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Bringing Juvenile Justice and Public Health Systems Together to Meet the Sexual and Reproductive Health Needs of Justice-Involved Youth

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Abstract

Constitutional mandates require access to medical testing and treatment in correctional settings, including sexual and reproductive health (SRH) care services. These same mandates do not apply to youth supervised in the community, who represent the majority of justice-involved youth. Waiting until youth are in detention settings to provide access to SRH services misses an opportunity to improve health outcomes for youth who have earlier points of contact with the system. This mixed-methods study explored structural intervention development and policy geared toward increasing access to and uptake of SRH prevention, treatment, care and support services for court-involved, non-incarcerated (CINI) youth. Data were collected from a nationwide survey (N=226) and qualitative interviews (N=18) with juvenile justice and public health system stakeholders between December 2015 and January 2017. Results suggest both public health and juvenile justice stakeholders perceive CINI youth as having substantial, largely unmet SRH care needs due to a lack of services, policies or procedures to address these needs. Barriers to implementing programs and policies to improve SRH services for this population include: limited resources (e.g., staffing, time); perceived irrelevance for juvenile court, probation or other community supervision settings; and concerns about confidentiality, privacy and information-sharing. Recommendations for effective intervention included co-locating services, justice-to-community referrals and service linkages (e.g., through a community health navigator), and staff education around youth SRH confidentiality and information-sharing practices.

Introduction

Youth involved in the juvenile justice (JJ) system in the United States (US) exhibit elevated sexual and reproductive health (SRH) needs compared to those who do not have system contact (Barnert, Sun, Abrams & Chung, 2020). Rates of sexually transmitted infection (STI) among justice-involved youth range anywhere from 3 to 45% depending on the study, facility, type of STI, and youth gender, race and ethnicity (Belenko et al., 2008; Dembo et al., 2010; Dembo, Belenko, Childs, & Wareham, 2009; Dembo, Belenko, Childs, Wareham, & Schmeidler, 2009; Elkington et al., 2010; Teplin et al., 2003). Similar trends exist with reproductive health outcomes; justice-involved girls have higher pregnancy rates than their non-justice involved peers (Breuner & Farrow, 1995; Towey & Fleming, 2006). According to The Survey of Youth in Residential Placement, 9% of incarcerated girls report having children (Sedlak & Bruce, 2010), which is substantially higher than the rate of teen childbirth (3%) in the general population (Hamilton et al., 2013).

Complex risk profiles shape justice-involved youths' elevated rates of these SRH outcomes. Youth involved in the JJ system report initiation of sexual activity at earlier ages, report a higher number of sexual partners, and engage in condomless sexual activity at higher rates than their non-JJ involved peers (Belenko et al., 2008; Romero et al., 2007; Teplin et al., 2003; Tolou-Shams et al., 2008). Youth involved in the JJ system also have higher rates of substance use and other psychiatric disorders that contribute to or are associated with sexual risk behaviors, further increasing this group's risk of negative SRH outcomes. For example, an estimated 45% to 65% of JJ-involved youth meet criteria for a substance use disorder and

50 to 75% meet criteria for a diagnosable psychiatric condition (Grande et al., 2011; Teplin et al., 2013).

Racial and ethnic minority youth are overrepresented at all stages of the JJ system due to systemically racist policies, laws and institutional practices (Huizinga et al., 2007; Office of Juvenile Justice and Delinquency Prevention, 2020). These youth also encounter significant healthcare barriers due to lower socioeconomic status and family disruption, among other factors (Braverman & Murray, 2011). Within the JJ population, other at-risk populations are overrepresented (e.g., sexual and gender minority youth), who are further marginalized from accessing health care services (Hirschtritt et al., 2018), exacerbating inequities in access to SRH services. Focusing on the JJ system therefore addresses SRH disparities of these multiple underserved minoritized groups of youth.

Prior studies to improve SRH care access and outcomes have primarily focused on detained youth or “re-entry” (i.e., re-entering the community following residential placement) populations and have principally considered disease prevalence and mortality versus health screening and services outcomes (Binswanger et al., 2011). Justice-involved youth who are diverted from correctional facilities, but who remain under the supervision of the court or legal system while residing in the community (herein referred to as “court-involved, non-incarcerated” or “CINI” youth) are of particular public health significance because their limited access to critical SRH services is largely unaddressed. With few exceptions (Dembo et al., 2010; Dembo, Belenko, Childs, Wareham, & Schmeidler, 2009; Johnson et al., 2008), research to date neglects the 80% of arrested youth who are never incarcerated or detained (e.g., CINI youth); yet, these youth experience similar disparities in access to SRH services --driven in large part by societal and structural determinants of health, such as poverty, neighborhood disorganization, and lack of access to general healthcare—as incarcerated youth (Puzzanchera, 2009). To wait until youth are detained to provide SRH prevention, treatment, care, and support services misses a tremendous public health opportunity (Tam et al., 2019).

Constitutional mandates require access to medical testing, SRH services, and treatment *within correctional* settings. CINI youth, who engage in similar sexual behaviors as detained youth, with increased risk for contracting HIV and other STIs (Puzzanchera, 2009a; Tolou-Shams et al., 2007), lack access to the SRH services available to those detained. Family and juvenile courts throughout the U.S. have developed effective community diversion programs to assess and treat substance use (e.g., Juvenile Drug Courts) and mental health problems (e.g., Mental Health Courts) with the aim of preventing residential placement and decreasing recidivism (Harp, 2020). However, to our knowledge, these diversion programs do not include policy or programmatic emphasis on SRH, and no study has attempted to address the persistent SRH disparities among CINI juveniles. Systems that serve CINI youth, such as juvenile courts, probation departments, and community-based organizations providing diversion services, present a unique opportunity to reduce SRH disparities for this population of community-supervised justice-involved youth.

Addressing access to and uptake of SRH screening, prevention, treatment, care and support services among CINI youth is of urgent importance. Understanding how to develop JJ-public

health (PH) partnerships to increase access to and uptake of SRH services is one way in which the field can advance health equity for CINI youth. The aims of this mixed-methods study were two-fold: 1) provide an in-depth, qualitative understanding of attitudes, perceptions, practices and policies in JJ and PH related systems that limit or enable access to SRH services for CINI youth; and 2) through a nationwide survey of JJ and PH system stakeholders, advance structural intervention and policy development by providing essential scientific evidence relevant to improving access to and uptake of SRH services for CINI youth.

Methods

Data were collected following a sequential exploratory mixed methods design (Creswell & Clark, 2017). Phase 1 of the study employed formative, semi-structured qualitative interviews to inform the development of a nationwide survey of JJ and PH stakeholders designed to identify and understand barriers and facilitators to SRH care among CINI youth. Phase 2 of the study entailed the development, testing, and administration of this nationwide survey. All study procedures were approved by the University of California Institutional Review Board.

Phase 1 Qualitative

Participants and Recruitment Strategy

An Expert Consultant Panel (ECP) comprised of 5 multidisciplinary professionals from 3 cities in the United States (US) with expertise in SRH, the JJ system, adolescent health inequities, and health policy informed Phase 1's interview guides, sampling frame, and recruitment. In total, ECP members referred an initial 15 JJ and 15 PH stakeholders for potential interview participation.

