UCLA
UCLA Previously Published Works

Title

Barriers to Health Care for Latino Youths During Community Reentry After Incarceration: Los Angeles County, California, 2016-2018.

Permalink
https://escholarship.org/uc/item/2r94s019

Journal
American journal of public health, 110(S1)

ISSN
0090-0036

Authors
Barnert, Elizabeth S
Lopez, Nathalie
Chung, Paul J

Publication Date
2020

DOI
10.2105/ajph.2019.305374

Peer reviewed

eScholarship.org Powered by the California Digital Library
University of California

Publisher: APHA; Journal: AJPH:American Journal of Public Health; Copyright: , ; Volume: 110; Issue: 1s; Manuscript: 201926719; Month: ; Year: 2019
DOI: ; TOC Head: ; Section Head:
Article Type: RESEARCH ARTICLE; Collection Codes: , , , , ,
Subject codes: Child and Adolescent Health, Adolescent Health, Minority Children
2 Figures/2 Tables
Michelle
10.2105/AJPH.2019.305374

Barriers to Health Care for Latino Youths During Community Reentry After Incarceration, Los Angeles County, California, 2016–2018

Elizabeth S. Barnert, MD, MPH, MS, Nathalie Lopez, BS, and Paul Chung, MD, MS

Objectives. To examine barriers to health care for Latino youths during reentry.

Methods. For this in-depth qualitative study, we conducted 69 semistructured interviews with 22 Latino youths and their parents at 1, 3, and 6 months after incarceration. We performed thematic analysis of interview transcripts, from which a preliminary conceptual model emerged describing barriers to care for Latino youths. We then conducted trajectory analyses of dyadic youth–caregiver pairs to test the conceptual model. We collected longitudinal interviews in Los Angeles County, California, from November 2016 to March 2018.

Results. Beyond recognized stressors experienced by youths during reentry, most of which families related to poverty and neighborhood environment, Latino youths also experienced cultural barriers to care (i.e., self-reliance/ and pride, religiosity/ and reproductive care as taboo,

preference for home remedies, language) as well as barriers to care because of undocumented status (i.e., fear of deportation, job insecurity).

Conclusions. Reentry is challenging and Latino youths face additional barriers to care during reentry related to culture and legal status and have cultural strengths. Increased access to culturally sensitive, safety-net health care, regardless of immigration status, may reduce health inequalities for Latino youths undergoing reentry. (*Am J Public Health.* 2020;110;xxx–xxx.)

In 2017, US courts committed more than 26|000 juveniles to residential placement,[1] a group disproportionately poor,[2] of color,[2] and with high morbidity.[3] One in 5 were Latino (i.e., of Latin American origin or descent),[1] which is likely an undercount.[4] Most incarcerated youths (i.e., youths court-ordered to confinement) are released within 4 months,[5] marking the beginning of the challenging 6-month transition period termed reentry. During reentry, youths must meet court requirements, which can include connecting to mental health care, while navigating settings that may feel chaotic or unsafe.[6,7] Lacking sufficient support during reentry, such as access to mental health interventions shown to reduce recidivism, can contribute to rearrest.[8,9] Access to health care, however, can transform trajectories.[8,9]

During reentry, many youths, regardless of race/ethnicity or gender, face common barriers to health care. The limited literature on youths’ health care access during reentry identifies the following barriers to care: parents

uninformed about correctional health diagnoses and aftercare plans[10]; youths' fear of health care, often because of fear of rearrest[11,12]; lack of insurance[13]; difficulty scheduling health visits[11,14]; lack of transportation[13]; and uncomfortable provider interactions.[11]

Meanwhile, the broader health care access literature has identified barriers to care for youths of color relative to non-Hispanic White youths, including lack of health insurance, lack of usual source of preventive care, low quality of care, different health beliefs, and discrimination.[15,16] Of these, lack of insurance and parental beliefs about illness emerge as especially pertinent to Latino youths relative to African American or non-Hispanic White youths.[15,16] These barriers interact with known disparities in the justice system[17–19] including "hypercriminalization," in which the justice and other systems of care take a more punitive approach toward boys of color.[20] Incarcerated girls, meanwhile, face high mental and reproductive health risks,[21] and Latinas in the justice system confront additional gender, race, and class prejudices that have a negative impact on health care access.[22]

Although Latino youths who are incarcerated have higher rates of substance use disorders and anxiety compared with other incarcerated youths and are at high risk for poor access to nonemergency health care in the community,[13,23] to our knowledge, no previous study has focused on the experiences of Latino youths with health care access (or lack thereof) throughout reentry. We therefore sought to understand barriers to care for

male and female Latino youths during reentry, from the perspectives of Latino youths and their parents, across a 6-month reentry period.

METHODS

This in-depth qualitative study applied a community-partnered participatory research[24] approach with Los Angeles (LA) County, California, juvenile justice agencies. Community partners participated throughout the study, including identifying the research question, developing the study protocol and instruments, and providing input on analysis and dissemination.

Participants and Recruitment

Youths returning to a home setting after incarceration in an LA County juvenile detention facility during the study enrollment period (November 2016–March 2018), who were aged at least 12 years, fluent in English or Spanish, and without severe cognitive delay, were eligible for our larger mixed-methods study on reentry and health. The larger study included 50 closed-ended youth surveys, as well as 42 youth and 52 caregiver open-ended interviews, including 7 youth and 18 caregiver interviews from participants not identifying as Latino. The response rate for the overall study was 44%, which is consistent with previous studies of justice-involved youths.[25] The current analysis focuses on male and female participants self-identifying as “Latino.”

