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Health Care for Youth Involved with the Correctional System

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KEYWORDS

• Adolescents • Juvenile detention facilities • Correctional system

KEY POINTS

- Youth involved with the correctional system are disproportionately impacted by negative health outcomes, related to both physical and mental health.
- Detention settings allow time for providers to ensure that health issues for adolescents are addressed, but many challenges exist to providing care in these facilities.
- Community-based providers should be aware of adolescent patients who have a history of being detained and ensure that all necessary aspects of their health and well-being are followed closely after the youth is released home.

INTRODUCTION

Youth who are currently or who have been incarcerated represent a significant number of adolescents, a group that is often medically underserved and that has substantial physical and mental health needs.[1–3] In 2011, more than 60,000 youth in the United States spent time in correctional facilities.[4] Both the absolute numbers of youth who are detained and the rate of detention has steadily decreased over the past several years as a result of declining arrest rates and changing state and local legal policies regarding the management of youth who commit delinquent acts.[3,5,6] However, those who are detained often have the greatest need for physical and mental health care.

DEMOGRAPHICS

The demographics of youth in detention are important to consider because of health disparities that are related to gender, race, and ethnicity. Detained women account for

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nearly 14% of all incarcerated youth, and tend to have more physical and mental health needs.[3,4,6] Youth of racial or ethnic minorities are overrepresented in correctional facilities: black youth represent 40% of detainees and Hispanic/Latino youth represent 23%. In comparison, white youth constitute 32% of detainees.[4] Another significant demographic consideration is that lower socioeconomic status is correlated with juvenile delinquency and is especially prevalent among the black and Hispanic youth who are detained.[3,6] These characteristics of incarcerated youth help define the health needs of these adolescents, because many of the social determinants of poor health are also associated with delinquency.[3]

JUVENILE JUSTICE PROCESS

Youth generally enter the juvenile justice system through law enforcement (ie, after an arrest). Other referrals to the juvenile courts may be made by parents, schools, victims, or probation officers. Fortunately, the rates of arrest and confinement for all crimes—violent crimes, person offenses, property offenses, drug offenses, public order offenses, technical violations, and status offenses (acts that are illegal based on the age of the offender, but not for adults)—have been steadily decreasing over the past decade.[5,7]

Youths arrested for an alleged infraction may be diverted to management outside of the court system (eg, to a community-based treatment program). According to the U.S. Department of Justice, in 2009 this accounted for 22% of police cases.[8] For other arrests, the police will determine if the youth can be safely released home with a date to return to court, or the police or judge may order the youth to stay in a secure detention facility until their court hearing (either because of the seriousness of the crime or because a stable place for release cannot be identified). After the court hearing, a youth who is found to be guilty (often referred to in juvenile courts as "the petition is sustained") may be released on house arrest or will be ordered to serve time in a residential treatment or rehabilitation facility. These residential facilities may be referred to as *placement homes*, *group homes*, *camps*, *ranches*, *halls*, or other names, depending on the jurisdiction. Residential placement accounted for 27% of adjudications in 2009.[8] After residential placement, youth will be released home and will remain on probation for a court-determined length of time, during which the youth remains under supervision of the court or the juvenile corrections department.

HEALTH CARE SERVICES IN DETENTION FACILITIES

Although the spectrum of services on-site varies widely between correctional facilities,[9] federal law requires that detention halls and residential treatment facilities offer health care services to all detained youth. Additionally, individual state case laws may mandate more specific provisions regarding the extent to which correctional health care services must be available. These laws dictate areas of care, including initial screening and evaluation, access to urgent care during detention, preventive care services, staff training, nutritional services, and several other areas.[10]

In addition to these laws, correctional facilities may voluntarily seek accreditation by the National Commission on Correctional Health Care (NCCHC), which sets standards for providing appropriate health care in all corrections facilities and has specific standards for juvenile facilities.[10] For example, NCCHC standards mandate a process for emergency care and a system of sick call in which youths' requests for care are assessed daily by a nurse and appropriate action is taken based on the urgency of the situation. They also require physical health, oral health, and mental health

screenings on admission, and respective follow-up care by a trained professional within a specifically determined period.[10]

Various national provider organizations have policy statements that support the provision of comprehensive health care services to detained juveniles and offer guidelines for care. The American Academy of Pediatrics (AAP) Committee on Adolescence recently updated their extensive policy statement, "Health Care for Youth in the Juvenile Justice System," which reviews the health status of detained juveniles and suggests standards of appropriate care.[6] The Society for Adolescent Health and Medicine and the American Public Health Association also have policy statements supporting comprehensive health care in correctional settings.[11,12] The American Medical Association's Guidelines for Adolescent Preventive Services (GAPS) and the AAP's Bright Futures guidelines offer complete lists of all services that should be provided for adolescent health visits.[13,14] The NCCHC also publishes several clinical guidelines (available at http://www.ncchc.org/guidelines) specifically developed to address the needs of incarcerated youth.[15] All of these resources provide useful recommendations for providing optimal care to youth in correctional settings.