Referred stakeholders were from Pennsylvania, California and Florida. Specific cities are not reported to protect participant confidentiality; these states were chosen because they are well-represented in other SHR research on CINI youth and because they broadly represent the US East, South and West coasts (Dembo et al., 2010; Johnson et al., 2008; Tolou-Shams et al., 2012). To be eligible for qualitative interview participation, system stakeholders had to be: 1) ≥18 years old, 2) employed in PH or JJ settings, 3) working in one of the three study locations, and 4) fluent in English. Stakeholders from the PH system included nurses, infectious disease doctors, medical directors, pediatricians, and directors of health-focused nonprofits. Juvenile justice stakeholders included probation staff (officers, supervisors, administrators), judges and public defenders.

Initially referred respondents (N=30) received study invitations via email, and ECP members also reached out to prospective participants about interest in participation. Given that not all referred participants chose to participate, additional potential study participants were identified using snowball sampling methods, i.e., enrolled participants were asked to provide contact information of local stakeholders whom they thought might also be eligible to participate in an interview (Crosby et al., 2006). To prevent all participants from representing one occupational network, referral chains were limited to two study

participants. A total of 18 key stakeholder interviews were conducted (n=9 JJ stakeholders; n=9 PH stakeholders). Most participants were female (77.8%), between 45 to 54 years (44.4%), and reported working in their field for approximately 17 years (range: 2 to 34 years).

Procedures

Qualitative data were collected between December 2015 and June 2016. Semi-structured qualitative interviews were conducted by phone at a date and time convenient to the participant. Hour-long interviews were completed by four researchers including the study principal investigator (MTS).

Prior to interviews, participants were provided a written copy of the consent form via email and verbal consent was obtained at the beginning of the telephone interview. Interviewers followed a standardized, semi-structured interview guide focusing on three main domains related to improving access to and uptake of SRH services for CINI youth: (1) attitudes about SRH programs for youth, (2) existing SRH programming or policies for CINI youth, and (3) perceptions of barriers and facilitators to the provision of SRH care for CINI youth. A note-taker was present for all interviews. After each interview, a short interviewer-administered questionnaire was completed to track each participants' professional experience, educational background, gender, and race and ethnicity. All participants were offered a $50 gift card as compensation for their participation.

Analytical strategy

All interviews were audio-recorded. Within 48 hours of each interview's completion, interviewers and note-takers reviewed audio recordings and wrote notes and constructed executive summaries of the main discussion points and topics. Executive summaries provided data quickly to assist with identification of theme redundancy. Prior to further analysis, audio files were transcribed verbatim and de-identified. Using principles of Inductive Thematic Analysis (Braun & Clarke, 2006), all interview transcripts were double coded by trained qualitative coders. After independently coding each transcript, each pair of coders reviewed codes and resolved discrepancies to improve reliability and ensure adequate inter-coder agreement. This process culminated in a master coded transcript for each interview. Next, coded segments were reviewed and members of the analytic team generated memos to highlight connections between codes and subcodes relevant to the study's primary research questions. Quotations from participants were compiled and concepts and relationships pertinent to core themes were developed. The final set of codes and memos were compared and combined into overarching themes and subthemes. Themes were discussed, refined, and named for the final analysis. We used NVivo (QSR International Pty Ltd. NVivo qualitative data analysis Software. Version 11, 2015) to facilitate qualitative analysis.

Phase 2 Quantitative Survey

Survey development

Following methods outlined by Creswell, Clark, and Plano (2017), the study team created a survey draft informed by qualitative interview data and existing, published surveys of HIV and other STI testing practices and other health-related practices and policies in justice settings (e.g., NIDA Criminal Justice-Drug Abuse Treatment Studies or CJ-DATS survey of adult correctional settings (Belenko et al., 2013), National Survey of Juvenile Justice Professionals (Willison et al., 2013), the National Pregnancy Prevention Campaign of Judges survey (National Campaign to Prevent Teen and Unplanned Pregnancy, 2009) (see Appendix for sample constructs and items). We conducted three rounds of cognitive interviews (CI) (N=15) by phone with key informants in the same systems and locales as in Phase 1 to identify whether: questions were consistently understood, respondents could satisfactorily answer them, answers accurately described respondent experiences, and answers were valid measures of what the questions were designed to measure (Fowler, 2002). Half of the CIs were conducted with previous qualitative interview participants (i.e., with those who expressed interest in and agreed to participate in Phase 2) to confirm that the survey questions captured members experiences, and half were new participants from the same locales and systems. New participants were recruited for Phase 2 from the sampling frame derived from the Phase 1 snowball sampling approach. CIs lasted approximately 60 minutes (range 45–90 minutes). We took an iterative approach to CIs and survey development to obtain feedback on survey item revision until the instrument and items were stabilized and no new problems were identified.

Sampling Frame and Approach

We conducted a nationwide survey of 226 JJ and PH staff (to understand the provision and availability of SRH services for CINI youth). Among the survey respondents, 122 were staff in JJ, 92 were in PH, and 12 were identified as having expertise in both JJ and PH systems (referred to as JJ/PH). Survey data were collected between May and July 2017. Guided by Phase I qualitative findings, we limited the sampling frame for JJ participants to probation personnel (chiefs, supervisors, and line officers) to collect data from individuals most closely supervising CINI youth. The PH sampling frame was limited to individuals working on adolescent SRH. Survey subjects were recruited with assistance from relevant professional organizations (e.g., American Probation and Parole Association; National Network of State Adolescent Health Coordinators and the National Coalition of STD Directors), who distributed survey-related information to their members. To increase recruitment of PH stakeholders, study staff attended professional conferences (e.g., 2017 National Sexual Health Conference) to disseminate survey recruitment material. Electronic surveys administered via Qualtrics took approximately 20 minutes to complete. Participants who provided their email addresses (not linked to data responses) were compensated with a $10 electronic gift card for survey completion.

Survey Measures

The passive consent information sheet provided to all prospective participants included a description of the study purpose (“to better understand provision and availability of SRH

services for youth who are diverted from detention and court-supervised in the community"). The survey consisted of 31 closed-ended questions that included list, ranking, true/false or Likert response options; items also included an "other" option to elicit open-ended responses. Some items elicited single responses and others were "check all that apply". One open-ended item was included at the end of the survey to provide respondents the option to share anything else about SRH for CINI youth that they thought was important for researchers to know. Participants were also asked to provide their personal demographic (i.e., age, race and ethnicity, gender, and state locale) and occupational information (e.g., role, length of time working in their system). Remaining survey items were grouped into six domains examining stakeholder's perceptions related to CINI youth: 1) primary health concerns, 2) types of system-level assessments and interventions, 3) perceptions of system barriers and enablers, and openness to addressing SRH needs, 4) system roles and responsibilities in providing access to SRH services, 5) privacy and information sharing, and 6) specific health intervention strategies to address SRH needs. See the Appendix for additional survey information.