Publisher: APHA; Journal: AJPH:American Journal of Public Health;
Copyright: , ; Volume: 110; Issue: 1s; Manuscript: 201926719; Month: ; Year: 2019
DOI: ; TOC Head: ; Section Head:
Article Type: RESEARCH ARTICLE; Collection Codes: , , , , ,

During the study enrollment period, youths exiting incarceration received a study flyer informing families about the study and inviting them to contact the research team. In addition, each week, the county probation department provided the study team the contact information of youths released from confinement during the previous week. The study team then telephoned families and invited them to participate in the study. We conducted consent/ and assent discussions by telephone, emphasizing the confidential and voluntary nature of the study and its independence from the justice system. Participants received a $30 gift card for completion of each survey or interview.

Data Collection

At 1 month after incarceration, youth participants completed a confidential telephone survey on demographics and contextual health care information. We invited youth survey participants and their primary caregiver to participate in confidential, longitudinal, qualitative interviews about health care access during reentry. We initially invited all participants for interviews and then purposively oversampled girls and fathers to obtain a breadth of perspectives as we more frequently encountered boys and mothers during recruitment. Eight Latino survey participants declined the interview invitation. Ten parents requested to participate despite their child declining or being unavailable; we allowed these parents to participate.

Open-ended interviews took place at 1, 3, and 6 months after incarceration. Interviews explored views about youths' health and experiences accessing, or not accessing, a health visit (see Appendix A: Interview Guide, available as a supplement to the online version of this article at http://www.ajph.org). We conducted interviews in the language and at the timing and location of participants' preferences, either in-person or via telephone. We interviewed youths and parents separately. Interviews lasted 30 to 60 minutes and were audio recorded. We continued interviews until we reached and surpassed saturation of themes about barriers to care.[26] Twenty-two Latino-identifying youths and 21 parents completed interviews, including 13 youth–caregiver pairs, 9 unpaired youths, and 8 unpaired caregivers (69 interviews total). Appendix B (available as a supplement to the online version of this article at http://www.ajph.org) shows interview participation for the entire sample by time point. Appendix 4 (available as a supplement to the online version of this article at http://www.ajph.org) demonstrates reasons for attrition among Latino participants. Caregivers were 85% mothers, 10% fathers, and 5% grandmothers; for simplicity, we use the term "parent."

[ID]TBL1[/ID]Table 1 shows sociodemographic characteristics of Latino youth interviewees. [ID]TBL2[/ID]Table 2 summarizes contextual information regarding health care access at 1 month after incarceration; participants

described good general health, forgone care, and high exposure to childhood adversity. Appendix 3 details responses on childhood adversity.

Analysis

We performed inductive thematic analysis[27] of the qualitative interviews. First, a transcription service transcribed the audio files and the team verified the transcripts. Second, using Atlas.ti version 5.0 (ATLAS.ti GmbH, Berlin, Germany), 2 team members open-coded youth and parent transcripts across the time points and developed a preliminary codebook on youths' health care access during reentry. Once we reached agreement on the codebook, 2 team members iteratively coded the transcripts, aware of dyadic relationships. We extrapolated codes into themes and examined for similarities and differences between youth–parent dyads. We then performed a second round of thematic analysis[27] focusing on the subsample of Latino participants. We developed a preliminary codebook on barriers to care experienced by Latino youths during reentry, iteratively refined the codebook, reached consensus, and then applied it to the transcripts of Latino participants. We separately categorized aspects that, based on the literature, the families' statements, and our understanding of Latino identity (2 authors are Latina), seemed tied to families' racial/ethnic identity as Latino.

During the process of extrapolating codes into themes, a conceptual model depicting barriers to care experienced by Latino youths during reentry

emerged. We tested the model by performing trajectory analysis[28] of youth–caregiver dyads. We did so by iteratively reviewing transcripts by dyads across time points to assess the extent to which each family's experiences fit the model, adjusting the model accordingly so that the final model fit the data.[28] For completeness, we also longitudinally examined transcripts from interviewees not in dyadic pairs for model fit. Interviews were ongoing during analysis, and member checking was performed. A native Spanish speaker conducted the Spanish-language interviews (31 total).

RESULTS

Three main themes emerged regarding barriers to care experienced by Latino youths during reentry: stressors of reentry, cultural barriers to care, and undocumented status.

Stressors of Reentry

Latino youths and parents, as did the larger study sample, described reentry stressors of youths reconnecting to school, finding employment, connecting to health care, and staying out of trouble. Families expressed logistical barriers to accessing health care, chiefly lack of transportation, lack of insurance, and difficulty obtaining timely, convenient appointments. Families felt stressed about meeting court requirements. They described that poverty caused them to live in violent neighborhoods with risky peer

influences, which exacerbated youths' challenges during reentry. Despite probation officer support, families conveyed that poverty made accessing health care during reentry difficult as families had limited flexibility, could not afford copays, and relied on care settings that were difficult to navigate.

Cultural Barriers to Care

Self-reliance/ and pride.