HEALTH OF DETAINED YOUTH AND GOALS FOR CARE IN DETENTION

Several studies and surveys have confirmed that youth involved in the juvenile justice system are disproportionately affected by poor health outcomes.[1,3,6,9,11,16–18] By the very nature of being involved in the juvenile justice system, these youth represent a group who are frequently involved in risky health behaviors related to substance use, sexual experiences, and delinquent activities.[1–3,6,11,16] Many of the physical, development, and mental health needs seen in juvenile detention settings are more prevalent than among the general adolescent population (**Box 1**). Furthermore, many enter detention facilities with medical or mental health issues that were previously undiagnosed or inadequately managed.[1,3,6,16]

Immunizations

In line with the standard guidelines for promoting adolescent health, immunizations are important for preventive care, and detention provides an opportunity to offer these services, particularly because many detained youth have not had a regular source of primary care before being incarcerated.[16] The Centers for Disease Control and

Box 1
Health disparities affecting incarcerated youth

- Sexually transmitted infections
- Teenage pregnancy and parenthood
- Chronic conditions affecting ethnic minorities and low socioeconomic status communities (eg, asthma, type II diabetes, sickle cell disease)
- Attention-deficit/hyperactivity disorder and learning disorders
- Behavioral problems (eg, conduct disorder, anger management)
- Posttraumatic stress disorder
- Mood disorders (eg, depression)
- Substance abuse
- Suicidality

Prevention (CDC) recommends that all adolescents older than 11 years receive tetanus, diphtheria, acellular pertussis (Tdap); meningococcal; and human papillomavirus vaccines. In addition, adolescents who are not up-to-date on other childhood vaccines (hepatitis A, hepatitis B, varicella, mumps, rubella, and polio) should receive vaccines according to the catch-up schedule.[19]

Chronic Illnesses

Chronic illnesses are very important health considerations in juvenile detention facilities. Regardless of whether the facility provides short-term detention while awaiting trial and disposition or longer-term residential custody, chronic conditions can be addressed and managed so that the health of the youth is stabilized. At a minimum, providing relevant health education and setting health goals for patients with chronic disease are important elements of care, and these recommendations are emphasized by the NCCHC Juvenile Standards.[10] Certain illnesses, such as seizure disorders, diabetes, sickle cell disease, and asthma, can have serious medical consequences if not managed adequately. Therefore, these conditions must be identified early on admission and managed appropriately.

Sexual and Reproductive Health Issues

Sexual and reproductive health issues are a significant area of morbidity among detained youth.[1,3,6,11,18] Compared with a general high school population, incarcerated youth report higher rates of sexual activity, a higher average number of lifetime partners, and lower use of contraception or condoms.[1,3,18] As a result, these youth are at a higher risk for sexually transmitted infections (STIs) and unplanned pregnancies. In 2011, the rate of chlamydia among women in juvenile correctional settings in 2011 was 13.5%, and was 6.7% for men entering juvenile detention facilities.[20] These rates, and those for gonorrhea, are significantly higher than STI rates in similar gender and age groups in the general population. Many incarcerated youth are also at higher risk for HIV and hepatitis C infection, particularly if they are involved in commercial sex work or injection drug use.[6] Education about STIs is important for this population. The U.S. Preventative Services Task Force (USPSTF) recommends high-intensity behavioral counseling to prevent STIs for all sexually active adolescents.[21] Furthermore, the CDC, in their 2010 Sexually Transmitted Disease Treatment Guidelines, recommends routine screening for sexually active adolescents, regardless of whether they are symptomatic (**Table 1**).[22] The common practice of only screening youth with symptoms misses many youth who are infected asymptomatically. Diagnosing and treating asymptomatic infections can prevent complications for individuals (eg, pelvic inflammatory disease) and may limit the spread of infections in the communities to which the detainees will be released. Despite the high prevalence of STIs among detained youth, less than one-quarter of juvenile detention facilities currently screen admitted youth for STIs or HIV.[9]