Data analysis

Preliminary analyses consisted of descriptive characteristics of the study sample (see Table 1). Primary analyses focused on differences in key outcomes across the six domains described above, both overall and stratified by stakeholder expertise (i.e., JJ, PH, or both). Chi-square analyses were used for categorical outcomes (e.g., identification of mental health as a top 3 need) and one-way ANOVAs were used for continuous outcomes (e.g., importance of addressing youth SRH health needs). Post-hoc analyses were computed using the Tukey HSD test. We used Bonferroni corrections to adjust for Type I error in computing one-way ANOVAs to examine the feasibility and helpfulness of sexual and reproductive health resources and services. Data were cleaned and analyzed using IBM SPSS statistical software version 26.

Results

Phase 1. Qualitative

Three major themes emerged: 1) CINI youth have unmet SRH needs; 2) existing screening tools do not effectively assess CINI youths' SRH needs; and 3) provision of care is blocked by a variety of system-level barriers (e.g., related to policy and privacy laws).

Theme 1: CINI youth have substantial, largely unmet SRH needs

Both JJ and PH stakeholders identified CINI youth as having substantial, largely unmet, SRH needs including: lack of SRH education, lack of access to HIV/STI testing and contraceptives, early and unintended pregnancies. Stakeholders in both systems described youth possessing "a profound lack of [SRH] information"; one JJ-system stakeholder with ≥25 years of experience described the need to address gaps in the availability of developmentally appropriate and tailored SRH education when stating:

> [H]ealth education that is age-appropriate and should start relatively early, even as early as maybe nine or ten years of age. Making sure that they're knowledgeable

> about their own development, but also knowledgeable about ways that they can keep themselves healthy and safe…I think that a lot of young people just don't know what's - what the risks are for them, and ways that they can take control and keep themselves safe.

The majority of stakeholders (10/18) described SRH needs differently for CINI boys and girls. There was a particular emphasis on unintended and early pregnancy as being a major concern for CINI girls. One PH stakeholder (20-years of experience) highlighted this difference in perceived needs when commenting:

> I think there would be the belief that these [sexual health] services were more needed for girls. I think that's the mindset, and that particularly centers around sexual assault and pregnancy.

Among male CINI youth, unidentified and untreated mental health and substance use needs were of primary concern. Other SRH needs perceived to uniquely impact girls included commercial sexual exploitation, access to safe contraception and abortion services, sexual assault, and unhealthy (i.e., violent or abusive) partnerships.

Theme 2: Systems serving CINI youth implement a variety of behavioral health screening tools and interventions, yet SRH needs are rarely addressed

Participants from the JJ system described a variety of screening tools used in justice settings. The screening tools used in the JJ system included those focused on identifying needs related to substance use and trauma (i.e., the Massachusetts Youth Screening Instrument [MAYSI]) (Grisso & Barnum, 2000), supporting decision-making related to healthcare service planning (i.e., the *Child and Adolescent Needs and Strengths* [CANS]) (Lyons et al., 1999), and assessing recidivism risk. While each of these tools includes at least one item assessing aspects of sexual behavior and/or sexual identity, none were designed to address SRH needs specifically or directly. Consequently, stakeholders noted they referred youth out to receive these services.

Participants in the JJ system described a limited number of SRH-related interventions available to CINI youth – most often, voluntary STI, HIV, and pregnancy testing. PH participants described a greater variety of interventions, including HIV and STI testing, clinic referrals, and collaborations with faith-based agencies, school nurses, and health educators. Only one participant described a program that leveraged collaboration between local JJ and PH systems. However, this program emphasized treatment of co-occurring mental health and substance use disorders and did not explicitly address SRH needs.

Participants described that while existing screening tools rarely addressed SRH needs, informal conversations between system stakeholders and youth do occur on this topic, but only when a youth initiates the conversation. Conversations varied according to the JJ system stakeholder and their role. For example, attorneys were less likely to have conversations about youth's SRH needs given their focus on legal processes, while JJ-appointed social workers were more likely to have these conversations given their focus on the youth's overall health. Two PH staff shared similar communication barriers, indicating

youth did not have a way to communicate or discuss their sexuality or sexual health needs during routine health care appointments:

> *I would see it frequently with the patients that I provided care for in the clinic, people are embarrassed about having sex. You know, they don't feel it's their right. They don't necessarily have a way to talk about it.* (~ PH stakeholder, ≥25 years in the PH system)

Theme 3: System-level barriers affect the implementation of SRH services for CINI youth; however, creative solutions can facilitate service delivery

Barriers to health services implementation included lack of system-specific SRH policies, confidentiality and health information sharing, and challenges in working with caregivers regarding CINI youths' SRH needs.

SRH-specific policies.—JJ and PH stakeholders mentioned few to no policies related to SRH, particularly for CINI youth. JJ stakeholders only mentioned SRH policies when speaking about detained youth, and three explicitly stated they had no policies related to teen SRH at all. Though PH stakeholders did not mention policies related to SRH for CINI youth, stakeholders in two locales believed local policies that mandated testing for HIV, syphilis, and Hepatitis B and C be available to all individuals, at no cost. These policies were perceived to have some positive impact on CINI youths' ability to access SRH services.

Confidentiality and health information-sharing.—With few exceptions such as youth who were dually involved in the JJ and child welfare systems, JJ and PH system staff described difficulties gathering CINI youth health information. One limitation was the perception that CINI youth are hesitant to share health information if they believe this information might be shared with their parents, caregivers, or court staff. Further, a system-wide lack of knowledge around confidentiality laws and HIPAA limited sharing between and within JJ and PH systems and contributed to a culture that deterred JJ and PH staff from discussing or addressing general health concerns of youth in their care. For example, one PH stakeholder (≥10 years of experience) identified how the lack of HIPAA knowledge created challenges in facilitating service coordination and delivery:

> And maybe it's someone who doesn't understand HIPAA that well. And they won't speak to me because I don't have a release. When trying to explain, 'But under HIPAA, I'm not asking you for any details under HIPAA. We can speak for the purposes of coordinating care for this youth.

In rare cases when they perceived it as relevant or important, stakeholders described sharing information with their JJ or PH counterparts via signed consent forms, releases of information, or memorandums of understanding. The most frequently reported reason by both sets of stakeholders to "allow" information sharing was for CINI youth pregnancy care coordination (n=7). Participants also expressed that information sharing was important in the context of residential placement (n=3 JJ stakeholders), and cases involving sexual assault (n=2 PH stakeholders). Most participants (15 of 18; 83%) across both systems felt that SRH information sharing was not necessary with JJ partners. Fear of discrimination of youth based on SRH-outcomes (e.g., HIV/STI status) and the impact that this might have on youth

willingness to engage in SRH services were the two primary factors shaping stakeholder's reluctance to support sharing SRH information with the JJ system. Such factors can limit the court's ability to identify and address SRH needs of CINI youth, as exemplified by a JJ stakeholder participant:

> "But a pregnancy is a fairly high risk situation, not only for the youth, but for the unborn child. And for that reason, I think that the court and the probation department and others in the juvenile justice system have an added level of responsibility for that unborn child, to make sure that whatever plans or decisions we're making relative to the mother, that they don't compromise the health of the unborn child."

