SERVICE PROVIDERS' PERSPECTIVES ON ORGANIZATIONAL AND POLICY LEVEL FACTORS IMPACTING THE SEXUAL HEALTH OF JUVENILE OFFENDERS: A GROUNDED THEORY STUDY

by

CHIOMA NNEAMAKA KAS-OSOKA

(Under the Direction of Nathan Hansen)

ABSTRACT

Juvenile offenders bear a disproportionate burden of sexually transmitted infections (STIs) such that rates are 8 to 10 times higher than their non-offending peers. A number of factors impact the sexual health of juvenile offenders at the individual, interpersonal, organizational, and policy level. However, minimal research has addressed the organizational and policy level factors impacting the sexual health of juvenile offenders. The purpose of this study was to explore the policies and procedures that impact the sexual health infrastructure for juvenile offenders. The three specific aims of the study were to (a) identify how sexual health needs are determined; (b) identify the current sexual health programs and services provided; and (c) identify the barriers and facilitators impacting the sexual health infrastructure for juvenile offenders.

This qualitative study used semistructured interviews ($N = 6$) to collect data from service providers who work directly with juvenile offenders in varying professional roles. Grounded theory methodology was used to analyze interview data and develop an emergent theoretical framework resulting from the individual, interpersonal, community, organizational, and policy

level barriers and facilitators mentioned by service providers. Service providers reported conducting assessments, exploring trends in data, and conversing with juvenile offenders to assess their sexual health needs. However, service providers mentioned their lack of knowledge and training as significant barriers impacting juvenile offenders' access to and use of sexual health services. Nine policy recommendations resulted in response to the barriers mentioned by service providers and were presented according to their level of implementation within a socio-ecological framework.

At the individual level, consent education and probation officer inclusion along with educating parents/guardians at the interpersonal level were recognized as policy recommendations. Community collaboration is a community level policy recommendation. At the organizational level, providing a sexual health education exit program for juvenile offenders and sexual health training for service providers were identified as policy recommendations. Policy level recommendations included mandating evidence-based sexual health education and providing sexual health education as part of probation requirements. Future research should incorporate quantitative methodology into understanding how the sexual health of juvenile offenders can be addressed from an organizational and policy perspective.

INDEX WORDS: Juvenile Offender, Sexual Health, Policy, Qualitative Research, Grounded Theory, Socio-Ecological Model

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DEDICATION

First and foremost, this dissertation is dedicated to the Lord. Without you, none of this would be possible. To all the young people, educators, scholars, and service providers I have met along the way, this dissertation is dedicated to you. You have helped shape me into the scholar I am today. To my family and friends who have guided and supported me during my educational pursuits, your belief in my abilities, words of encouragement, and prayers kept me going on this trying journey. I am truly grateful.

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Psalm 23:1-6

The Lord is my shepherd; I shall not want.

He maketh me to lie down in the green pastures: he leadeth me beside still waters.

He restoreth my soul: he leadeth me on the path of righteousness for his name sake.

Yea, though I walk through the valley of the shadow of death I will fear no evil: for thou art with me; thy rod and thy staff they comfort me.

Thou preparest a table before me in the presence of thine enemies: thou anointest my head with oil; my cup runneth over.

Surely goodness and mercy shall follow me all the days of my life: and I shall dwell in the house of the Lord, forever.

Amen.

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CHAPTER 1

INTRODUCTION

Background

Approximately one million adolescents aged 10-17 years are arrested in the United States (Puzzanchera, Sladky, & Kang, 2017). Of the adolescents arrested, the majority are 16 or 17 years of age (44%) and classified as part of a minority population (57%; Puzzanchera & Kang, 2017). After arrest, adolescents wait until their court hearing to determine what happens next. During that waiting period, the police department determines, depending on the offense and prior convictions, whether the wait will be under the supervision of a guardian or in a detention facility.

When a judge rules on the case at a hearing, the cases are classified as disposition cases. Over the years, the number of disposition cases has declined significantly, mainly as a result of lower arrest rates and policy changes addressing state and local approaches to nonviolent offenders (Annie E. Casey Foundation, 2013). In 2014, 974,000 cases were handled by the juvenile courts, a decline of 27% since 2008 (Puzzanchera & Kang, 2017). If an adolescent is found guilty of an offense, the case can be handled in a few ways: the adolescent can be placed on house arrest, detained or referred to a treatment facility (Barnert, Perry, & Morris, 2016). Adjudicated adolescents are defined as those who the court has deemed guilty of committing an offense. Here, the terms adjudicated adolescents and juvenile offenders will be used interchangeably.