Parenthood and pregnancy status also impact incarcerated youth more than the general adolescent population, with 1 of 5 detained youth either having a child or expecting a child.[2,3,23] A 2009 survey found that 14% of incarcerated youth had children; 15% of men and 9% of women. In comparison, 2% of teenage men and 6% of teenage women in the general US population had children. Additionally, 12% of incarcerated youth were expecting a child while detained. More than one-third of detained women reported having ever been pregnant.[2] Less than one-fifth of all facilities test all entering women for pregnancy, although most offer testing when necessary or when requested by a youth.[23]

Table 1
CDC recommendations for STI testing in detained adolescents

	Women	Men
Chlamydia	Universal screening of all adolescents at intake in juvenile or jail facilities	All sexually active in adolescent clinics, correctional facilities, and sexually transmitted disease clinics on intake
Gonorrhea	Universal screening of all adolescents at intake in juvenile or jail facilities	Not recommended universally, but for men who have sex with men: urethral screening for insertive intercourse and anal screening for receptive intercourse Pharyngeal testing for receptive oral intercourse
Syphilis	Universal screening based on local area and institutional prevalence	Universal screening based on local area and institutional prevalence Screen all men who have sex with men
HIV	Screening for all sexually active and users of injection drugs	Screening for all sexually active and users of injection drugs Screening is especially important for men who have sex with men

Data from Workowski KA, Berman S, Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines. MMWR Recomm Rep 2010;59(RR-12):1–110.

General Health Complaints

General health complaints, although similar to those in nondetained youth, are more common in the juvenile justice population, because of the social determinants of health existent in the youths' lives before detention (eg, community-based health risks or exposures and a lack of access to medical care), and problems created by the institutional environment.[3] On admission to a detention center, the most common acute complaints include headache, abdominal pain, back or joint pain, and upper respiratory symptoms.[1,16] In long-term detention facilities, dental, dermatologic, musculoskeletal/trauma, and respiratory issues are among the more prevalent acute health needs, aside from psychiatric or behavioral issues.[1,16]

Mental Health Issues and Suicidality

Mental health issues represent some of the most predominant health needs of detained youth. Attention-deficit/hyperactivity disorder (ADHD), learning disorders, depression, anxiety, disruptive behaviors (eg, conduct disorder), posttraumatic stress, and substance abuse are among the most common diagnoses seen in this population, and are much more prevalent among detained youth than in the general population of adolescents.[1,3,6,11,17,18,24] In fact, although the prevalence of serious psychiatric conditions within the general pediatric and adolescent population is estimated to be 7% to 12%, the rate among detained youth is 60% to 80%, with rates generally higher for women.[1,24] Furthermore, many youth have more than one psychiatric diagnosis.[1,24] Diagnosing and treating these disorders during adolescence is crucial because of the associations with other mental health conditions later in life, such as the relation between disruptive disorders of adolescence and personality disorders in adulthood.[25] Early and effective management is also important to prevent worsening of the clinical or behavioral manifestations and to avoid the potential of more serious legal consequences as the youth enter adulthood. Screening for general mental health issues with validated tools, such as the Massachusetts Youth Screening Instrument,

the Beck Depression Inventory, or the Patient Health Questionnaire, is offered to youth at many facilities, but not all.[1,17]

Histories of suicidal ideation, attempts, and completions are more than twice as frequent among youth in custody than among nondetained adolescents.[1–3,18,24,26] Even in the controlled setting of detention facilities, suicide attempts remain a significant concern. The stresses of being incarcerated, awaiting court decisions, and being separated from family and peers; a history of physical, sexual, or emotional abuse and/or substance use; and any preexisting mental health issues contribute to the risk of suicidality.[1,3,18,24,27] A study found that 52% of detained youth reported current suicidal ideation and more than one-third reported suicide attempts, with a direct relationship between suicidality and reported histories of abuse.[28] The rate of suicide completion among detained youth is more than 4 times higher than the rate for youth overall.[29] Additionally, even after release, youth with a history of incarceration have an ongoing substantial risk of suicidal attempts during their lifetime.[1,30] Effective suicide prevention programs that involve all staff who interact with youth are a vital part of correctional health services and should begin on a youth's admission to a facility.[6,27]