Perceptions of JJ and PH roles and responsibilities with regard to SRH.— Several JJ participants noted the JJ system had antiquated views of sexuality, gender, and their intersection, which ultimately impacted service delivery, particularly for female clients. For example, one participant working in the JJ system for ≥10 years, described the JJ system's approach to addressing SRH needs of justice-involved girls as focused on restricting their freedom for the purposes of "protecting" them:

> [The JJ system has] old-fashioned notions about morals and moral behavior that says this girl - if we don't lock her up, if we don't do something to restrain, restrict and confine her - she's going to go out and she's going to get herself pregnant or she's going to go out and get another STD.

No JJ stakeholders felt the provision of SRH prevention services for youth involved in the system but living in the community should fall solely under the purview of the JJ system. One exception to this perception was if the youth had an emergent SRH need (e.g., an untreated STI) that they needed assistance seeking services for. Two stakeholders noted that SRH service provision was the sole responsibility of the PH system. One participant stated the purpose of the JJ system is to intervene on delinquent behavior in youth through police, court, and correctional involvement, with the overall goal of rehabilitation. Therefore, addressing SRH needs is not mandated and, subsequently, the JJ system lacks authority to require tests for SRH, nor can they require an individual attend health-related education programs that might address these issues.

Challenges in working with caregivers regarding CINI youths' SRH needs.—In addition to the system-barriers described above, stakeholders from both systems expressed that parents and caregivers: 1) may not feel comfortable providing SRH information to their children; 2) experience discomfort when having to discuss relevant youth risk behaviors; and 3) may have unaddressed needs themselves (e.g., undiagnosed mental health and substance use disorders), which limit their capacity to address the specific SRH needs of their youth.

Creative solutions to overcome barriers.—Facilitators of health service implementation included: 1) co-located services (e.g., behavioral health services staff co-located with juvenile probation staff); 2) individuals who have the knowledge and skill to link separated and siloed systems and/or a professional attitude that seeks to creatively find and offer services to youth who need them (system "champions"); 3) interdisciplinary or

interagency case planning meetings where behavioral health and service needs for CINI youth are discussed on an individual basis; and 4) specific programs or procedures (e.g., programs for adjudicated youth who get STI testing and are referred to relevant services if they test positive; "[STI-testing] is a point of access to these very high-risk youth"), some of which target particular populations (e.g., young children).

Phase 2. Survey Results

Demographics.—Of 226 survey participants surveyed across 42 US states and territories (Figure 1), 122 (54.0%) were from the JJ system, 92 (40.7%) identified as PH participants and 12 (5.3%) worked in both systems (herein referred to as JJ/PH) (Table 1). Most participants working in the JJ system were probation officers (36.6%). Participants in the PH system primarily identified as program coordinators (41.4%). Characteristics of youth served are also presented in Table 1.

Primary Health Concerns for CINI Youth.—Of 226 respondents, 193 (85.4%) reported their system/organization has contact with CINI youths. Across PH and JJ sectors, for CINI boys, the top three health needs identified were mental health, substance use and violence prevention. For CINI girls, similar to CINI boys, the top two identified health needs were mental health and substance use, but the third top health need was sexual health.

Types of system-level assessments and interventions provided to CINI youth.—There was variability in the screening and intervention services offered by JJ versus the PH systems (Figures 2 and 3). JJ participants offered mental health and substance use screening and intervention services at higher rates than those in the PH system, while PH participants reported offering general health and SRH screening and intervention services at higher rates than respondents in the JJ system. Specifically, the JJ system was more likely to refer out for SRH screening (52.4%) and intervention (69.0%) services, while the PH system was more likely to provide on-site SRH screening (74.2%) and intervention (62.3%) services.

Openness to addressing SRH.—There were significant differences in stakeholder openness to addressing health topics [$F(2, 219) = 39.95$, $p < .001$]. Compared to JJ stakeholders, PH stakeholders reported greater openness to addressing SRH topics including sexual or dating violence, HIV and planned or unplanned pregnancy, compared to both PH and JJ/PH, JJ stakeholders were also less open to addressing STIs and safer sex behaviors (see Table 2).

Perceived importance of and confidence in system addressing SRH.—JJ stakeholders rated the importance of addressing SRH with youth significantly lower (M=7.13, SD=2.37) than stakeholders in PH (M=9.47, SD=1.19) and JJ/PH (M=9.33, SD=1.50) systems. Similarly, JJ stakeholders were significantly less confident in their ability to address youth's SRH needs (M=5.41, SD=2.64) compared to PH and JJ/PH stakeholders (M=6.88, SD=2.45; M=7.42, SD=2.31, respectively) [$F(2, 219) = 10.19$, $p < .001$].

Roles and responsibilities in providing access to SRH services for CINI youth.—We identified significant differences in JJ and PH stakeholders' perspectives regarding each systems' roles and responsibilities in providing access to SRH services for CINI youth. Compared to stakeholders in the PH system and JJ/PH stakeholders, JJ stakeholders were significantly less likely to believe the PH system should create media campaigns to enhance youth's awareness of SRH risks ($X^2(2, N=222) = 8.89, p = .012$), implement SRH screenings in all juvenile probation settings (X^2 (2, N=223) = 30.00, $p < .001$), provide consultation to juvenile probation settings on how to enhance SRH service access and referrals (X^2 (2, N=220) = 13.71, $p = .001$), and to rely entirely on juvenile probation to improve access to SRH services (X^2 (2, N=220) = 16.21, $p < .001$). JJ stakeholders were also significantly less likely to believe the JJ system should incorporate training for staff on the SRH needs of CINI youth (X^2 (2, N=221) = 19.28, $p < .001$), implement SRH screenings in all juvenile probation settings (X^2 (2, N=220) = 49.84, $p < .001$), or combine SRH screenings with existing behavioral health screenings (X^2 (2, N=222) = 21.21, $p < .001$). There were no significant differences in beliefs that the PH system should provide SRH access directly to CINI youth, or that the JJ system should provide CINI youth with referrals to local public health clinics to access SRH services or rely entirely on the PH system to improve access to SRH services (data not presented).

Privacy and information-sharing regarding SRH services.—Stakeholders in the PH (74.0%) and JJ/PH (83.3%) systems were more likely to say providers should know about youth's involvement with the JJ system than JJ stakeholders (57.4%) ($X^2(2, N=221) = 10.22, p = .006$). Stakeholders in the JJ system most commonly agreed that youth should be allowed to share health information with JJ staff if they want to [97.5% of JJ versus 90.2% of PH and 83.3% of JJ/PH ($X^2(2, N=223) = 7.85, p = .020$]. Similarly, JJ stakeholders were most likely to agree that youth's legal guardians should be allowed to share youth's health information with JJ staff if they want to [95.1% of JJ compared to 60.9% of PH and 66.7% of JJ/PH ($X^2(2, N=222) = 38.01, p < .001$)]. Stakeholders with expertise in JJ/PH (66.7%) and JJ stakeholders (50.0%) were more likely than PH stakeholders (29.4%) to agree JJ staff should have access to results of sexual health screenings ($X^2(2, N=222) = 10.86, p = .004$). Similarly, JJ/PH stakeholders (66.7%) and JJ stakeholders (56.6%) were more likely than PH stakeholders (34.8%) to agree that JJ staff should have access to prenatal care records if the youth is pregnant. There was more general agreement across stakeholders that providers and JJ staff should share information with one another (JJ=71.3%, PH=57.6%, JJ/PH=66.7%).

