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Justice involvement and girls' sexual health: Directions for policy and practice

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Abstract

Arrested girls in the United States (US) are often diverted from detention through referrals to juvenile specialty courts (e.g., juvenile drug court), community-based diversion programs, or pre-adjudicated probation services. Limited research suggests that sexual and reproductive health needs for diverted, or court-involved, non-incarcerated (CINI) girls are similar to that of their detained counterparts. Despite the US justice system's emphasis on diverting youth from detention, research and programmatic efforts to improve sexual and reproductive health outcomes has primarily focused on detained girls. Policy and programming for CINI girls is scant and thus warrants further attention. This report details the immediate sexual and reproductive health needs of CINI girls. We discuss implications of current health care policies and practices for this population and conclude with recommendations for research focused on improving access to sexual and reproductive health care.

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juvenile justice; sexual health; court-involved; non-incarcerated youth; justice-involved girls; health care standards; access to care

1. Introduction

Girls account for over one-quarter of the approximately 1.1 million adolescents whose cases are handled in the United States (US) juvenile justice system annually (Hockenberry & Puzzanchera, 2014; Sickmund, Sladky, & Kang, 2015). While the overall rates of youth arrest have declined in the past two decades, the rate of female adolescent juvenile justice involvement (i.e., any contact with the juvenile justice system, from arrest to detention, among those who are under 18 years old) continues to rise (Sherman & Balck, 2015). In 2014, 17% of girls with delinquency cases involved detention (compared to 24% of male delinquency cases); the vast majority were diverted (or redirected) from further processing in the system following arrest (Hockenberry & Puzzanchera, 2017). We refer to these girls herein as court-involved, non-incarcerated or CINI (Kemp et al., 2016; Tolou-Shams, Harrison, Conrad, Johnson, & Brown, 2017), i.e., those who are justice-involved but remain supervised while living in the community.

This paper details the sexual and reproductive health (SRH) status of CINI girls in the US whose needs are similar to those of detained girls but remain unmet. We argue that the time period prior to more entrenched justice involvement (i.e., detention) is a critical intercept to consider for comprehensive SRH intervention. First, we provide the justice system context for examining the needs of CINI girls in particular. We then detail the unique pathways to justice involvement among adolescent girls compared to boys and highlight the increased need for SRH interventions in this particular population. Within the justice-involved population, we differentiate CINI girls from their detained counterparts and explain how these groups have similar ecological, social, and individual risk factors for negative health outcomes, and highlight that CINI girls receive far less attention in both research and in practice. We conclude by proposing several recommendations with respect to establishing standards of care for this population.

1.1 Overview of Reproductive Health Care Standards in Detention versus Diversion

International standards, as put forth by the United Nations, require that every detained juvenile should “receive adequate medical care, both preventative and remedial” (“Rules for the Protection of Juveniles Deprived of their Liberty,” 1990). Several governing bodies and medical associations in the US (e.g., The National Commission on Correctional Health Care, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists) have developed recommendations regarding standards of care including that of sexual and reproductive care for youth in juvenile detention. Guidelines and standards of SRH care for detained girls include: 1) gathering histories of reproductive health; 2) administering pregnancy tests; 3) providing prenatal care when relevant; 4) gynecologic assessments; and 5) laboratory or similar diagnostic tests for communicable diseases for sexually active youth or youth aged 11 or older (Braverman, 2011).

Recent reforms in the US juvenile justice system aim to divert apprehended youth from further processing in the juvenile justice system, but the provision of health care remains varied for CINI girls compared to detained girls who have access to care. Roughly 80% of arrested youth are not detained (Hockenberry & Puzzanchera, 2018), and most youth referred to diversion programs are first-time, low-level offenders (Wilson & Hoge, 2013). Girls may be diverted from detention at several points throughout the juvenile justice continuum. Munetz and Griffin's (2006) Sequential Intercept Model (SIM) (see Figure 1) provides an overview of the justice involvement continuum and highlights five possible "intercepts" for intervention implementation. This model was originally developed to pinpoint junctures where people with mental health issues may be served by stakeholders across multiple systems (e.g., behavioral health, addictions, justice) to prevent further entrenchment in the justice system. The SIM provides a potential framework to consider for the integration of SRH screening and service linkages with mental health and substance use services at the earliest points of the continuum. SIM intercepts begin from the earliest point of contact with the justice system (e.g., "Pre-Arrest" or contact with law enforcement), extend through detention (i.e., Phase IV), and end with an individual's reentry from detention (or other residential placement) back into the community (i.e., Phase V).