Latino youths and parents reported a strong self-reliance or pride that created a barrier to care. One youth stated, "Parents believe that until they see me dying, like not even able to walk, that's time for the doctor." Although many youths had diagnoses and care recommendations in place by the court, Latino youths and parents tended to associate receiving mental health care services with being "crazy," perceived accessing care as a weakness, and would only access care in extreme situations. In 1 scenario, the mother of a youth on antidepressants and diagnosed with substance use disorders expressed, "[He] says he is depressed, but I think he's fine. A depressed person is going to be sleeping, but he watches television and plays." A father stated about his son's mental health: "He's not crazy; he's fine." Families described having mental health conditions as shameful. One mother expressed,

> No, that was another culture thing, which I feel terrible about. I was in denial. I never wanted to take him to an actual psychologist or him being evaluated

> for ADHD [attention deficit hyperactivity disorder] because he's extremely intelligent. . . . Because for us it's a shame.

In essence, families' resilience, pride, and self-reliance, which some families directly connected to Latino culture, led to avoidance of mental health care, even when youths or professionals viewed treatment as necessary. Receiving medical advice from YouTube or "TV doctors," rather than in a health care setting, was also common.

Religiosity and /reproductive care as taboo.

For Latina youths, access to reproductive health care services was often limited by family beliefs regarding premarital sex and unwillingness to discuss sexual health. A female 16-year-old participant forwent testing for sexually transmitted infections during reentry after having unprotected sex because

> I don't want my parents to know. My mom doesn't like talking about it [sex]. To her, I shouldn't even have sex. . . . She believes in holy—you gotta be Holy Mary until you get married.

Another Latina participant described her mother feeling "angry" about a contraceptive implant she obtained while incarcerated. Once released, the youth was questioned judgmentally by her mother and subsequently had it removed. In contrast, boys and parents of boys did not reference reproductive care as taboo.

Preference for home remedies.

Publisher: APHA; Journal: AJPH:American Journal of Public Health; Copyright: , ; Volume: 110; Issue: 1s; Manuscript: 201926719; Month: ; Year: 2019
DOI: ; TOC Head: ; Section Head:
Article Type: RESEARCH ARTICLE; Collection Codes: , , , , ,

Latino youths and parents described preferring home remedies to visiting a physician. A male 17-year-old participant explained, “We turn to *remedios* [home remedies] first and, if we don’t get better, then we go [to the doctor].” One youth even shared her mother’s home remedy: “If my stomach hurts, my mom will give me oil, lemon, and salt.”

Language.

Several monolingual Spanish-speaking parents reported not receiving discharge instructions, including health care recommendations, in Spanish upon their child’s release from incarceration, which limited access to care during reentry. When asked about mental health care recommendations received from the justice system, a monolingual Spanish-speaking mother of a 15-year-old boy responded, “Well, they only gave me information in English.” Parents described language as a barrier when interacting with probation officers during reentry. Many parents sought translations from their children. Neither the youths nor US-born parents reported language as a barrier.

Undocumented Status as a Barrier to Care

Although we did not directly query immigration status, 5 families conveyed undocumented status as a substantial barrier to health care during reentry. Families tended to mention undocumented status when discussing insurance eligibility. Mothers of undocumented youths reported applying for

Emergency Medicaid for youths, but stated that it could not be used for programs required by the juvenile court. Youths did not discuss their own undocumented status; youths' undocumented status was disclosed by parents. Overall, being undocumented heightened families' sense of job insecurity and fear of deportation.

Job insecurity.

Families generally prioritized employment security over accessing health care during reentry. For parents, the decision to not miss work rather than take their child to the doctor was difficult but deemed necessary. Many parents feared losing their job because of missed work. Most parents described living paycheck to paycheck, making every paying hour crucial to their finances. As 1 youth shared,

> My grandma can't take her kid to the doctor because she has to be at work to make that small check. . . . Obviously, she can't miss a day because she's barely making ends meet.

Job insecurity was heightened for parents who were undocumented as their jobs were often not regulated and paid lower wages. Youths viewed finding a job as the most critical lever for promoting their health (i.e., above health care).

Fear of deportation.

Publisher: APHA; Journal: AJPH:American Journal of Public Health; Copyright: , ; Volume: 110; Issue: 1s; Manuscript: 201926719; Month: ; Year: 2019
DOI: ; TOC Head: ; Section Head:
Article Type: RESEARCH ARTICLE; Collection Codes: , , , , ,

For parents who were undocumented, fear of deportation compounded the fear of losing employment because of missing work to facilitate youths' health visits. One mother explained: "When one doesn't have papers, one is scared." Because her employer knew she was undocumented, she feared being fired and deported if she missed work to take her son to a court-mandated mental health appointment during reentry. When youths were undocumented, fear of deportation interfered with parents' encouraging youths to access reentry services, as parents feared additional systems contact put youths at risk for deportation. One mother described having explosive conflicts with her daughter for longer than 1 month. Rather than getting needed help, the mother stated, "I kept her in the house because I was afraid they would deport her." Thus, youths being undocumented inhibited care access.

Conceptual Model of~~:~~ Barriers to Care ~~for Latino Youths~~ During Reentry

The conceptual model in [ID]FIG1[/ID]Figure 1 illustrates barriers to health care experienced by Latino youths and their families during reentry. Our framework derived from previous interviews with incarcerated youths guided the model; the framework depicts the "no exit" cycle between juvenile hall and the community.[29] The new model demonstrates that youths exiting juvenile incarceration, as expressed by interviewees, experienced "stressors

of reentry.” The stressors of reentry had a negative impact on youths’ mental health and contributed to reduced health care access, whereas probation officers and court-mandated care encouraged use. Thus, families conveyed that reentry in some ways increased and in other ways decreased health care access. We highlight barriers to care that families expressed as related to Latino culture or undocumented status in the center of the model; these barriers reduced health care access. We postulate that reduced health care access may contribute to worse health and reincarceration.