Specific health intervention strategies to address SRH needs.—Stakeholders had differing perspectives on the helpfulness and feasibility of SRH resources and services for youth; however, specific intervention strategies that had average rating of 3 or higher (i.e., rated as a beneficial strategy) by both JJ and PH included: instituting a systematic SRH referral process between JJ and community partners; co-locating PH staff at JJ facilities to provide SRH on location; training for JJ staff on adolescent SRH needs and placing a community health navigator in the JJ setting who would help youth access SRH services. Overall, JJ staff rated the helpfulness of each of the intervention strategies lower than PH but

generally rated the feasibility of these strategies similarly to PH stakeholders. Figures 4 and 5 present stakeholder perceptions of the specific SRH intervention strategies by sector.

Discussion

Study findings support concerns that the SRH of justice-involved youth living in the community are largely unaddressed by two key relevant service systems: juvenile courts/probation and public health. Nearly three-quarters of all participants reported that the CINI youth they serve in the community lack accurate information about and have poor access to SRH services. In-depth interviews with JJ and PH stakeholders working directly with or within systems serving CINI youth identified three major contributing themes: 1) lack of adoption and implementation of SRH screening tools and interventions; 2) JJ and PH system-level barriers that preclude SRH care provision; and 3) lack of understanding and accurate knowledge about macro-level policies and laws that complicate implementation of necessary cross-system information-sharing practices to foster positive SRH outcomes. Nationwide survey results support these themes across 42 states and 226 stakeholder participants in juvenile justice and adolescent public health settings. Most notably, respondents perceived that the majority of CINI youth lack accurate information about SRH needs, and over half of survey respondents indicated their systems serving these youth have no mandated funding or policies around addressing youths' SRH needs. Justice and PH stakeholders identified four intervention strategies as potentially beneficial with two interventions as most likely to be helpful and feasible: a sexual health navigator embedded in JJ settings and trainings for justice staff on the topic of adolescent health. Overall, however, JJ stakeholders perceived these interventions as less helpful and beneficial than PH stakeholders, which suggests JJ system buy-in and attitudes toward perceived helpfulness of such interventions will need to be addressed (and studied) as part of next steps for implementation.

Adoption and implementation of screening measures and intervention approaches for those identified in need are lacking. Data demonstrate that justice-involved youth have greater SRH needs and risks than their general adolescent population counterparts (Gates et al., 2016); stakeholders in both the JJ and PH sectors working with these youth acknowledge this is a true need, but have different perceptions of which system is responsible to address these service gaps. Justice systems, in particular, feel that screening and/or intervention related to SRH is well outside the scope of their role in working with CINI youth and families. And yet, this same perception of relevance or exceeding scope of practice, often referred to as "net-widening" (McElrath et al., 2016), occurred over a decade ago when the JJ system began screening for mental health symptoms and substance use behaviors for youth in detention. This "net widening" eventually was the precursor to the now widespread U.S. implementation of the MAYSI-2 across juvenile detention and probation settings. Many of the concerns around screening and intervention for mental health and substance use (e.g., privacy, information-sharing, exceeding scope of JJ system role) that have since been overcome in in the provision of behavioral health services are the same as those expressed in the current study related to youth SRH. Perhaps one notable difference is that mental health and substance use are linked to increased likelihood of committing illicit acts (e.g., assault, larceny) that can result in continued justice contact and recidivism (Tolou-Shams et al.,

2014). For example, achieving justice stakeholder buy-in for integration of SRH screening and intervention into existing mental health and substance use screening procedures may be more challenging because there is not a direct relationship between SRH risk/needs and youth legal outcomes. However, given that mental health and substance use screening has become more of a standard in juvenile probation settings, the idea of integrating or adding SRH screening for intervention recommendations or service linkage purposes may not be a substantial additional or separate system burden—and could perhaps feasibly be integrated into *existing* system screening and linkage procedures. A key point for PH partners –who see meeting the SRH needs of CINI youth as necessary and important –is a concern that their JJ partners may view addressing SRH as of lower importance for the JJ context. Lastly, available interventions tested with CINI youth have been HIV prevention-focused with small samples, primarily in juvenile drug court settings and with varying effects on CINI youth sexual health outcomes (Tolou-Shams et al., 2010). Such interventions have also not moved from the efficacy to effectiveness and implementation trial stages thereby leaving the justice system without that intervention resource once the study ends. More research is needed on developing efficacious SRH interventions and conducting hybrid efficacy/effectiveness trials (Curran et al., 2012) to keenly and quickly identify system barriers to and facilitators of SRH intervention adoption and sustainability.

Our data suggest the multiple system-level barriers that affect the implementation of SRH services for CINI youth may be overcome through creative cross-system approaches. Examples could include co-locating PH staff in juvenile court or probation offices or using the movement toward integration of electronic medical records and databases as an opportunity to systematize processes and procedures for justice system to community referrals and service linkages. Incorporating SRH referrals and linkages into existing processes centered on mental health and/or substance use could also be another approach. Further, empirical testing of any of these approaches is critical to moving the field forward and reducing SRH disparities for these youth.

Another significant area for development and study relates to system information sharing and confidentiality/privacy laws. Limitations to sharing information *between and within* systems was the most significant barrier to developing and implementing policies and programming necessary to address CINI youths' SRH needs. Limitations can perhaps be accounted for by 1) JJ and PH staff and systems' lack of knowledge and understanding of privacy and confidentiality (i.e., HIPAA) regulations, 2) the laws' actual versus perceived restrictions and 3) relevance about information-sharing depending on role, discipline and system. For example, JJ stakeholders offered various reasons why they believed SRH information should not be shared within the JJ or court system (e.g., a probation officer providing information to a judge). There is, however, an emergent institutional awareness of the unique pathways to justice involvement and health needs of sexual and gender minority youth. Such emerging awareness may impact systems-level responsivity to addressing SRH needs to certain groups (Office of Juvenile Justice and Delinquency Prevention, 2016). Public health stakeholders shared cross-system concern that JJ stakeholders might be privy to a youth's SRH need, but that this was not automatically leading to referral or linkage to SRH services. Further study could include intervention to enhance the relevance of addressing CINI SRH issues for JJ and PH stakeholders and/or staff education and training

in JJ and PH systems on youth SRH confidentiality and information-sharing practices. Information-sharing practice and confidentiality laws vary by jurisdiction and geographical location. Such variation must be considered when developing and testing structural-level interventions to address SRH needs of CINI youth. Until the challenges described by our participants are addressed, preferably through empirical tested approaches, the gaps in disparities for these highly underserved youth will continue unabated.