Depending on the availability of police diversion programming (i.e., initiated by a police department to link youth with community resources), CINI girls may be referred for community-based diversion options (e.g., counseling, community service, juvenile specialty court) in Phases I (Pre-Arrest), II (Post-Arrest), or III (Post-Initial Hearings), or they may be detained per Phase IV. If police diversion programs are not available, girls are typically diverted by a hearing officer or judge in Phase II. During detention in Phase IV, US federal law mandates that all girls have a constitutional right to medical and mental health care within residential or juvenile hall facilities (Gamble, 1976).

For CINI girls (e.g., those arrested or remanded to probation but not detained), there are no such mandates for health care. Unlike girls in detention, CINI girls' access to health services is dependent upon available local programming/services, justice staff perception of the girls' SRH needs and/or the girls' level of engagement with such services during the time of diversion. For example, case managers or juvenile justice staff in many locales may only refer CINI girls to SRH services if these referral agents recognize the girls' needs and/or these girls disclose that they are in need of SRH services. There is no set standard of health care for CINI girls, which therefore represents critical missed opportunities at earlier intercepts in the SIM continuum, for referral to SRH care for this high risk and vulnerable population.

1.2 Risks for Girls' Involvement in the Juvenile Justice System

Girls' involvement in the juvenile justice system is often an indicator of profound underlying social and/or behavioral health needs. Many justice-involved girls have histories of child abuse and neglect and, as a result, experience greater psychiatric impairment (Belenko, Langley, Crimmins, & Chaple, 2004) and increased risk for recidivism relative to boys. Approximately 31% of girls compared to 7% of boys detained in the juvenile justice system (n = 64,329) have experienced sexual abuse (Saar, Epstein, Rosenthal, & Vafa, 2015) and

CINI girls evaluated in a juvenile court clinic who reported a history of childhood sexual abuse were more likely to be detained in the coming year than their male and non-abused female counterparts (Conrad, Tolou-Shams, Rizzo, Placella, & Brown, 2014). One study involving 162 girls who were court-ordered to a mental health evaluation found that 23% recidivated within 12 months (Conrad et al., 2014).

Other risks for justice-involved girls include mental health symptoms, academic difficulty, dating violence, family conflict, parental substance use, parental criminal history, and under-resourced community conditions (Ruffolo, Sarri, & Goodkind, 2004; Twill, Green, & Traylor, 2010; Veysey & Hamilton, 2007). The leading causes for girls' arrests are non-violent crimes such as misdemeanors and status offenses, such as running away and truancy, and outstanding warrants (Sherman, 2012). Moreover, girls account for a small proportion of the most serious types of juvenile offenses, including homicide and robbery (Puzzanchera, 2013). Taken together, this evidence suggests that girls' pathways into the juvenile justice system greatly differ from that of boys and that girls would benefit from both gender-specific and developmentally-appropriate approaches to assessment, intervention, and treatment that consider the interplay of determinants that elevate their risks for contact with the system.

2. Sexual and Reproductive Health (SRH) Needs of Justice-Involved Girls

In addition to having greater psychosocial and behavioral health needs compared to boys in the juvenile justice system, justice-involved girls are more likely to have unmet physical health needs (Braverman, 2011), including significant unmet SRH needs. Current research related to SRH care is mostly limited to detained girls; however, emerging studies on CINI girls suggest similar risk factors for and pathways into justice involvement as detained girls (Crosby et al., 2004; Perry & Morris, 2014; Sedlak & Bruce, 2010). There is also emerging evidence on SRH needs for CINI girls (Tolou-Shams et al., Under Review; Tolou-Shams & Dauria, 2016). Table 1 presents some examples of studies that have reported prevalence rates of SRH risks for CINI and detained girls. Such data suggest that CINI girls who are diverted from detention—80% of those who are justice-involved (Hockenberry & Puzzanchera, 2018)—where access to SRH services are mandated, are in great need of access and linkage to such SRH services in the community.

Estimates suggest that detained girls reported greater frequency of sexual risk behaviors than girls in general population surveys. The national Youth Risk Behavior Survey (YRBS), representative of 9th through 12th grade US students, reported that 37.7% of girls were ever sexually active and 2.0% of girls had sexual intercourse before 13 years old. Among high school girls, about 8% had four or more lifetime partners and 46% did not use a condom during last intercourse (Kann et al., 2018). Although not entirely representative of all justice-involved populations, Table 1 shows there is indication of higher prevalence of sexual risk behaviors among justice-involved girls (both detained and CINI) across various studies relative to those surveyed in the YRBS.

