Justice-Involved Youth: The Newest Target for Health Equity Approaches?

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In 2015, over 900 000 US youth <18 years of age were arrested. This is a 68% decrease from the peak in 1996 but still represents 1 in every 36 youth between the ages of 10 and 17, 1 in every 26 boys, and 1 in every 16 African American youth.[1] In their article "Preventive Care Use Among Justice-Involved and Non–Justice-Involved Youth," Aalsma et al[2] use a novel linkage of Medicaid claims data and juvenile justice records to test the relationship between juvenile justice involvement (JI) and use of health care services. Despite a few notable limitations described in the article, they make a strong case that Medicaid-enrolled youth who have been arrested at least once have less frequent use of primary care, more frequent use of the emergency department, and lower Medicaid coverage continuity. These health care disparities experienced by justice-involved youth (JIY) are concerning and deserving of attention, but they must be considered within the context of a system that draws such a high number of teenagers (particularly poor, urban, and minority teenagers) into contact with the justice system. Simply put, the best way to address health care disparities for JIY is keep youth from becoming justice involved through proactive interventions.

WHO ARE JIY?

Most youth who are arrested are not convicted of any crime. Seven out of 10 youth arrests result in a referral to the court system, and of those referred to the courts, only 30% result in an adjudication of delinquency (equivalent to a guilty verdict in the adult system).[1] This means that, rather than just representing "delinquents" or "criminals," the term JIY captures a broad spectrum of teenagers, ranging from those arrested and sent home with a warning for "reasonable suspicion" of delinquency (eg, being out after curfew, loitering "suspiciously") to those convicted of serious violent offenses.[1] Importantly, the probability of becoming a JIY is driven not just by youth's activities but by a diverse set of behaviors, exposures, policies, and biases that have led to the overrepresentation of specific populations.[3] Youth of color experience higher rates of arrest, detention, and out-of-home placement than their white counterparts, with the greatest racial disparities in lower-severity offenses.[3] These observed disparities are not consistently aligned with differences in self-reported frequencies of delinquent behavior. For example, white youth are more likely than African American youth to report using or selling drugs, but African American youth are more than twice as likely to be arrested and detained for drug offenses.[4] Differential JI for youth of color has been explained by social and cultural factors, including earlier age at first police contact, parental history of arrest, disproportionate school disciplinary actions, and delinquent peer networks.[5] Given this complexity, it can be reasonably argued that JI is a proxy for a plethora of social and demographic determinants of health, as much as it is a unique exposure to be targeted by health care policy.

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HOW DOES JI INFLUENCE HEALTH CARE USE?

On the basis of their findings, the authors argue that health care use and quality for JIY could be improved through targeted interventions such as enhanced school-based health services and increased use of collaborative care models that address emotional health and substance use in the primary care setting. They also specifically explore 1 potential mechanism through which JI could influence patterns of use, namely, discontinuity of Medicaid coverage, finding that JIY experience more and longer breaks in Medicaid coverage. Interestingly, those breaks were not associated with lower preventive service use or higher emergency department use in JIY, but this does not mean that the disparate coverage breaks are inconsequential. Additional research is needed on whether the effects of coverage breaks differ at different levels of JI (eg, arrested and released versus detained), on how state policies on Medicaid continuity for JIY affect coverage breaks, and on the coordination-of-care transitions between juvenile facilities and community pediatricians. Along with considering the influence of Medicaid breaks, other research on usage disparities could be done to explore the underlying differences in health status, primary care provider availability in high crime communities, provider biases in caring for youth at risk for JI, and differential family cohesion and support.

A HEALTH EQUITY LENS FOR JIY

Ultimately, addressing health care disparities after children have been scarred and labeled in this system is too little, too late. Closing the gap will require upstream approaches that keep youth from becoming engaged in the justice system, and midstream approaches that reduce the risk of further JI after initial contacts with the system. Truly addressing this health care disparity requires a health equity approach that recognizes that doing the best thing for all groups is not necessarily doing the same thing for all groups. Research is needed on the effectiveness of risk-informed anticipatory guidance and parent training programs in the primary care setting, community-engaged policing strategies that explicitly address bias, and multisectorial initiatives on neighborhood safety and revitalization. Such research will require expanded data sharing among the health care system, the justice system, the education system, and others. It will also require expanded collaborations between health services researchers and social scientists to balance the rights of children and achieve the goal of improved health for the population.

ABBREVIATIONS

JIY: justice-involved youth
JI: justice involvement

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