This study has several limitations that warrant mention. For the qualitative phase, we only recruited participants from three locales in the United States and in the quantitative phase, we recruited few participants from each sector in each state to participate in the national survey. Consequently, our findings may not be as generalizable to other settings or particular US regions. To alleviate participant burden, we also did not request responses on specific descriptive data of the youth populations served (e.g., race, ethnicity, gender, income and insurance status), which limits us in being able to more fully describe the justice-impacted youth populations served in these US locales. Lastly, given our sampling methods we have no information to determine potential non-response bias. Despite these limitations, this study presents a unique contribution to the literature by examining cross-system perspectives US nationwide on addressing SRH among a population of youth greatly impacted by structural health inequities.

In summary, a paradigm shift in the field is needed to bring together JJ and PH stakeholders to collaborate on efficiently and effectively reducing SRH disparities for justice-involved youth residing in the community. It is highly insufficient that for many of these youth, particularly girls, contact with a juvenile detention setting represents their first access to necessary sexual health care. Juvenile justice and public health stakeholders have identified the importance of addressing CINI youth's SRH needs, but greatly differ in respect to the "who," "how" and "where" these disparities should be addressed. Future research should focus on bridging the gap between these two systems of care in the United States to improve SRH for some of the most underserved youth. The problem is not one-directional, and the US health care system must also do its part to create a culturally and trauma responsive healthcare system that does not exacerbate marginalization of justice-involved youth.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Public Policy Relevance Statement

Identifying ways the juvenile justice and public health systems can partner in the community to promote access and linkage to sexual and reproductive health (SRH) services for justice-involved youth is key to informing public policy geared toward reducing adolescent disparities in access to healthcare services. Data collected from public health and juvenile justice key stakeholders provide novel insight into the system-level barriers to implementing programs and policies to address SRH needs of court-involved, non-incarcerated youth. Findings address each system's perceived relevance in addressing these types of needs and present ways these systems might effectively collaborate to address current SRH service gaps and unmet needs for these underserved youth.

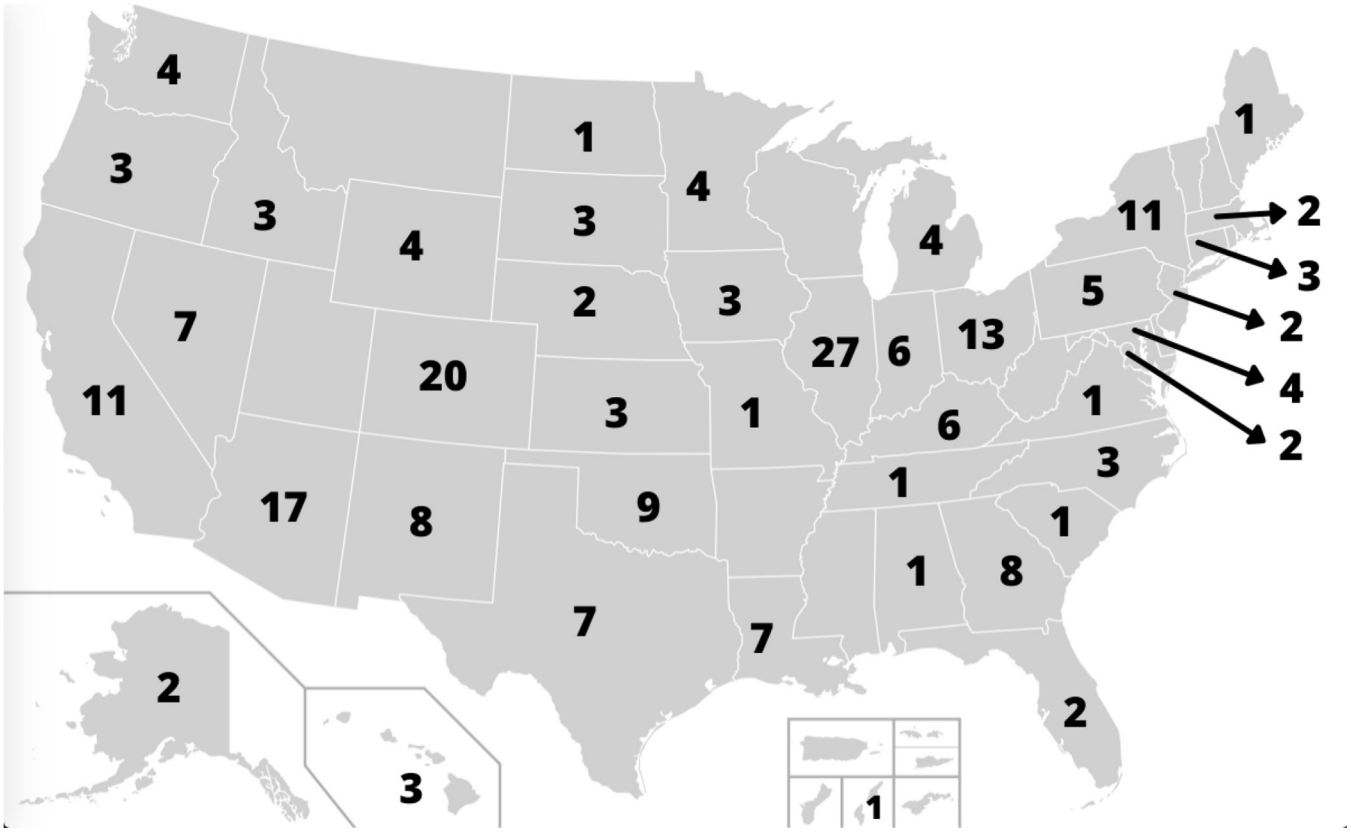

Figure 1. Geographic Distribution of Number of Survey Respondents from Juvenile Justice and Public Health Systems (N=226)