Disposition cases resulting in detainment or incarceration have also declined. Of the disposition cases in 2014, approximately 80% of adolescents were not detained (Puzzanchera & Kang, 2017). Although disposition cases resulting in detention or incarceration have declined other the years, 48,043 youth were placed into residential treatment by the juvenile courts in 2015 (Office of Juvenile Justice and Delinquency Prevention, 2015). Residential placement refers to detention facilities and treatment programs that are under the jurisdiction of the Department of Juvenile Justice (DJJ). Majority of adolescent placement (98%) resulted in commitment to DJJ (Sickmund, Sladky, Kang, & Puzzanchera, 2017). This means DJJ is authorized to provide food, shelter, rehabilitation, treatment and education to juvenile offenders (Georgia Department of Juvenile Justice, 2017b). Facilities that house offenders are classified as detention centers, treatment programs and correctional facilities. These terms will be used interchangeably.

In Georgia, an adolescent cannot be found guilty of a crime unless they are thirteen years of age or older at the time they committed the criminal act (Georgia Department of Juvenile Justice, 2017b). Currently, approximately 10,000 youth aged 13-17 are detained in detention centers across the state of Georgia (Niles, 2017). Eight-two percent of detained adolescents are minorities, with black males being detained at higher rates than any other race, regardless of offense (Office of Juvenile Justice and Delinquency Prevention, 2015). For every 100,000 nonHispanic Black males, 153 are detained compared to 50 Hispanic and 25 White male adolescents (Georgia Department of Juvenile Justice, 2017b).

Statement of the Problem

Detained adolescents must rely on the Department of Juvenile Justice to provide their medical, mental, dental and other health care needs. Correctional health care is provided through

local health departments and partnering agencies (Acoca, Stephens, & Van Vleet, 2014). National standards exist outlining the essential policies and procedures for health care among incarcerated youth. According to the Standards for Health Services in Juvenile Detention and Confinement Facilities, all youth entering correctional facilities must have access to care; meaning that a juvenile in custody can be seen by a clinician and be given professional clinical consultation, and must receive requested care in a timely manner (National Commission on Correctional Health Care, 2015). Not all facilities are accredited by these standards, but some facilities adhere to these standards without accreditation. The Centers for Disease Control and Prevention recommend screening for STIs upon entry into the detention or treatment facility (Centers for Disease Control and Prevention, 2017a), however, less than 20% of facilities screen all youth for STIs (Gallagher & Dobrin, 2007). Despite guidelines, sexual and reproductive health services vary widely by facility (Barnert et al., 2016).

The sexual health of adolescents is negatively affected by incarceration. Incarceration disrupts stable relationships and increases vulnerability to concurrent partnerships and multiple new sexual partnerships (Khan et al., 2008). Conversely, incarceration could positively impact the sexual health of adolescents. For instance, detention facilities may provide the initial point with which adolescents gain access to health care services (Barnert et al., 2016). Limited access to health resources in the community where juvenile offenders reside contributes to their lack of exposure to sexual health information and reproductive health (Barnert et al., 2016). This is of importance when researchers examine the factors that may contribute to sexually transmitted infections, including HIV among incarcerated youth.

Juvenile offenders are a sub-group of adolescents that experience a disproportionate burden of sexually transmitted infections (STIs). Adolescent offenders experience rates of STIs 8

to 10 times higher than their nonoffending peers (Centers for Disease Control and Prevention, 2013). Juvenile offenders also engage in risky sexual behaviors more frequently than their nonoffending peers. Adjudicated adolescents are younger at first intercourse, engage in more anal sex, and have more sexual partners compared to their nonoffending peers (Broaddus & Bryan, 2008). Additionally, rates of substance use are higher among adolescents involved in the juvenile justice system (Mouttapa, Watson, McCuller, Reiber, & Tsai, 2009; Rowe, Wet, Greenbaum, & Liddle, 2008; Marina Tolou-Shams et al., 2017; Valera, Epperson, Daniels, Ramaswamy, & Freudenberg, 2009).