Substance Use and Abuse

Substance use or abuse is also common among detained youth and often exists comorbidly with other mental health issues.[1–3,6,18] The rates of tobacco, alcohol, and drug use among youth in custody are much higher than among the overall adolescent population (**Table 2**).[1,6,17,18] Despite high rates of substance use and abuse in association with psychiatric issues and delinquent behavior, not all facilities screen universally for substance use or offer individualized treatment plans for substance abuse.[6,17]

SPECIAL POPULATIONS

Girls

Girls in corrections are different from boys. Braverman and Morris outlined some of the medical differences, including a greater likelihood of having any psychiatric disorder, specifically anxiety and mood disorders.[3] Related to this is the common finding of physical, sexual, and emotional abuse in incarcerated girls that is associated with risky sexual behaviors and suicidality. Girls' substance abuse compared with boys is more likely to involve substances other than alcohol and marijuana.[3,31]

As a consequence of high exposure to all types of abuse, many girls are often in unequal power relationships with boys. This unequal relationship makes it difficult for delinquent girls to develop self-esteem or skills in self-protection. For this reason,

Table 2
Lifetime substance use among detained youth and general adolescent population

Substance	Detained Youth (%)	General Population of 12- to 20-Year Olds (%)
Alcohol	74	56
Marijuana or hashish	84	30
Cocaine or crack	30	6
Ecstasy	26	6
Crystal methamphetamine	22	2

Data from Sedlak AJ, McPherson KS. OJJDP Juvenile Justice Bulletin: youth's needs and services. 2010. Available at: https://www.ncjrs.gov/pdffiles1/ojjdp/227728.pdf. Accessed November 24, 2013.

it has been suggested that facilities for girls be staffed exclusively by women or, at minimum, that all staff are trained to help girls learn to be appropriately assertive in their relationships with both genders.[31] Health care providers should also understand these dynamics to avoid actions that may seem to be insensitive or domineering of female patients.

In 2002, Congress passed the Juvenile Justice and Delinquency Prevention Act mandating that states assess their services to girls and implement gender-specific services.[32] Other agencies have also documented the need for gender-specific services, including prenatal and postpartum health services, guidelines for overall treatment of pregnant detainees, and contraceptive options available during incarceration and on release.[10,31,33] Unfortunately, many of the recommendations have not been adopted by the various jurisdictions that govern coed and female juvenile justice facilities.[31]

Gay, Lesbian, Bisexual, or Transgender Youth

Gay, lesbian, bisexual, or transgender (LGBT) youth are particularly vulnerable while in correctional facilities, and constitute a significant proportion of the population, although they tend to remain "hidden."[34,35] In 2010, Irvine conducted a survey of 2100 youth in corrections and found that overall, 15% reported being LGBT, representing 11% of boys and 27% of girls, and with equal distribution among different races.[35] Most (80%) of these youth behave in a gender-conforming way and therefore are not immediately obvious to the staff.[36] As a result, most LGBT youth in corrections may not be identified unless they disclose this information.

Once in detention, LGBT youth often believe they must keep their sexual orientation a secret to avoid harassment, differential treatment, or sexual and physical assault from other detainees and staff.[36] In fact, they are significantly more likely to be sexually assaulted, with 12.5% of nonheterosexual youth reporting sexual victimization compared with 1.3% of heterosexual youth.[37] As a result of these fears, problems such as school troubles and family discord that are related to their sexuality may not be addressed, and LGBT youth may experience higher levels of stress than other detainees.[34]

Gender-nonconforming youth in the justice system are significantly more likely than heterosexual and gender-conforming LGBT youth to have experienced home removal, lived in foster homes, been homeless, been detained in a juvenile facility for running away, and been charged with nonviolent offense.[35] Because LGBT youth often have problems at school due to harassment by classmates, and problems at home due to rejection, they are more likely to be detained once arrested, because the authorities may judge their social situation as unstable and may assume that a detention facility is a safer setting. However, this results in incarceration that may be unnecessary and that may actually be more harmful to the youth because of the risks of assault or harassment in detention settings.[38] If the court deems home life undesirable, LGBT youth may be detained for long periods, further subjecting them to stress and interruption of their normal adolescent development.[38] On disposition, many LGBT youth will be placed on probation with stipulations, such as following parental dictates and attending school—requirements with which the youth may not be able to comply because they would be placed in unsafe situations.