Health Care Linkages Across Reentry

[ID]FIG2[/ID]Figure 2 displays results from the trajectory analysis for 1 dyad; Appendix C shows results from all 13 dyads. Families described that linkages to mental health care occurred between 1 and 3 months after incarceration, often facilitated by probation officers. Families most commonly linked to mental health care when “wraparound” providers met youths at home or school. At 6 months, few youths remained connected to mental health care. In contrast, connections to medical and reproductive care seemed less temporally related.

DISCUSSION

In addition to experiencing recognized stressors[7,30] and barriers to health care[10–13] during reentry, Latino youths experienced barriers to care linked to

Latino culture and family immigration status. These barriers provide insight into mechanisms through which reentry perpetuates health inequities.[31] Notably, families did not discuss racism as a barrier to access. Given endemic racism and discrimination in the US juvenile justice and health care systems,[20,32] reasons for this potential underacknowledgment should be explored. Instead, families described behaviors and attitudes consistent with values and norms of Latino culture while also focusing on practical and legal barriers related to job insecurity, undocumented status, and underlying poverty.

Cultural Barriers to Care

Several aspects of Latino culture, especially *marianismo* and *machismo*,[33] relate to the identified barrier of self-reliance and pride. *Marianismo* and *machismo* emphasize that women should embrace suffering with dignity and men should be strong, respectively. Because strength is valued, admitting symptoms or uncertainty, or accessing care and treatment, may be seen as signs of weakness.[33] Latino youths and parents promoted the notion that care should only be accessed in extreme circumstances, despite correctional health recommendations and court mandates. Self-reliance seemed to correlate with preference for home remedies and lack of understanding of health needs. While families may be justified in not accessing care, judicial and health professionals may need to be more culturally attuned to factors

leading to these decisions. Simultaneously, cultural attributes such as *familismo*[34]—strong family bonds—can be leveraged to promote youths' health care access and success during reentry. For example, parent participants described involving siblings and other relatives in youths' care, such as for transportation or translating during health visits. Furthermore, love for family and wanting to provide younger siblings a positive example motivated youths to reform.

The taboo nature of accessing—or even discussing—sexual health care was a challenge for Latina youths. Latino culture places a high value on virginity, especially for girls, encouraging abstinence until marriage. Latino parents may presume that adolescents are not sexually active and do not need reproductive health care.[35] These perspectives contradict the need for continued sexual health care access during reentry, especially when hormonal implants or intrauterine devices necessitating follow-up have been placed. One third of incarcerated girls have been pregnant,[36] indicating a potential disconnect between parental perceptions and youths' reproductive health care needs. Most youths exiting juvenile incarceration are aged younger than 18 years and rely on parents for transportation and insurance. Findings suggest the importance of confidential reproductive health services in settings easily accessible to youths, such as school-based clinics. Cultural attentiveness when providing reproductive care to Latino youths might enhance youths' and parents' acceptance of services.[37]

Language emerged as another key cultural barrier to health care. Some families stated that they did not receive information regarding health care recommendations in Spanish, and language limited their ability to collaborate with probation officers in guiding youths to services. Providing linguistically appropriate health care services and materials could mitigate a solvable barrier.[38,39] Youths whose families speak languages less common than Spanish may face even more barriers.

Undocumented Status

Undocumented status created a formidable barrier to care, largely related to fears of deportation or loss of employment. In California, our study state, all youths under 19 have access to Medicaid regardless of immigration status.[40] That undocumented status creates a perceived barrier, despite existing care coverage for youths, is especially concerning in the context of reentry, when care may be required by courts. The findings suggest potential misinformation about available resources and care opportunities. Although undocumented status is not unique to Latinos, the experiences of Latino families can lend insight into challenges faced by immigrant communities.

Public Health Implications

Findings reinforce that inequities in health care during reentry are driven by social circumstances, specifically culture, immigration status, employment security, and poverty. In addition to bolstering the health safety

net more generally, providing culturally targeted interventions, such as *promotoras* (i.e., lay health workers)[41] and linguistically appropriate care, may help Latino families overcome cultural and logistical barriers to care during reentry. In addition, promoting employee rights, especially for undocumented individuals and those who work low-wage, poorly regulated jobs, can support families in meeting youths' health care needs during reentry. Families connected to care most often when logistical barriers were minimized, such as through in-home "wraparound" therapy.[42] Finally, youths attributed successful care access to internal motivation. Further attention to youth and family resiliency factors can guide a strengths-based approach that complements efforts to dismantle barriers perpetuating health inequity after incarceration.

Limitations

As with other studies with justice-involved youths in community settings, recruitment was difficult and likely introduced selection bias. Differential loss to follow-up may have occurred. However, our trajectory analysis[28] indicated that barriers to health care remained stable over time, and we allowed parents to participate even if youths were unavailable, which offered insight into the health care access of hard-to-reach youths.[25] Additional concerns include lack of trust in the interviewer, especially during telephone

interviews, and lack of generalizability, given the predominance of older adolescent males all residing in a single urban county.