According to the Youth Risk Behavior Survey (YRBS) 2015 data, a nationally representative sample of high school adolescents in the United States, approximately 4% of high school students initiated sexual activity before 13 years of age (Centers for Disease Control and Prevention, 2015b). Samples of adjudicated adolescents indicate that sexual debut occurred at or before the age of 13 (Son, Miller, Tossone, Butcher, & Kuo, 2017). YRBS data also shows that 57% of sexually active high school youth used a condom during last intercourse (Centers for Disease Control and Prevention, 2015b). Recent studies indicate that rates of condom use are lower among adjudicated adolescents with estimates stating 28% (Son et al., 2017) to 31% (Donenberg, Emerson, Mackesy-Amiti, & Udell, 2015) of juveniles reporting using a condom at last sexual intercourse. Self-reported STI diagnoses is approximately 20% for detained juveniles (Son et al., 2017; Tsay, Childs, Cook-Heard, & Sturdevant, 2013).

As juvenile offenders are placed in short-term juvenile detention facilities, almost half of them are released back in the community within 48 hours (Centers for Disease Control and Prevention, 2017a). However, the majority of juvenile offenders awaiting adjudication, disposition or placement in other facilities (78%), remain in a facility for at least a week (Office

of Juvenile Justice and Delinquency Prevention, 2015). Because of the short stay in custody, adolescents diagnosed with a sexually transmitted infection (STI) may not (a) have been notified of their status prior to their release, (b) have not completed treatment prior to their release, or (c) have not received any treatment at all (Centers for Disease Control and Prevention, 2017a).

Previous studies have examined the sexual health of incarcerated youth from a behavioral perspective, with a strong focus on the individual level factors that impact the sexual health of this population (Malow, Dévieux, Jennings, Lucenko, & Kalichman, 2001; Mouttapa et al., 2010; Robertson, Thomas, St. Lawrence, & Pack, 2005; Steinberg, Grella, Boudov, Kerndt, & Kadrnka, 2011; Voisin, Neilands, Salazar, Crosby, & DiClemente, 2008). Juvenile offenders experience higher rates of substance use (Stephens, Holliday, & Jarboe, 2015), are younger at first sex, engage in more unprotected sexual activity and have multiple sexual partnerships at higher rates than their nonoffending peers (Belenko et al., 2008). For instance, 70% of a sample of adjudicated youth reported sexual debut before age 13 and 6 or more lifetime partners (Son et al., 2017). A review of STI/HIV prevention interventions for justice system-involved youth demonstrated an emphasis on individual behaviors (Hong, Voisin, & Crosby, 2015). However, researchers suggest that although juvenile offenders are engaging in riskier sexual behaviors when compared to their nonoffending peers, interventions should also target interpersonal relationships, community factors, and public policies that impact the sexual health of juvenile offenders (Hong et al., 2015). My research will focus on the organizational and policy level factors that influence the sexual health of juvenile offenders, unlike traditional studies that solely focus on individual and behavioral level factors affecting adjudicated adolescents.

Theoretical Framework

The socio-ecological framework posits that there are multiple influences on behavior, including factors at the interpersonal, community and policy level and these levels of influence interact with one another (Bronfenbrenner, 1979). An integral component of ecological models is that policy changes are able to impact populations of people and establish a baseline for sustainable changes (Glanz, Rimer, & Viswanath, 2008). Researchers suggest that a combination of individual and environmental factors contribute to the high incidence of STIs experienced by juvenile justice system-involved youth (DiClemente, Salazar, & Crosby, 2007; Hong et al.). Examining individual behaviors is crucial; however, minimal research has examined the sexual health of adolescents involved in the juvenile justice system from an ecological perspective. This is important because positive health behaviors are maximized when environments and policies support healthier choices (Glanz et al., 2008). This study will use an adapted version of the Ecological Model of Health Behavior to focus on the policy and organizational factors that impact the sexual health of adjudicated adolescents. Figure 1.1 displays a visual representation of the theoretical model. This model will be addressed in greater detail in Chapter 2.