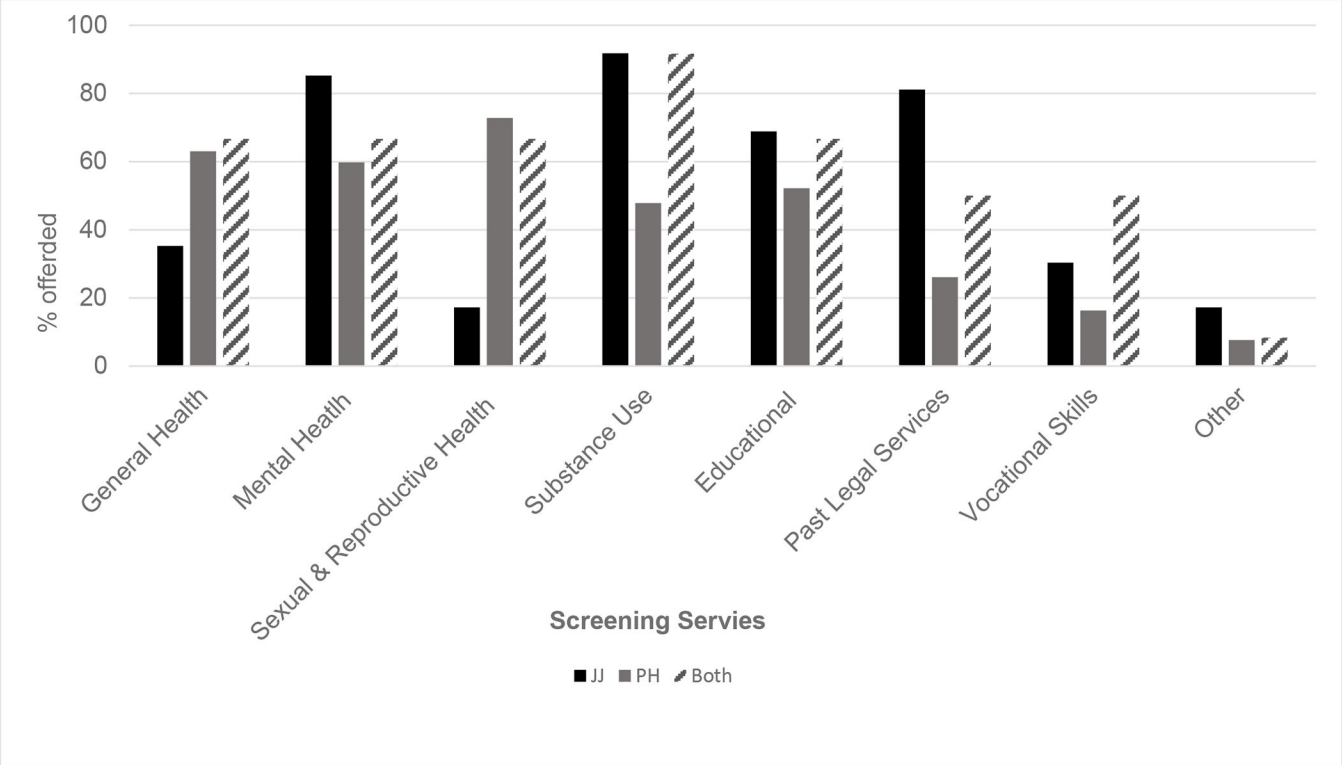

Figure 2. Screening Services Offered to Court-Involved, Non-Incarcerated Youth (CINI), by System

Note. The "other" category includes a wide range of services including those related to youth risk of recidivism, familial characteristics (e.g., family criminal history), and risk assessment.

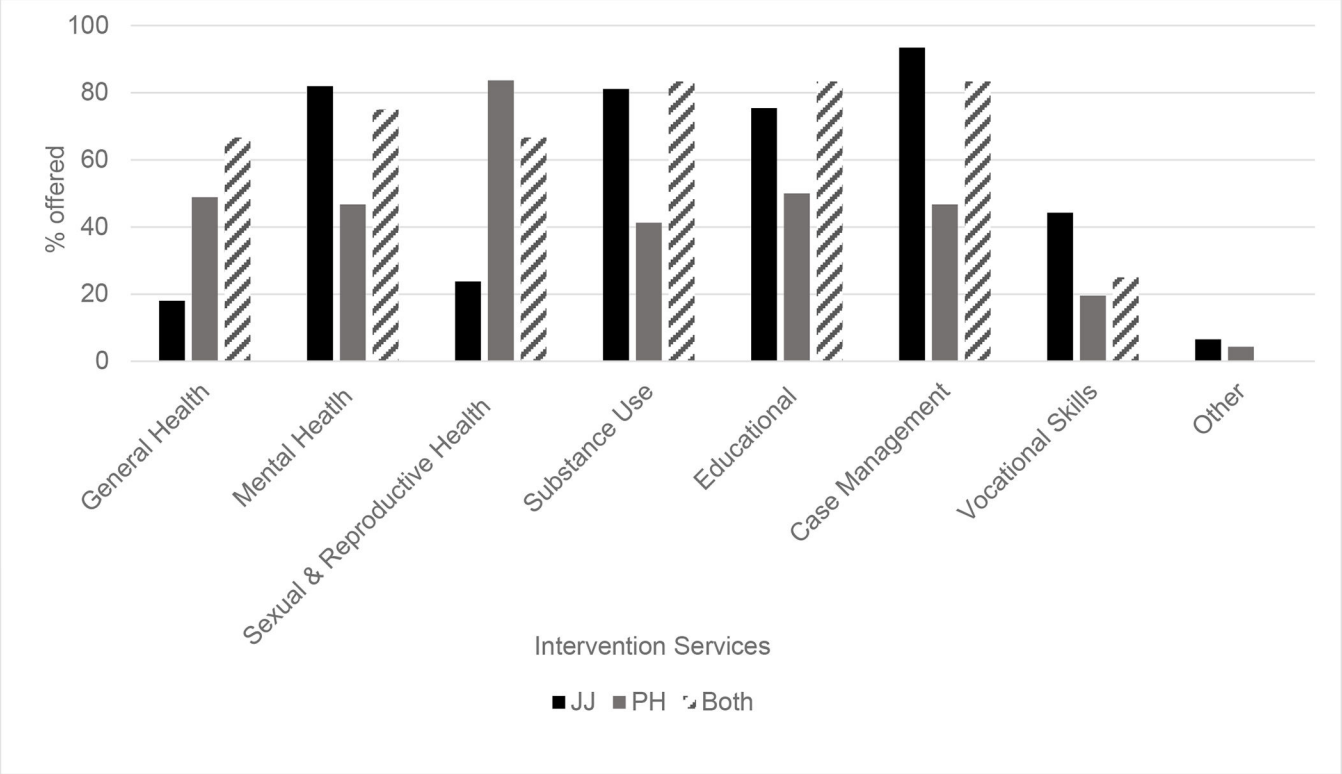

Figure 3. Intervention Services Offered to Court-Involved, Non-Incarcerated Youth (CINI), by System

Note. The "other" category includes a wide range of services related to sexual violence perpetration, housing services, and community service learning.

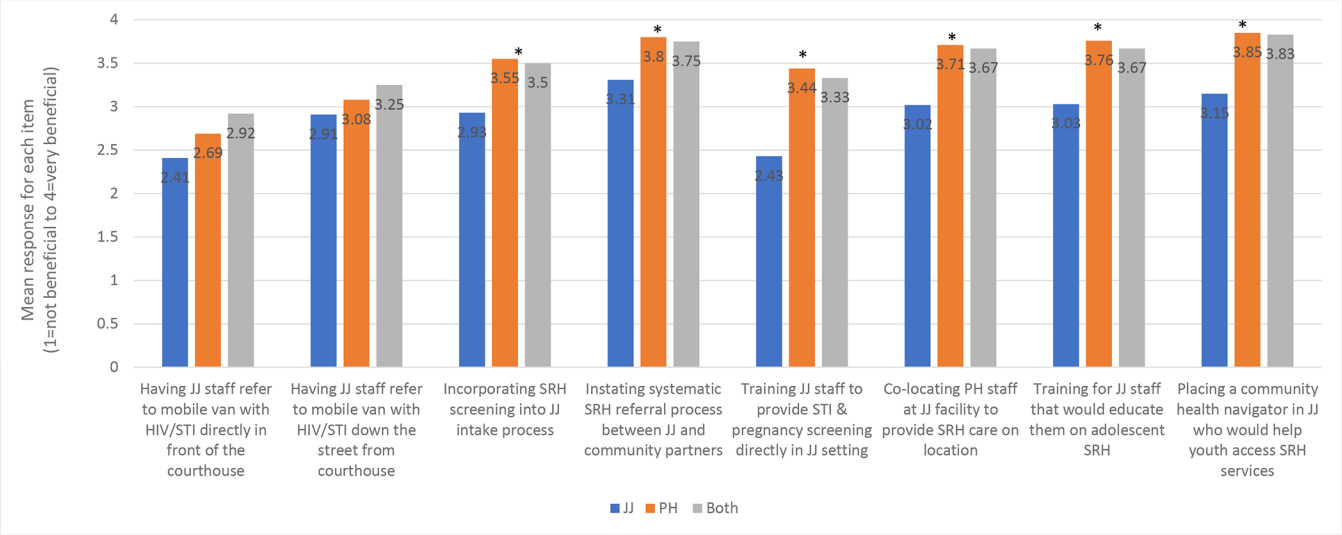

Figure 4. Perceptions of the Helpfulness of Sexual and Reproductive Health Resources and Services for CINI youth, by System