While the study described the experiences of Latino youth, we cannot state with certainty which barriers were experienced only by Latino youths versus, for example, all youths of color or other youths from immigrant families. To mitigate this limitation, we examined the Latino interviews against data collected for our larger reentry study, which included African American and Native American families. It is our impression that poverty and systemic racism underlay barriers for all participants and that some cultural barriers were likely shared among youths from racial/ethnic minority groups. For example, fear, mistrust, and stigma toward mental health care, known barriers to care for justice-involved youths and communities of color in general,[11] may have contributed to Latino families' strong sense of self-reliance. However, other barriers, such as preference for home remedies, emerged as specific for Latinos, as did language barriers and undocumented status, which would likely be present among other low-income immigrant communities. Finally, families' immigration status likely affected results; 80% of participating families had a parent born in Latin America. Families in the United States for more than 1 generation may be more aware of systemic racism or may feel more comfortable discussing it.

Conclusions

During reentry, Latino youths face known stressors and additional barriers to health care linked to poverty, culture, legal status, and racial discrimination that merit further attention. These barriers perpetuate health and justice system inequities. Ultimately, being attuned to the perspectives, vulnerabilities, and strengths of marginalized Latino youths and their families can advance efforts to meet youths' health care needs during reentry.

About the Authors

At the time of the study, all authors were with the University of California Los Angeles (UCLA) David Geffen School of Medicine and Mattel Children's Hospital at UCLA, Los Angeles, CA.

Correspondence should be sent to Elizabeth S. Barnert, UCLA Department of Pediatrics, 10955 Le Conte Ave, Los Angeles, CA 90095 (e-mail: ebarnert@mednet.ucla.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This article was accepted September 6, 2019.

doi: 10.2105/AJPH.2019.305374

Contributors

E.|S. Barnert led the study, including conceptualization, recruitment and data collection, analysis, and writing of the article. N. Lopez participated in recruitment and data collection activities, analysis, and writing the article. P.|

J. Chung oversaw all aspects of the study and provided strategic input throughout.

Acknowledgments

E.|S. ~~–~~Barnert's time was supported by a grant from the UCLA Clinical and Translational Science Institute~~TSI~~ (NIH KL2U000124) and by a National Institutes of Health–National Institute on Drug Abuse (NIDA) ~~IDA~~ Career Development Award (K23 DA045747-01). The study was also funded by a medical research grant from the California Community Foundation.

We thank participating families and our community partners at the Los Angeles County Departments of Probation, Mental Health, and Health Services.

Conflicts of Interest

The authors have no conflicts of interests to disclose.

Human Participant Protection

This project was approved by the UCLA Office of Human Research Protection Program and by the Los Angeles County Juvenile Court.

References

trueeref<eref1true0false>true _id="b1"trueeref<eref1true0false>true1.

Sickmund M, Sladky T, Kang W, Puzzanchera C. Easy access to juvenile

court statistics: 1997–2017. 2019. Available at: https://www.ojjdp.gov/ojstatbb/ezajcs. Accessed June 7, 2019.trueeref</eref>truetrueeref</eref>true

truebok<bok1true0false>true _id="b2"truebok<bok1true0false>true2. Laub J. *Understanding Inequality and the Justice System Response: Charting a New Way Forward*. New York, NY: William T. Grant Foundation; 2014.truebok</bok>truetruebok</bok>true

trueedb<edb1true0false>true _doi="10.1002/9781118093375.ch3" _id="b3"trueedb<edb1true0false>true3. Braverman P, Morris R. The health of youth in the juvenile justice system. In: Sherman F, Jacobs F, eds. *Juvenile Justice—Advancing Research, Policy, and Practice*. Hoboken, NJ: Wiley; 2011:44–67. https://doi.org/10.1002/9781118093375.ch3trueedb</edb>truetrueedb</edb>true

truebok<bok1true0false>true _id="b4"truebok<bok1true0false>true4. *Latino Disparities in Youth Incarceration*. Washington, DC: The Sentencing Project; 2017.truebok</bok>truetruebok</bok>true

truebok<bok1true0false>true _id="b5"truebok<bok1true0false>true5. Office of Juvenile Justice and Delinquency Prevention. Trends and characteristics of youth in residential placement, 2017. Washington, DC: US Department of Justice; 2019.truebok</bok>truetruebok</bok>true

truejrn<jrn1true0false>true _doi="10.1300/J076v44n02_02" _id="b6" _pubmed="NOT_FOUND"truejrn<jrn1true0false>true6. Abrams LS. From corrections to community: youth offenders’ perceptions of the challenges of transition. *J Offender Rehabil*. 2006;44(2-3):31–53 https://doi.org/10.1300/J076v44n02_02.truejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1177/1541204003260048" _id="b7" _pubmed="NOT_FOUND"truejrn<jrn1true0false>true7. Altschuler DM, Brash R. Adolescent and teenage offenders confronting the challenges and opportunities of reentry. *Youth Violence Juv Justice*. 2004;2(1):72–87 https://doi.org/10.1177/1541204003260048.truejrn</jrn>truetruejrn</jrn>true

truebok<bok1true0false>true _id="b8"truebok<bok1true0false>true8. Schubert C, Mulvey E. Behavioral health problems, treatment, and outcomes in serious youthful offenders. Washington, DC: US Department of Justice, Office of Juvenile Justice and Delinquency Prevention; 2014.truebok</bok>truetruebok</bok>true

truejrn<jrn1true0false>true _doi="10.1023/A:1026440406435" _id="b9" _pubmed="NOT_FOUND"truejrn<jrn1true0false>true9. Burns B, Schoenwald S, Burchard J, Faw L, Santos A. Comprehensive community-based interventions for youth with severe emotional disorders: multisystemic therapy and the wraparound process. *J Child Fam Stud*.