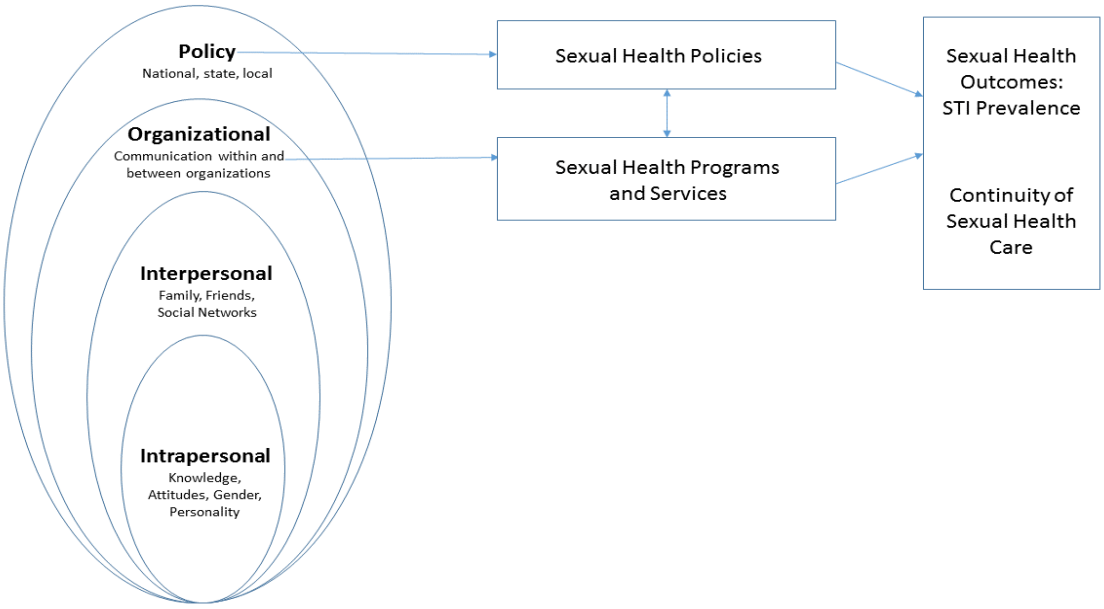

Figure 1.1. Theoretical framework examining organizational and policy factors impacting the sexual health of juvenile offenders. Adapted from "An Ecological Perspective on Health Promotion," by K. R. McLeroy, D. Bibeau, and K. Glanz, *Health Education Quarterly*, *15*, pp. 351-377. Copyright 1988 by SAGE Journals.

Purpose

The purpose of this qualitative grounded theory study is to explore the policies and procedures that impact the sexual health of juvenile offenders in Georgia. Data will be obtained through semistructured interviews with individuals who work directly with juvenile offenders. There are three specific aims for this study:

Aim 1: Identify how sexual health service needs are determined for adjudicated adolescents.

Aim 2: Identify the current sexual health services provided to adjudicated adolescents

Aim 3: Identify the systems or structures that impeded or support sexual health infrastructure for adjudicated youth.

Public Health Implications

Examining the sexual health of juvenile offenders from a service provider perspective can help determine the gaps in health care policies as compared to the actual services provided to juvenile offenders. Learning from provider experiences can offer insight into how juvenile justice system institutions navigate sexual health concerns and provide reproductive and sexual health services to adolescents involved in the juvenile justice system. To affect the decline in the occurrence of STIs and unplanned pregnancy in adolescents involved in the juvenile justice system, we must understand the role service providers play in working alongside youth and eliminating barriers to receipt of care for this population. Addressing the needs of incarcerated youth is imperative in reducing adverse sexual health outcomes.

CHAPTER 2

LITERATURE REVIEW

The goal of this chapter is to describe the juvenile offending population and summarize existing literature outlining the sexual health of juvenile offenders. This chapter describes the history of the juvenile courts, sexual development among adolescents, prevalence of STIs, demographics of detained youth, juvenile detention within Georgia, and the general factors impacting the sexual health of juvenile offenders. The factors impacting the sexual health of juvenile offenders are organized according to the socio-ecological model, within intrapersonal or individual factors, interpersonal, community and policy level factors explored.