Compared to girls in the general population, justice-involved girls experience earlier sexual debut, higher rates of sexual activity, and higher numbers of lifetime partners (Biswas &

Vaughn, 2011; Braverman, 2011; Dembo, Belenko, Childs, Greenbaum, & Wareham, 2010; Dembo et al., 2017; Gallagher, Dobrin, & Douds, 2007; Golzari, Hunt, & Anoshiravani, 2006; Hatcher, King, Nordberg, Bryant, & Woolen, 2018; Kaplan et al., 2001; Kelly, Morgan-Kidd, Champion, & Wood, 2003; Morris et al., 1995; Odgers, Robins, & Russell, 2010; Rizk & Alderman, 2012). Other risks are also prevalent in studies with justice-involved samples: One study reported that 19% of detained girls (n = 197) disclosed exchanging sex for money or drugs within the previous two months (Crosby et al., 2004). Detained girls also have significantly higher rates of sexually transmitted infections (STIs) and unplanned teen pregnancies relative to their non-justice involved peers (Crosby et al., 2004; Perry & Morris, 2014).

Literature on CINI girls, although scant, typically focuses on mental health concerns and substance use behaviors. There are several reasons why the evidence base on this population is limited. First, this is an oftentimes overlooked, hidden population in which juvenile justice reforms assume that the same programs and mechanisms that are applied to the majority (i.e., boys) will work for girls. Second, the system is primarily focused on factors that increase risk for recidivism, such as mental health and substance use, and thus SRH needs—despite being highly important from a public health perspective—have received less attention.

Emerging evidence suggests that the sexual risk behaviors of CINI girls mirror those of detained girls. Findings from a recent longitudinal study examining sexual risk behaviors of a cohort of first-time offending CINI youth (n = 423) highlight that nearly 40% of girls reported ever being sexually active and over three-quarters reported sexual activity in the previous four months (Tolou-Shams et al., Under Review). Girls who were sexually active reported engaging in risky sexual behaviors: over 40% reported not using a condom during their last sexual encounter and sexually active girls reported having an average of two sexual partners in the last four months (Tolou-Shams et al., Under Review). Pregnancy is also common among both detained (Sedlak & Bruce, 2010) and CINI girls, especially for those with a history of adverse childhood experiences or are involved in foster care (Kerr, Leve, & Chamberlain, 2009). Despite similar risk factors in arrest for girls prior to detention or assignment to diversion programming, detained girls hold constitutionally mandated access to sexual health services whereas CINI girls may never be offered SRH services during the time of their justice involvement.

2.1 Barriers to SRH Care for CINI Girls

While some justice-involved girls may have contact with health care providers in the community, many also have inadequate, inconsistent, or nonexistent contact with health services (Tilson et al., 2004) and therefore are less likely to receive routine health care services compared to girls in the general population (Lederman, Dakof, Larrea, & Li, 2004). Factors such as poverty, lack of health insurance, or lack of transportation provide barriers to accessing appropriate health care in the community (Sickmund & Puzzanchera, 2014). These factors are compounded for racial/ethnic groups such as Blacks and Hispanics who are disproportionately represented in the justice system (Hockenberry & Puzzanchera, 2017) and already face barriers in access to and use of care (Betancourt, Green, Carrillo, &

Ananeh-Firempong, 2003). Furthermore, justice-involved girls who face SRH challenges may face other personal motivations that conflict with provider recommendations (e.g., a desire for pregnancy), coercive or abusive relationships, and other situations that affect their decision-making and may influence their ability to access care (Johnston et al., 2016) compared to those in the general population. As a result, the juvenile justice system may provide one of the first points of contact for SRH prevention and intervention services for detained girls (Johnston et al., 2016) while CINI girls do not have the same access to care in the community.