2000;9(3):283–314
https://doi.org/10.1023/A:1026440406435.truejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1186/1471-2458-14-117" _id="b10" _pubmed="24499325"truejrn<jrn1true0false>true10. Aalsma MC, Brown JR, Holloway ED, Ott MA. Connection to mental health care upon community reentry for detained youth: a qualitative study. *BMC Public Health*. 2014;14(1):117 https://doi.org/10.1186/1471-2458-14-117. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1177/0743558416653219" _id="b11" _pubmed="NOT_FOUND"truejrn<jrn1true0false>true11. Udell W, Mohammed S, Breland D. Barriers to independently accessing care among detention youth. *J Adolesc Res*. 2017;32(4):433–455 https://doi.org/10.1177/0743558416653219.truejrn</jrn>truetruejrn</jrn>true

truebok<bok1true0false>true _id="b12"truebok<bok1true0false>true12. Jacobs F, Oliveri R, Greenstone J, Miranada-Julian C. Massachusetts Health Passport Project evaluation final report. Boston, MA: Boston Law School; 2009.truebok</bok>truetruebok</bok>true

truejrn<jrn1true0false>true _doi="10.1515/ijamh-2013-0008" _id="b13" _pubmed="23324374"truejrn<jrn1true0false>true13. Golzari M, Kuo A.

Healthcare utilization and barriers for youth post-detention. *Int J Adolesc Med Health*. 2013;25(1):65–67 https://doi.org/10.1515/ijamh-2013-0008.
PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1515/ijamh-2018-0128" _id="b14" _pubmed="30888964"truejrn<jrn1true0false>true14. Balogun T, Troisi C, Swartz MD, Lloyd L, Beyda R. Factors associated with knowledge of where to access health care among youth in juvenile detention: a mixed methods study. *Int J Adolesc Med Health*. 2019; epub ahead of print March 19, 2019 https://doi.org/10.1515/ijamh-2018-0128.
PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.2105/AJPH.83.7.960" _id="b15" _pubmed="8328617"truejrn<jrn1true0false>true15. Lieu TA, Newacheck PW, McManus MA. Race, ethnicity, and access to ambulatory care among US adolescents. *Am J Public Health*. 1993;83(7):960–965 https://doi.org/10.2105/AJPH.83.7.960.
PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _id="b16" _pubmed="9532442"truejrn<jrn1true0false>true16. Flores G, Vega LR. Barriers to health care access for Latino children: a review. *Fam Med*. 1998;30(3):196–205. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1001/jama.288.1.82" _id="b17" _pubmed="12090866"truejrn<jrn1true0false>true17. Flores G, Fuentes-Afflick E, Barbot O, et al. The health of Latino children: urgent priorities, unanswered questions, and a research agenda. *JAMA*. 2002;288(1):82–90 https://doi.org/10.1001/jama.288.1.82. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1111/j.1475-6773.2012.01394.x" _id="b18" _pubmed="22417169"truejrn<jrn1true0false>true18. Lau M, Lin H, Flores G. Racial/ethnic disparities in health and health care among US adolescents. *Health Serv Res*. 2012;47(5):2031–2059 https://doi.org/10.1111/j.1475-6773.2012.01394.x. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1016/j.acap.2015.09.004" _id="b19" _pubmed="26548359"truejrn<jrn1true0false>true19. Barnert ES, Perry R, Morris RE. Juvenile incarceration and health. *Acad Pediatr*. 2016;16(2):99–109 https://doi.org/10.1016/j.acap.2015.09.004. PubMedtruejrn</jrn>truetruejrn</jrn>true

truebok<bok1true0false>true _doi="10.1057/9780230607347_2" _id="b20"truebok<bok1true0false>true20. Rios VM. Hypercriminalization of Black and Latino male youth in the era of mass incarceration. In: Marable M, Steinberg I, Middlemass K, eds. *Racializing Justice,*

Disenfranchising Lives. The Critical Black Studies Series. New York, NY: Palgrave Macmillan; 2007:17–33. https://doi.org/10.1057/9780230607347_2truebok</bok>truetruebok</bok>true

truejrn<jrn1true0false>true _doi="10.1016/j.jaac.2018.07.870" _id="b21" _pubmed="30274642"truejrn<jrn1true0false>true21. Kelly MA, Barnert E, Bath E. Think, ask, act: the intersectionality of mental and reproductive health for judicially involved girls. *J Am Acad Child Adolesc Psychiatry*. 2018;57(10):715–718 https://doi.org/10.1016/j.jaac.2018.07.870. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1111/soc4.12338" _id="b22" _pubmed="NOT_FOUND"truejrn<jrn1true0false>true22. Lopez V, Nuno L. Latina and African-American girls in the juvenile justice system: needs, problems, and solutions. *Sociol Compass*. 2016;10(1):24–37 https://doi.org/10.1111/soc4.12338.true**jrn</jrn>**truetrue**jrn</jrn>**true