History of the Juvenile Courts

The first juvenile court system was established in 1899 to support the identification, treatment, and cure of delinquency for adolescents. Delinquency is a term used to describe someone who has committed a crime (Sherman & Jacobs, 2011). In the 1970s, deinstitutionalization was promoted, and youth were diverted away from detention to community-based programs (Sherman & Jacobs, 2011). In the 1980s, there was a shift away from rehabilitation and more emphasis was placed on crime control, which involved preventative detention, transfer of juveniles to the adult criminal system, and the use of the death penalty (Sherman & Jacobs, 2011). Both approaches can currently be found throughout the juvenile justice system, as states vary in their viewpoints on the purpose of the juvenile justice system (Sherman & Jacobs, 2011). More recently, adolescent development has played a role in juvenile

justice policy formation, such that the social and physical development of adolescents is considered in determining punishment.

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) was established in 1974 to assist local, state and tribal entities in addressing the needs of juvenile offenders, and recognizing that adolescents are different from adults and should be treated as such (National Research Council, 2014). Developmental research indicates that adolescents do not have the same skills as adults when examining the costs and benefits of a situation and acting rationally (E. Scott & Steinberg, 2008). In particular, the prefrontal cortex, the area of the brain responsible for decision-making, is not completely developed until mid-20s (S. Scott & Walsh, 2014). This highlights the need for adolescent offenders receiving developmentally appropriate services and interventions (National Research Council, 2014).

Prior to the creation of the juvenile court system, adolescents under the age of 7 years were not prosecuted for any crimes, those between the ages of 7 and 14 years were considered innocent, and adolescents over the age of 14 years were treated as adults (McMillin, 2014). When the first juvenile court system was created it gave the court jurisdiction over adolescents under the age of 16 years who committed criminal offenses (McMillin, 2014; Sherman & Jacobs, 2011). Currently, the age at which child is under the juvenile court's jurisdiction varies by state; some states specify a minimum age ranging from 6-10 years, with maximum ages ranging from 16-18 years (Snyder & Sickmund, 2006).

Adolescents enter the juvenile justice system through referral by law enforcement, schools, victims, parents or social service agencies (Sherman & Jacobs, 2011). The decision to detain an adolescent involves notifying the parent and review of evidence by a law enforcement officer or prosecutor (Sherman & Jacobs, 2011). A delinquency case handled in juvenile court

involves a hearing and ultimately a disposition by the judge. Crimes committed by adolescents are classified as status and delinquency offenses. Delinquency offenses are those that are considered criminal for adults whereas status offenses are those that are considered illegal because the individual committing the offense is a minor (ex: truancy, alcohol possession and consumption, running away, etc.). The Juvenile Justice and Delinquency Prevention Act of 1974 prohibits the use of secure detention—facilities under the jurisdiction of the Department of Juvenile Justice—for juveniles who commit status offenses (Sherman & Jacobs, 2011). States are required to use alternative services outside of the juvenile justice system that include group homes and shelter facilities (Sherman & Jacobs, 2011). However, status offenders can find themselves in detention if they violate a court order, which most often occurs if they violate the terms of their probation (Sherman & Jacobs, 2011). Delinquency offenders account for 86% of offenders held in residential placement (Sickmund & Puzzanchera, 2014). Residential placement facilities include detention centers, shelters, group homes, boot camps and treatment programs.

According to the Juvenile Residential Facility Census (JRFC), detention centers accounted for 36% of residential placement facilities and held 44% of youth involved in the juvenile justice system (Hockenberry, Wachter, & Sladky, 2016). Juvenile detention centers provide secure custody for adolescents along with services to support the physical, educational, mental and social development of adolescents who are involved with the juvenile justice system (Clark, 2014). There are two primary goals for placing youth in detention. The first goal is to prevent harm to the youth and the community, while stopping the adolescent from committing further offenses (Clark, 2014). The second goal is to provide services and quality care to adolescents who come in contact with the juvenile justice system (Clark, 2014). Juvenile

detention ranges from community-based supervision with minimal restriction to major restriction in the form of placement in a secure facility.