3. Current Policies and Practices and their Implications for CINI Girls' Health

Despite research suggesting that girls who make contact with the juvenile justice system (i.e., incarcerated and non-incarcerated) engage in similar risk behaviors, there are no mandates for the provision of health care for CINI girls living in the community. Generally, judges may require that CINI girls be linked to a variety of programs in the community setting, including case management, individual treatment, family treatment, youth court, or restorative justice (Schwalbe, Gearing, MacKenzie, Brewer, & Ibrahim, 2012), which may or may not include SRH services. Furthermore, some states, counties and cities in the US also have police diversion or community-based juvenile hearing programming (i.e., to divert juveniles who had contact with police from appearing in front of a judge) which may inadvertently prevent juveniles from being connected with services mandated by a judge or the court. To our knowledge, there are currently no comprehensive approaches that address the SRH needs of CINI girls.

Diversion programming tends to range in design and monitoring (Schwalbe et al., 2012) and therefore remains inconsistent. Oftentimes, diversion programming involves a piecemeal approach that provides services as needed (Cocozza, 2005; Lipsey, 2009). As a result, the resources that are available to CINI girls depend on a variety of factors including local practices and policies, the reason(s) for their justice involvement, and the availability of and access to community-based services, rather than being part of a comprehensive services model.

3.1 Summary and Implications

Although the sexual risk behaviors of CINI girls are similar to those of detained girls, CINI girls are not guaranteed the same access to the treatment and continuity of care afforded to detained girls. It is critical to provide systems linkages, especially between justice and health, to ensure that this particular population receives the appropriate medical care that they need. CINI girls under the supervision of the juvenile justice system but living in the community represent a population with unmet SRH needs, and meeting these needs would have a significant public health impact, especially as the number of CINI girls continues to rise. Connecting them with health care is a crucial first step to addressing their unique needs during adolescence to prevent undesired pregnancies, sexually transmitted infections (STIs), and the spread of HIV. Juvenile justice and community settings, therefore, represent an

important opportunity to address SRH disparities by linking this high-risk population to relevant health care services.

4. Recommendations for Improved Access to Sexual and Reproductive Health Care

Linking these young, medically underserved CINI girls with SRH services through assessment, triage and referral at the earliest stage of the justice-involvement trajectory (i.e., via the SIM framework) may capitalize on a unique window of opportunity to improve SRH outcomes. As such, we propose the following recommendations to improve access to SRH care among CINI girls in the US:

4.1 Establish Standards of Care for Court-Involved, Non-Incarcerated Girls

Establish standards of care for CINI girls that align with those for incarcerated women and girls, such that this vulnerable population should be referred to:

- Sexual and reproductive health care services that are equivalent to those recommended by the American College of Obstetricians and Gynecologists (2012) for detained women and adolescent females. These services may include:
  - Incorporating an optional sexual risk behavior (self-report) screening into a comprehensive physical examination for all girls upon arrest;
  - Providing health education related to sexual health and healthy relationships;
  - Referrals to laboratory screening for STIs (e.g., gonorrhea, chlamydia, HIV) and treatment if relevant;
  - Referrals for routine vaccinations, including that for the Human Papilloma Virus (HPV);
  - Offering referrals for contraceptive services and screening for pregnancy; and
  - Providing information and linkages to prenatal/abortion services when relevant.
- Court-appointed case management services to provide linkages to health care access for under- and un-insured girls and their dependents.

4.2 Provide Training for those Involved with Diversion Programming

To meet the established guidelines for CINI girls, US juvenile justice entities should provide training tailored for staff involved with diversion programming (e.g., police, specialty court judges, community-based clinicians) (Tolou-Shams, Dauria, Levine, & Rosen, 2017). Training components could include:

- Identifying gender-specific SRH risks for juvenile justice involved girls; and
- Building knowledge on local available resources providing SRH care to youth.

4.3 Build and Maintain Partnerships with Community Organizations and Service Providers

The juvenile justice system should build and maintain partnerships with public health community partners and service providers to ensure that developmentally appropriate, gender-responsive and culturally-congruent programming and services are made available through diversion programming. This includes:

- Trauma-informed care that emphasizes and recognizes the prevalence of childhood adversity among these girls;
- Culturally competent care that recognizes the diverse needs in access to and engagement in healthcare across different populations; and
- Establishing a continuum of care between healthcare providers, community organizations, juvenile justice organizations, and the child welfare system.

