively Xanax; Meth stands for methamphetamine; PCP stands for Phencyclidine; Prevalence obtained from NIH Monitoring the Future Study (2020); *NIH reports both cocaine (2.5) and crack (.9) separately, while our study asked about them with a single item; *The figure for Opioid from the NIH study is only referencing OxyContin and does not include other opioids identified in the NIH study.

N=83

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 5

Service Needs Identified by Social Worker

	N	%
Job Training	61	73.5
Mental Health Services	35	42.2
Obtaining ID	31	37.4
School Credit Recovery	20	24.1
Academic Tutoring	15	18.1
Food Support	15	18.1
Physical Health Services	14	16.9
Housing	14	16.9
Substance Use Treatment	12	14.5
Transportation	11	13.3
College Prep	9	10.8
Extracurricular Activities	8	9.6
Financial Support	5	6.0
Legal Support	3	3.6
Parenting Classes	3	3.6
Missing	4	4.8

Note. Percentage represents the proportion of the sample on that single need as youth often had multiple needs.

N=83