The Juvenile Facility Standards of the Prison Rape Elimination Act issued by the U.S. Department of Justice in 2012 mandates national standards related to sexual assault and sensitivity toward LGBT inmates.[39] The promulgation of these regulations should bring a measure of uniformity to the appropriate management of LGBT youth in detention and allow for corrective action when the mandates are not met in a facility.

SELECTED RELEVANT BIOLOGICAL AND CONGENITAL GENETIC DISORDERS

A variety of biological issues are overrepresented in delinquent youth, although none of them are reliably predictive of criminal behavior. Shonkoff and colleagues[40] published a review of 114 studies in 2009 that argued that the roots of maladaptive behaviors that may lead to incarceration are associated with fetal and neonatal toxic stresses, such as nutritional deficiencies, obesity in the mother, drug/alcohol exposure, postnatal child abuse/neglect, extreme poverty, and family violence. These stresses can modify epigenes, which determine how genes are read and expressed. The epigenes can ultimately act to induce a negative health status and behavior difficulties. These transformed epigenes are then passed to the next offspring, amplifying the bad effects from generation to generation. Given the poor social structures many incarcerated youth experienced in childhood, this work provides a theoretic framework to understand the genesis of much delinquent behavior.[40]

Klinefelter Syndrome

Klinefelter syndrome is a genetic disorder (47,XXY) that affects boys and can led to gonadal dysfunction and in some cases social and/or cognitive problems. The physical findings include very firm small testes approximately the size of shelled peanut. A patient with Klinefelter syndrome may be tall and lack typical secondary characteristics associated with testosterone effects; they may have scant facial hair, gynecomastia, and features of a female habitus. Although most of these boys are sterile, they may otherwise have normal sexual function. Laboratory tests will show low or low normal testosterone and elevated follicle-stimulating and luteinizing hormones. Shortly after puberty, the testosterone level may be normal, but will eventually decrease to low levels. Testosterone replacement therapy will cause appropriate androgenization for the boy and may ameliorate some of the various social/cognitive problems. The phenotype of these patients varies from obvious to near-normal, except for the small testicles. Therefore, they are often not diagnosed until adulthood when their sterility is discovered.[41]

If this diagnosis is made in a detained youth, a provider may opt to discuss the possible need for testosterone replacement therapy, but should avoid discussing the possibility of sterility because this might cause additional stress to the patient. A better course of action might be to reassure the youth that on release he will have continuing management by a pediatric endocrinologist who is knowledgeable about Klinefelter syndrome.

Some youth with Klinefelter syndrome may have a propensity to offend, including fire setting,[42] although most never offend. Furthermore, this increased crime rate is not seen when socioeconomic status is taken into account.[41] The increased fire-setting propensity is controversial, and some authors do not believe it exists.[43]

Fetal Alcohol Spectrum Disorders

Ethyl alcohol ingestion during pregnancy causes a series of facial anomalies, growth failure, and variable levels of cognitive dysfunction, including ADHD.[44] As the child grows, some of the classic facial stigmata associated with fetal alcohol syndrome may lessen, making diagnosis more difficult.[45] Some evidence suggests that nutritional deficiencies during pregnancy magnify the deleterious effects of alcohol on the brain.[46,47] These children have substantial problems with memory and a poor understanding of the consequences of behavior, and they tend to be easily influenced by peers and make poor decisions in life.[48,49] For these reasons, youth with fetal alcohol spectrum disorders (FASDs) may be more likely to commit offenses and be detained.

However, their underlying medical condition may not be diagnosed by facility staff.[49] A recent study highlighted the implications of FASDs as important precursors to delinquency and discussed the relevance to law enforcement, the correctional system, and the judicial system.[49]

Recent experimental work with animals exposed to alcohol during gestation found that a combination of postnatal choline, folate, and vitamin A reversed many of the learning problems in the animals even if they were adults when treatment began.[50,51] One-fifth of school age children and adults with FASD are diagnosed with anxiety, and many receive neuroleptic drugs for this.[51] Other evidence-based interventions include "Math Interactive Learning Experience," "Good Buddies," "Language to Literacy Program," and "USFA Kids." Additionally, "Parents and Children Together" and "Families Moving Forward" provide positive parenting interventions for children 4 to 12 years of age.[51] Details of some of these programs are available at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/fetal-alcohol-spectrum-disorders-toolkit/Pages/default.aspx.