5. Directions for Future Research

This report highlights that the SRH needs of CINI girls mirror those of detained girls. However, access to health care for CINI girls is far from equivalent to those of their detained counterparts. Remedying the limited evidence base begins with conducting gender-responsive studies in which gender-specific analyses are conducted (in samples that include male and female-identified CINI youth) or only female-identified samples are recruited and analyzed. Given that girls represent only up to a third of all justice-involved youth (Hockenberry & Puzzanchera, 2018), studies typically combine girls into the overall sample and neglect to examine gender-specific behavioral health needs of CINI girls. In addition, collecting data across all potential intercepts of justice contact (e.g., with police, probation, community clinics across the SIM) will help to establish a robust data repository to move forward on creating best practices for this population across the various points of justice contact. Finally, researchers may consider identifying high-risk and CINI girls within specific communities with greater barriers to healthcare to enable access and linkages to SRH services through school-based intervention strategies. In providing equal access to SRH care for all girls who have contact with the juvenile justice system, we will be able to help ensure the fundamental human right to access to care for the nation’s most vulnerable populations.

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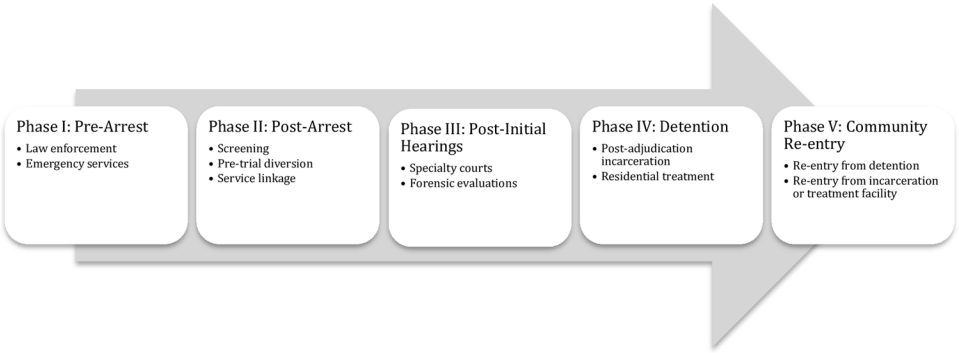

Figure 1.
Overview of Processing in the Juvenile Justice System (Munetz & Griffin, 2006)

Table 1.

Examples of Studies Illustrating Sexual Health Risk Prevalence Estimates among Arrested, Court-Involved, Non-Incarcerated (CINI), and/or Detained Girls (2007-Present)

Health Risk and Associated Reference	Justice Involvement	Girls' *N*	Age Range	US Region	Prevalence[1]
Sexually Active, Lifetime					
Tolou-Shams et al., under review	CINI	193	12–18	Northeast	40%
Hatcher et al., 2018	Detained	104	12–20	Southeast	93%
Kelly et al., 2007	CINI and detained[2]	539	11–18	South	86%
Sexual Activity Onset, <13 years					
Kelly et al., 2007	CINI and detained	539	11–18	South	52%
Multiple Sex Partners					
Odgers et al., 2010	Detained	141	*M* = 16.7	Southeast	55% (3+ partners)
Hatcher et al., 2018	Detained	104	12–20	Southeast	58% (4+ partners)
Biswas & Vaughn, 2011	Detained	101	14–19	Northeast	12% (>10 partners)
Condom Non-Use					
Tolou-Shams et al., under review	CINI	193	12–18	Northeast	46%
Hatcher et al., 2018	Detained	104	12–20	Southeast	48%
Dembo et al., 2010	Arrested[3]	440 or 441[4]	12–18	Southeast	24%
Odgers et al., 2010	Detained	141	*M* = 16.7	Southeast	23%
Sexually Transmitted Infection					
Biswas & Vaughn, 2011	Detained	101	14–19	Northeast	17% (Any diagnosis)
Odgers et al., 2010	Detained	141	*M* = 16.7	Southeast	42% (Any diagnosis)
Dembo et al., 2017	Arrested	311 to 378[4]	12–17	Southeast	13% (Chlamydia, gonorrhea, or both)
Dembo et al., 2010	Arrested	440 or 441	12–18	Southeast	19% (Chlamydia, gonorrhea, or both)
Sexual Abuse History					
Conrad et al., 2014	CINI	162	11–17	Northeast	23%
Biswas & Vaughn, 2011	Detained	101	14–19	Northeast	26%
Odgers et al., 2010	Detained	141	*M* = 16.7	Southeast	48%
Kelly et al., 2007	CINI and detained	539	11–18	South	29%

Note:

[1] Prevalence estimates rounded to the nearest whole number

[2] Combined sample

[3] Arrested youth were subsequently detained, diverted, or placed in home detention

[4] Estimates include cases with missing data