Demographics of Detained Youth

Males are involved in 3 out of 4 delinquency cases handled by the juvenile court each year (Sickmund & Puzzanchera, 2014) Adolescents aged 16-17 account for nearly 26% of the 10-17 age group, but they represent 50% of the youth arrested under the age of 18 (Sickmund & Puzzanchera, 2014). Majority of adolescents held in residential placement are 16-17 years of age (54%) and classified as Non-Hispanic Black (42%; Office of Juvenile Justice and Delinquency Prevention, 2015). Black youth are 27% more likely to be held in residential placement and 14% less likely to receive probation than their White counterparts (Knoll & Sickmund, 2010). Moreover, Black youth are 12% more likely than White youth to be formally processed and 9% more likely to be waived to adult court Minority youth account for 68% of youth in custody in the US and Black and Hispanic youth are more likely to live in poverty than their white counterparts (Sickmund & Puzzanchera, 2014).

Juvenile Detention in Georgia

In 2013, of the disposition cases for juveniles, approximately 80% of youth were not detained (Sickmund, Sladky, & Kang, 2015). Over the years, there has been a major shift in the number of incarcerated youth, with youth who come in contact with the juvenile justice system being deterred from incarceration to diversion programs (ex: treatment facilities, substance use programs, etc.). In Georgia, offenses warranting incarceration have shifted as a result of legislation passed by Governor Nathan Deal. House Bill 242 (HB 242) indicates that only the most serious and violent offenders will be held in custody; youth with misdemeanors and other

minor offenses will be directed towards community-based programs, which minimizes the number of youth incarcerated for status offenses (Georgia Public Policy Foundation, 2013). However, quite a number of youth are still incarcerated, with approximately 48,043 youth being held in residential placement facilities (Office of Juvenile Justice and Delinquency Prevention, 2015). As of 2016, roughly 9% of the adolescent population aged 10-17 years has been detained or committed to juvenile placement (Sickmund et al., 2017).

In Georgia, adjudicated adolescents can be placed into secure or nonsecure facilities. Nonsecure facilities are classified as group homes, probation services, diversion programs and substance use treatment programs, to name a few. Secure facilities are those under the jurisdiction of the Department of Juvenile Justice. Adolescents in custody are placed into Regional Youth Detention Centers (RYDCs) or Youth Detention Centers (YDCs) across the state. There are 11 districts across the state house 7 YDC and 19 RYDC campuses. RYDCs are classified as temporary and secure supervision for youth charged with offenses, awaiting trial, or adjudicated delinquent and awaiting placement (Niles, 2017). YDCs provide secure supervision, care, and treatment services to youth in the custody of the Department of Juvenile Justice for short and long-term programs (Niles, 2017). Most recent data indicates that of the 1,150,122 youth residing in Georgia (Puzzanchera et al., 2017), 34,946 youth were serviced by the Department of Juvenile Justice in the form of probation, residential placement or at home awaiting adjudication (Georgia Department of Juvenile Justice, 2013). YDCs follow departmental policies outlined by federal and state laws and some professional guidelines, whereas medical, behavioral, nutritional and general educational programming policies for RYDCs are established by regional administrators and RYDC directors (Niles, 2017).

Sexual Development among Adolescents

The World Health Organization (WHO) defines adolescence as a stage of growth and development after childhood, but before adulthood that occurs from ages 10-19 years (World Health Organization, 2015). Adolescence is a time when boys and girls transition to young men and women. Biologically, adolescents go through developmental processes that involve changes in hormone levels and physiological responses. Physical changes in the form of puberty are the main component of sexual development (S. Scott & Walsh, 2014). Puberty, primarily occurring during early adolescence, is defined as the point in which the hypothalamus begins secreting gondotropin-releasing hormone (GnRH) to the pituitary gland and the pituitary gland begins secreting leutenizing hormone (LH) and follicle-stimulating hormone (FSH; Dahl & Forbes, 2010). These hormones are responsible for stimulating cells in the reproductive organs to produce testosterone in males and estrogen and progesterone in females (Dahl & Forbes, 2010). These changes physically manifest differently for boys and girls.

For females during adolescence, breasts begin to develop, hair in the pubic region and underarms form, menstruation occurs, growth spurts happen and fat is stored in the hip and breast area (S. Scott & Walsh, 2014). For males, hair begins to appear on their pubic region, their voices deepen, growth spurts occur, their testicles enlarge and ejaculation begins during adolescence (Dorn, Dahl, Woodward, & Biro, 2006). These physiological changes during puberty prepare the adolescent for reproduction. Physiological responses occur during puberty and various emotional and social changes occur among adolescents. Sexual development happens not only within the individual, but as a result of the interaction between the individual and their environment.