CHALLENGES TO CARE

Correctional facilities are particularly unique settings for providing health care. Although the basic responsibilities of providers are similar to those in any clinical setting, many considerations are distinctive to youth detention facilities (**Box 2**). When youth are detained, their daily schedules are usually strict and structured. Although health care services are mandated for detention facilities, they must compete with several other required services for all youth. For example, correctional departments are responsible for ensuring educational periods that meet state and federal requirements, providing time and resources for daily physical activity, serving 3 meals per day, and administering other rehabilitative programs. Therefore, clinical visits must fit within the other daily activities. Court hearings may also interfere with scheduling clinical visits. Court processes generally take precedence over all other activities for youth. However, if the health care professional finds that a youth is not medically stable for a court appearance, the provider can engage the court and correctional departments in a discussion about balancing health needs with legal priorities.

Youth must be escorted to the detention facility clinic by correctional officers; therefore, appointments must be coordinated with correctional staff. Low staffing available within the correctional department may create a challenge. The safety and security of

Box 2
Challenges to providing health care in youth detention facilities

- Daily schedules/conflicting priorities (eg, school, court)
- Security concerns
- Transportation considerations
- Lack of parental presence during visit
- Youths' perceptions of the association between health care providers and the correctional/penal system
- Availability or proximity of emergency or subspecialty care
- Recruitment of health care providers

Data from Morris RE. Health care for incarcerated adolescents: significant needs with considerable obstacles. Virtual Mentor 2005;7:1.

the youth and staff are important, and therefore there may be a limit to the number of youth held in the clinical area at any given time. Additionally, the needs for gender separation and avoidance of rival gang problems may prevent certain youth from being allowed in the clinic at the same time.

During detention, youth will receive health care in clinic without the presence of their parents or guardians. State laws vary in the extent of health services to which minors can consent for themselves.[52,53] The rights remain applicable in detention facilities and are listed for each state and the District of Columbia at https://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf.[53] Additionally, some correctional systems attempt to obtain a general consent for medical care from the parents or guardians at the time of admission to the detention facility. States and local jurisdictions have varying statutory codes that confer legal authority to the correctional health care staff to provide routine and medically necessary care whenever indicated, although parental/guardian or court consent is usually required for surgery or other invasive procedures. An example detailing the nuances of consent specifically within the juvenile detention setting of California is available at http://www.teenhealthlaw.org/fileadmin/teenhealth/teenhealthrights/ca/Juv._Justice_Consent_Manual_11-09.pdf.[54]

Many youth are not accustomed to seeking care, receiving care, or answering health questions without the guidance or assistance of parents, which can result in incomplete past medical or family histories. Parents may be reached by phone to obtain more information when necessary, but the delay between the clinic appointment and the phone conversation with a parent is less optimal than real-time access to parents in community-based health clinics and offices. For nonbasic primary care needs, the policies of the detention facility will specify when parental consent is needed for vaccinations, procedures, or access to previous medical information. Challenges in obtaining consent from parents or guardians (eg, unknown contact information, inaccurate phone numbers provided by the youth, language barriers) can lead to delays in care.

Youth who are detained may understandably associate the doctors, nurses, and other providers with the correctional/penal system, although health care staff may not answer directly to the corrections administration.[55] For this reason, some youth are reluctant to cooperate with health care staff because they view them as part of the detention system that may further penalize them. In particular, youth may think that disclosure to health care providers about risky behaviors (eg, drug use, past violence) will affect their legal charges. Helping youth understand the separation between health services and the correctional/penal system and explaining the health-focused reasons why providers may inquire about risky behaviors will facilitate gathering important health information from the youth, especially their histories of substance use and other risk behaviors. Arrest and detention are upsetting experiences and can result in uncooperative behaviors, even when the youth is ill. Considerate providers can play an important role in helping youth cope with their situation, and can lead to acceptance of health care during detention.

When youth require a higher acuity of medical care than the level of resources available in a detention facility, the youth can be referred to a local comprehensive medical facility, emergency care center, or subspecialty clinic. In making arrangements for access to outside care, the aforementioned challenges of time priorities, security, and transportation may present difficulties. Providers must convey the medical necessity clearly to correctional staff so that youth can be transported to outside care in a timely manner. Depending on the location of the detention facility (eg, proximity to a tertiary care facility, availability of pediatric subspecialties), certain medical resources may not be easily accessible.[55] Providers in detention facilities must balance the medical need

with the availability of resources to develop the most feasible management plan for each youth.