true**bok<bok1**true**0**false**>**true **_id="b23"**true**bok<bok1**true**0**false**>**true23. Weemhoff MM, Villarruel FA. The Plight of Latino Youth in the Juvenile Justice System: Considerations for Mental Health Treatment. In: *Creating Infrastructures for Latino Mental Health*.; New York: Springer;2011:177–193.truebok</bok>truetruebok</bok>true

truejrn<jrn1true0false>true _doi="10.1001/jama.2009.1033" _id="b24" _pubmed="19602693"truejrn<jrn1true0false>true24. Wells K, Jones L. “Research” in community-partnered, participatory research. *JAMA*. 2009;302(3):320–321 https://doi.org/10.1001/jama.2009.1033. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1177/1473325010367821" _id="b25" _pubmed="NOT_FOUND;INVALID_JOURNAL"truejrn<jrn1true0false>true25. Abrams L. Sampling “hard to reach” populations in qualitative research: the case of incarcerated youth. *Qual Soc Work: Res Pract*. 2010;9(4):536–550 https://doi.org/10.1177/1473325010367821.truejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1177/1468794107085301" _id="b26" _pubmed="NOT_FOUND"truejrn<jrn1true0false>true26. Bowen GA. Naturalistic inquiry and the saturation concept: a research note. *Qual Res*. 2008;8(1):137–152 https://doi.org/10.1177/1468794107085301.truejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1191/1478088706qp063oa" _id="b27" _pubmed="NOT_FOUND"truejrn<jrn1true0false>true27. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77–

101

https://doi.org/10.1191/1478088706qp063oa.truejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1186/s13104-016-1954-1" _id="b28" _pubmed="26936266"truejrn<jrn1true0false>true28. Grossoehme D, Lipstein E. Analyzing longitudinal qualitative data: the application of trajectory and recurrent cross-sectional approaches. *BMC Res Notes*. 2016;9(1):136 https://doi.org/10.1186/s13104-016-1954-1. PubMedtruejrn</jrn>truetruejrn</jrn>true

true**jrn<jrn1**true**0**false**>**true **_id="b29" _pubmed="25521878"**true**jrn<jrn1**true**0**false**>**true29**.** Barnert ES**,** Perry R**,** Azzi VF**,** et al**.** Incarcerated youths' perspectives on protective factors and risk factors for juvenile offending: a qualitative analysis. *Am J Public Health*. 2015;105(7):1365–1371. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1007/s10566-010-9102-x" _id="b30" _pubmed="20730108"truejrn<jrn1true0false>true30. Fields D, Abrams LS. Gender differences in the perceived needs and barriers of youth offenders preparing for community reentry. *Child Youth Care Forum*. 2010;39(4):253–269 https://doi.org/10.1007/s10566-010-9102-x. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _id="b31" _pubmed="16186451"truejrn<jrn1true0false>true31. Freudenberg N, Daniels J, Crum M, Perkins T, Richie BE. Coming home from jail: the social and health consequences of community reentry for women, male adolescents, and their families and communities. *Am J Public Health*. ~~2005~~2008;98(9, suppl):S191–S202. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1016/j.socscimed.2013.09.006" _id="b32" _pubmed="24507906"truejrn<jrn1true0false>true32. Feagin J, Bennefield Z. Systemic racism and U.S. health care. *Soc Sci Med*. 2014;103:7–14 https://doi.org/10.1016/j.socscimed.2013.09.006. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1016/j.cpr.2011.05.003" _id="b33" _pubmed="21683671"truejrn<jrn1true0false>true33. Abdullah T, Brown T. Mental illness stigma and ethnocultural beliefs, values, and norms: an integrative review. *Clin Psychol Rev*. 2011;31(6):934–948 https://doi.org/10.1016/j.cpr.2011.05.003. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1002/pits.20580" _id="b34" _pubmed="NOT_FOUND"truejrn<jrn1true0false>true34. Reyes JA, Elias MJ. Fostering social–emotional resilience among Latino youth. *Psychol*

Sch. 2011;48(7):723–738

https://doi.org/10.1002/pits.20580.truejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1016/j.jadohealth.2013.05.003" _id="b35" _pubmed="23768462"truejrn<jrn1true0false>true35. Caal S, Guzman L, Berger A, Ramos M, Golub E. “Because you’re on birth control, it automatically makes you promiscuous or something”: Latina women’s perceptions of parental approval to use reproductive health care. *J Adolesc Health*. 2013;53(5):617–622 https://doi.org/10.1016/j.jadohealth.2013.05.003. PubMedtruejrn</jrn>truetruejrn</jrn>true

truebok<bok1true0false>true _id="b36"truebok<bok1true0false>true36. Sedlak A, McPherson K. Youth’s characteristics and backgrounds—findings from the survey of youth in residential placement. *OJJDP Juvenile Justice Bulletin.* Washington, DC: US Department of Justice; 2010.truebok</bok>truetruebok</bok>true