Adolescence is a time of experimentation as well as a point at which sexual behaviors are established (Borawski, Ievers-Landis, Lovegreen, & Trapl, 2003). During this crucial developmental stage, adolescents are navigating the realm of relationships, developing their own identity, and establishing connections with others. As adolescent bodies begin to mature, sexual desires increase; most adolescents begin experimenting with sexual behavior and start to develop a level of comfort with their sexuality (Florsheim, 2013).

According to a report defining sexual health presented by WHO, when considering healthy adolescent sexual development, three main issues emerge: cognitive development as it relates to decision making, gender identity and the socioeconomic environment surrounding physical development (2002). Cognitive development deals with the ability to think, make decisions, and weigh the consequences of those decisions, which is influenced by the context with which those decisions are made (World Health Organization, 2002). Gender identity is formed through cultural contexts and emphasizes what it means to be a man or woman. During this time, gender roles may not completely be formed; however, they are being constructed and reinforced by parental and peer influence (World Health Organization, 2002). Lastly, socioeconomic and cultural factors also influence adolescent sexual development. Cultures assign different meanings to the onset of puberty (World Health Organization, 2002). For boys this may mean freedom and more opportunities, whereas for girls it may mean restriction of freedom and onset of marriage and childbearing (World Health Organization, 2002).

Environmental factors as well as individual behavior contribute to the high incidence of STIs experienced by adolescents (Rotheram-Borus, 2000). One of the core contributing factors is adolescent engagement in risky sexual behaviors. Examples of risky sexual behaviors include, but are not limited, to unprotected sexual intercourse, multiple sexual partners and drug and

alcohol consumption prior to sexual activity (Centers for Disease Control and Prevention, 2010). During this stage of physical and cognitive development, engagement in risky sexual behaviors is exemplified, increasing the risk of contracting sexual infections, including HIV and unplanned pregnancy (Centers for Disease Control and Prevention, 2013).

Prevalence of STIs, HIV and Unplanned Pregnancy among Adolescents

Adolescents are disproportionately affected by sexually transmitted infections (STIs; Centers for Disease Control and Prevention, 2010). The Centers for Disease Control and Prevention (CDC) state that even though adolescents represent about one-fourth of the sexually active population, they account for nearly 50% of the 20 million new STI cases occurring annually (Centers for Disease Control and Prevention, 2013). Moreover, most reported cases of Gonorrhea (30%) and Chlamydia (25%) occur among individuals aged 15 to 19 (Centers for Disease Control and Prevention, 2013).

Contracting any type of STI increases one's vulnerability to contracting HIV, the virus that causes AIDS. Although HIV rates have remained relatively stable in older adults, from 2007-2010, HIV incidence among adolescents 15-19 continued to grow (Centers for Disease Control and Prevention, 2012). Approximately one fourth of the 50,000 people infected with HIV each year in the United States are between the ages of 13 and 24 (Centers for Disease Control and Prevention, 2012). Untreated STIs can lead to pelvic inflammatory disease, chronic pelvic pain, and even infertility (Centers for Disease Control and Prevention, 2015a).

Georgia ranks 6th and 7th in chlamydial and gonorrheal infections among the 50 states, respectively, with adolescents aged 15-19 years being the second highest group of individuals acquiring these infections (Centers for Disease Control and Prevention, 2015a). Approximately 1.2 million people were diagnosed with HIV in 2015 and 40% of those individuals resided in the

South (Centers for Disease Control and Prevention, 2016). Of the newly diagnosed HIV cases in Georgia in 2015, only a small percentage (5.6%) fell within 13-19 year age group (Georgia Department of Public Health, 2017). However, sexual risk-taking behaviors are established during adolescence and these behaviors place youth at risk for negative health consequences as they transition into adulthood.