Lastly, but not insignificantly, the challenges of providing adequate care in detention facilities may be amplified by the problems of inadequate health services staffing and difficulty recruiting providers.[55] Physicians may not be on-site regularly, which may limit the extent of care that can be provided in a timely manner.[9] This issue is even more significant because youth who are detained are at high risk for significant medical needs at the time of admission to the facility.[1,3,6,16]

FOLLOW-UP CARE CONSIDERATIONS

When youth are released from a detention facility, they must receive follow-up care by a community-based primary care provider so that they can continue to receive treatment for any ongoing health care issues, including monitoring their health status and health risk behaviors (**Box 3**). When seeing patients after they have been released from a detention facility, it is not essential to know the reasons for incarceration or to be concerned about innocence or guilt. Many youth involved with the correctional system have committed low-level offenses or may have been detained primarily because of poor home or social situations. However, it is important to know how long they were detained, whether they had any acute health issues while detained (eg, injuries during a fight, appendicitis, scabies), what immunizations and treatments they received in the facility, and whether any ongoing care was recommended. Community-based providers can contact correctional facilities to request copies of the health records with consent from the youth's parent. This exchange of information can help to ensure continuity of care, limit redundancy of medical workups, and prevent unnecessary changes to successful treatment plans. Providers should also ask the parent or guardian about whether any medical, mental health, or substance abuse therapy has been recommended or is required for the probation period.

Underlying factors that may have contributed to the reasons for being detained should also be investigated and managed by providers to help prevent repeated incarceration. For example, providing support and resources for a parent of an LGBT youth may help families manage related difficulties at home and school, thus avoiding behavioral problems that may lead to legal infractions. Likewise, working with a youth's school to ensure a safe environment or providing assistance to youth with learning difficulties may promote academic success and fewer behavioral troubles in school.

Box 3
Key points for community providers caring for formerly detained youth

- Request medical records or discharge summaries from detention facility
- Determine if patient needs subspecialty, mental health, or substance abuse treatment referrals
- Ask youth about current risk behaviors
- Communicate with youth's assigned probation officer as needed
- Understand requirements of probation
- Continue regular screenings for sexually transmitted diseases and mental health issues
- Assist family with academic needs (eg, request Individualized Education Program from school)

Many youth have histories of drug or alcohol abuse. To preserve an optimal patient-provider relationship, clinicians should avoid becoming involved in court or mandated drug testing, because these proceedings might result in reincarceration or other sanctions being placed on the youth. However, clinicians can work with youth to encourage them to remain in substance abuse treatment. As with all teens, clinicians should continue ongoing regular risk assessment and refer youth for drug abuse treatment as needed.

When ongoing follow-up appointments are required, providers must be aware of the youth's other priorities and responsibilities after release from the detention facility. The terms of probation are often strict, and they must be followed so that youth are not detained again. Youth may be released on house arrest, in which they are not permitted to be anywhere except home or school. Therefore, providers should be aware of this when suggesting follow-up appointments, and must be willing to call or write to probation officers or courts about the importance of medical visits. Similarly, scheduling of appointments during daytime hours may be challenging for recently released youth, because school attendance may be a monitored requirement of the probation period.

Physicians caring for youth should ideally monitor all aspects of well-being, not just physical health. Therefore, the physician must ask about a youth's sexual activity, substance use, school performance, home safety, and involvement in behaviors that may have legal consequences. The same social factors that led to the youth's arrest are also risk factors for poor health outcomes. Therefore, if any risky behaviors are identified, the provider should provide needed care and connect the youth with resources to prevent repeated arrests and negative health consequences.

It is wise to follow these youth regularly, at least twice per year, especially to assess their mental health status, because youth in the detention system have a much higher prevalence of mental health issues, including depression and suicidality. For further guidance in managing these youth, the AAP and AMA have publications that provide guidance to practitioners dealing with children involved in the juvenile justice system.[55,56]

SUMMARY

Although several challenges exist to providing optimal care for adolescents in correctional facilities, their medical and mental health needs are high, and it is critical to ensure that health care during detention is a priority. These needs also require attention once youth have been released from detention and are receiving health care in community-based settings. Providing well-rounded and sensitive care to these adolescents during and after incarceration has a great effect for each youth, and a positive impact on their families and communities.

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