* $p < .001$ differences in ratings between Juvenile Justice (JJ) and Public Health (PH) stakeholders

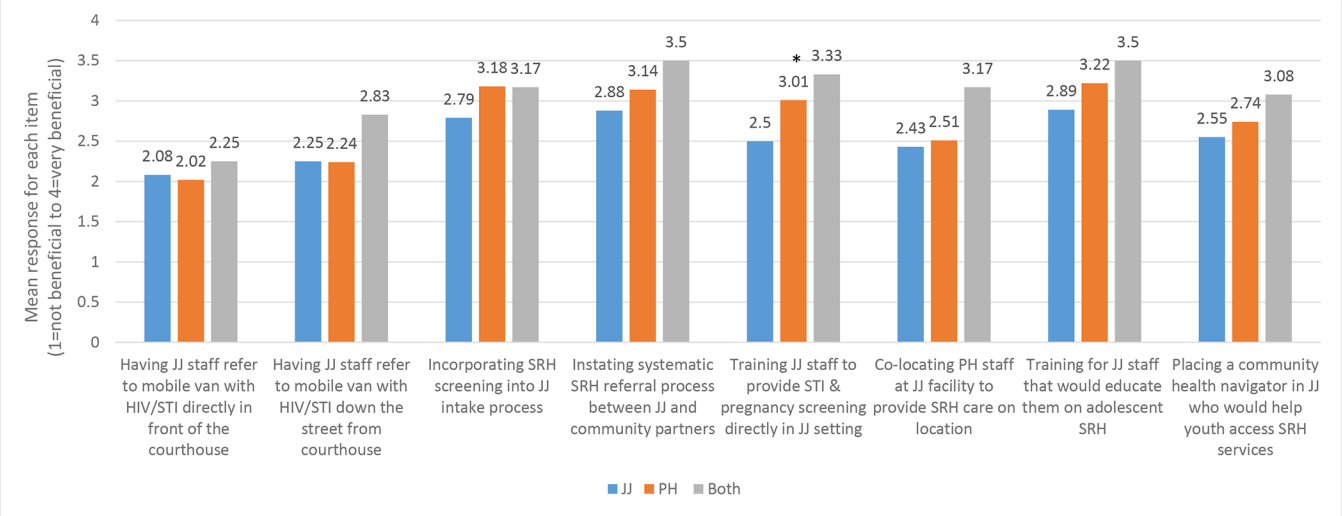

Figure 5. Perceptions of the Feasibility System Resources and Readiness to Provide Sexual and Reproductive Health Resources and Services for CINI Youth, by System

Note: $p < .001$ differences in ratings between Juvenile Justice (JJ) and Public Health (PH) stakeholders

Table 1.

Select Characteristics of Juvenile Justice and Public Health Stakeholders (N=226)

	n	%
System Expertise (*n*=226)		
Juvenile Justice	122	53.98
Public Health	92	40.71
Both	12	5.31
Juvenile Justice System Stakeholders (*n*=134)		
Occupational Role (*n*=133) *		
Probation Officer	49	36.57
Probation Administrators and Supervisors	42	31.34
Other Juvenile Justice System Roles	42	31.34
Embedded Health/Behavioral Health Staff	12	8.96
Justice Program Staff and Administrators	29	21.64
Other	2	4.76
Legal Intercept of Youth Served +		
Pre-adjudicated, non-detained	79	58.96
Post-adjudicated, non-detained	98	73.13
Detained youth	94	70.15
Youth in placement	79	58.96
Re-entry youth	60	44.78
Youth involved with a specialty court	45	33.58
Public Health System Stakeholders (*n*=104)		
Occupational Role		
Primary Care Physician	8	7.69
Clinic Physician	13	12.50
Medical Director	1	0.96
Case Manager	7	6.73
Program Coordinator	43	41.35
Health Educator	25	24.04
Other **	7	6.73
Youth Ages Served +		
Ages 0–9	14	13.46
Ages 10–18	89	85.58
Ages 18+	61	58.65

* There were missing data on role for n=1 Juvenile Justice stakeholder

** Other PH roles include clinicians (i.e. social worker, therapist) and research staff (i.e. epidemiologist, administrator)

+ Categories are not mutually exclusive.

Table 2.

Juvenile Justice and Public Health system openness to addressing health topics (N=226)

	Total M(SD) (*N*=226)	**Juvenile Justice M(SD) (*N*=122)**	**Public Health M(SD) (*N*=92)**	**Both M(SD) (*N*=12)**
Child abuse/neglect	3.60 (0.69)	3.71 (0.60)	3.45 (0.80)	3.67 (0.49)
General physical health	3.36 (0.85)	3.16 (0.92)	3.58 (0.72)	3.67 (0.49)
Sexual or dating violence *	3.47 (0.76)	3.33 (0.79) [a]	3.62 (0.71) [b]	3.75 (0.62) [a]
HIV **	3.24 (0.94)	2.90 (0.99) [a]	3.66 (0.67) [b]	3.50 (0.80) [a]
Mental Health	3.64 (0.66)	3.82 (0.47)	3.39 (0.82)	3.83 (0.39)
Nutrition	3.09 (0.94)	2.83 (0.96)	3.40 (0.83)	3.42 (0.90)
STIs **	3.33 (0.88)	2.97 (0.92) [a]	3.74 (0.59) [b]	3.75 (0.62) [b]
Planned or unplanned pregnancy **	3.15 (0.99)	2.84 (0.95) [a]	3.54 (0.79) [b]	3.42 (0.67) [a]
Safer sex behaviors **	3.34 (0.89)	3.00 (0.95) [a]	3.76 (0.61) [b]	3.67 (0.65) [b]
Substance Use	3.67 (0.64)	3.86 (0.42)	3.40 (0.79)	3.83 (0.39)
Violence prevention	3.46 (0.81)	3.66 (0.64)	3.18 (0.96)	3.64 (0.51)
Other	2.85 (1.33)	3.00 (1.27)	2.76 (1.40)	2.63 (1.41)

Note: In each row, means that do not share a common superscript indicate where a statistically significant difference is present.

* $p=0.01$

** $p<0.001$

note: responses range from 1=not open to 4=very open