truejrn<jrn1true0false>true _doi="10.1363/3614204" _id="b37" _pubmed="15321780"truejrn<jrn1true0false>true37. Russell ST, Lee FC. Practitioners’ perspectives on effective practices for Hispanic teenage pregnancy prevention. *Perspect Sex Reprod Health*. 2004;36(4):142–149 https://doi.org/10.1363/3614204. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1007/s11606-007-0366-2" _id="b38" _pubmed="17957427"truejrn<jrn1true0false>true38. Chen AH, Youdelman MK, Brooks J. The legal framework for language access in healthcare settings: Title VI and beyond. *J Gen Intern Med*. 2007;22(2):362–367 https://doi.org/10.1007/s11606-007-0366-2. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1001/journalofethics.2017.19.3.ecas2-1703" _id="b39" _pubmed="28323605"truejrn<jrn1true0false>true39. Basu G, Costa VP, Jain P. Clinicians’ obligations to use qualified medical interpreters when caring for patients with limited English proficiency. *AMA J Ethics*. 2017;19(3):245–252 https://doi.org/10.1001/journalofethics.2017.19.3.ecas2-1703. PubMedtruejrn</jrn>truetruejrn</jrn>true

trueeref<eref1true0false>true _id="b40"trueeref<eref1true0false>true40. California State Legislature. Health for All Kids. 2015. Available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB4. Accessed June 21, 2019.trueeref</eref>truetrueeref</eref>true

truejrn<jrn1true0false>true _doi="10.1007/s13187-012-0357-9" _id="b41" _pubmed="22488199"truejrn<jrn1true0false>true41. Moralez EA, Rao SP, Livaudais JC, Thompson B. Improving knowledge and screening for

colorectal cancer among Hispanics: overcoming barriers through a PROMOTORA-led home-based educational intervention. *J Cancer Educ*. 2012;27(3):533–539 https://doi.org/10.1007/s13187-012-0357-9. PubMedtruejrn</jrn>truetruejrn</jrn>true

truejrn<jrn1true0false>true _doi="10.1007/s10567-009-0059-y" _id="b42" _pubmed="19834802"truejrn<jrn1true0false>true42. Suter JC, Burns EJ. Effectiveness of the wraparound process for children with emotional and behavioral disorders: a meta-analysis. *Clin Child Fam Psychol Rev*. 2009;12(4):336–351 https://doi.org/10.1007/s10567-009-0059-y. PubMedtruejrn</jrn>truetruejrn</jrn>true

FIGURE 1—Conceptual Model: Barriers to Care for Latino Youths During Reentry

FIGURE 2—Example Trajectory Analysis of Youth–Parent Dyad on Barriers to Health Care During Reentry: Los Angeles County, California, 2016–2018

TABLE 1—Sociodemographic Characteristics of Latino Youth Participants, Los Angeles County, California, 2016–2018

	No. (%)
Age, y	
[ems]15	2 (9.5)
[ems]16	4 (19.0)
[ems]17	6 (28.6)
[ems]18	9 (42.9)
Gender	
[ems]Male	18 (85.7)
[ems]Female	3 (14.3)
Country of birth	
[ems]United States	19 (90.5)
[ems]Mexico	2 (9.5)
Mother’s country or region of birth	

[ems]Mexico	12 (57.1)
[ems]United States	4 (19.0)
[ems]Central America	3 (14.3)
[ems]South America	1 (4.8)
[ems]Do not know	1 (4.8)
Father's country or region of birth	
[ems]Mexico	12 (57.1)
[ems]Do not know	3 (14.3)
[ems]Central America	4 (19.0)
[ems]United States	1 (4.8)
[ems]Europe	1 (4.8)
Home language	
[ems]Both equally	9 (42.9)
[ems]English more than my other language	5 (23.8)
[ems]My other language more than English	4 (19.0)
[ems]Only English	2 (9.5)
[ems]Only my other language	1 (4.8)
Household family structure	
[ems]Biological mother and biological father	8 (38.1)
[ems]Two parents (at least 1 nonbiological)	7 (33.3)
[ems]Single mother	4 (19.0)
[ems]Single father	1 (4.8)
[ems]Other legal guardian	1 (4.8)
Highest grade completed	
[ems]9th grade	2 (9.5)
[ems]10th grade	7 (33.3)
[ems]11th grade	7 (33.3)
[ems]12th grade (high-school graduate)	5 (23.8)
Number of times detained	
[ems]1	4 (19.0)
[ems]2 or 3	9 (42.9)
[ems]≥|4	8 (38.1)

Note. n|=|21 participants.

TABLE 2—Latino Study Participants' Health and Health Care Access at 1 Month After Incarceration: Los Angeles County, California, 2016–2018

	No. (%)
Total Adverse Childhood Experience score	
[ems]0	4 (19.0)
[ems]1	5 (23.8)
[ems]2	4 (19.0)
[ems]3	0 (0.0)
[ems]4–7	8 (38.1)
Self-reported general health	
[ems]Excellent	4 (19.0)
[ems]Very good	9 (42.9)
[ems]Good	6 (28.6)
[ems]Fair	2 (9.5)
[ems]Poor	0 (0.0)
Youth insurance status	
[ems]Medicaid	10 (47.6)
[ems]Uninsured	5 (23.8)
[ems]Unknown	5 (23.8)

[ems]Private	1 (4.8)
Thought care was needed but did not go in the month since home from detention	
[ems]Forgone medical care	5 (23.8)
[ems]Forgone reproductive health care	5 (23.8)
[ems]Forgone mental health care	0 (0.0)

Note. n|=|21 participants. Adverse Childhood Experience score measures the number of distinct types of childhood adversity an individual was exposed to during childhood. Higher scores indicate exposure to more types of childhood adversity, whereas lower scores indicate exposure to a fewer number of types of childhood adversity.