The health consequences resulting from unsafe sexual behavior extend beyond STIs. Teen pregnancy rates have declined over the years, but the United States continue to have one of the largest teen pregnancy rates among industrialized nations (Sedgh, Finer, Bankole, Eilers, & Singh, 2015) with approximately 273,105 babies being born to young women aged 15 to 19 (Martin, Hamilton, Osterman, Curtin, & Matthews, 2015). Of the pregnancies that occurred for young women 15-19 years of age, 75% of them were classified as unintended (Finer & Zolna, 2016). There are a number of economic and social consequences that result from teenage pregnancy. Children born to teenage mothers are more likely to have lower school achievement, exhibit more health problems and be incarcerated as adolescents (Hoffman & Maynard, 2008).

Georgia is making significant strides in reducing teen pregnancy rates. From 2011-2013, birth rates for young women 15-19 in Georgia declined by 20% (Kost, Maddow-Zimet, & Arpaia, 2017). Even though progress is underway, pregnancy rates for adolescents aged 15-19 years in Georgia (47/1,000) remains slightly higher than the national average (43.4/1,000) and majority of these pregnancies are classified as unintended (Kost et al., 2017).

Sexual Health of Juvenile Offenders

Juvenile offenders are at an elevated risk of contracting and transmitting sexual infections (Castrucci & Martin, 2002; Kingree & Betz, 2003). Incarceration disrupts stable relationships increasing their vulnerability to concurrent partnerships and multiple partners (Khan et al.,

2008). Compared to their nonoffending peers, juvenile offenders are younger at first intercourse, report engaging in more anal sex, indicate lower rates of condom use and multiple partners (Broaddus & Bryan, 2008). High rates of STIs have been observed among adolescents involved in the juvenile justice system, with estimates suggesting rates 8 to 10 times higher than youth without a history of detention (Centers for Disease Control and Prevention, 2013). Among adolescents entering detention facilities, the rate of a positive chlamydia diagnoses is 6.6% and 14.8% for males and females, respectively (Centers for Disease Control and Prevention, 2009c). A study examining the medical records of 1,181 juvenile offenders determined that 29.2% of females and 11.1% of males had been diagnosed with any STI (Chlamydia, Gonorrhea, and Trichomoniasis; Aalsma et al., 2011). Additionally, results indicated that Black youth were twice as likely (18.2%) to be diagnosed with an STI compared to their White counterparts (9.2%; Aalsma et al., 2011). Unprotected sex, injection drug use, prostitution and substance use by incarcerated youth increases their risk for HIV infection (Sherman & Jacobs, 2011).

Theoretical Framework

One of the first theorists to describe human behavior and the importance of the environment was Bronfenbrenner (1979). He stated that what matters within the context of behavior is the perceived environment, which is examined in terms of systems. The Ecological Systems Theory, as described by Bronfenbrenner (1979) posits that behavior evolves as a function of the interconnectedness between the individual and the environment. There are four levels of the Ecological Systems Theory: microsystem, mesosystem, macrosystem and exosystem. The microsystem encompasses the roles and interpersonal relationships experienced by the individual within a particular setting (Bronfenbrenner, 1979). The mesosystem is defined as the interconnectedness between two or more settings in which the individual is an active

participant (Bronfenbrenner, 1979). The exosystem refers to settings in which the individual is not the active participant but the events impact what happens in the setting of the individual (Bronfenbrenner, 1979). Lastly, the macrosystem examines the culture or belief systems that may impact individual behavior at the meso-, micro-, and exosystems. Public policy is part of the macrosystem that determines what influences behavior and development at exosystem and microsystem levels (Bronfenbrenner, 1979).

This study will use an adaptation of the Ecological Model of Health Behavior as described by McLeroy and colleagues (1988) to examine the factors that impact the sexual health of adjudicated adolescents. The theoretical framework, similar to the Ecological Systems Theory, posits that one's behavior is influenced by internal and external factors and to understand behavior, one must consider the attributes of the individual as well as environmental influences (Glanz et al., 2008). This theory also emphasizes that the environment is as important as personal attributes in helping individuals make healthy choices and sustaining behavior change (Voisin et al., 2008). The Ecological Model of Health Behavior examines behavior using dimensions at the intrapersonal (attitudes and self-efficacy), interpersonal (social networks and peer relationships), community (organizations and institutions) and public policy (local, state and national laws; McLeroy et al., 1988). All levels of the model are included in this study with specific emphasis placed on the community and policy level factors that impact the sexual health of adjudicated adolescents. The sexual health outcomes examined in the theoretical framework focus on the services and policies that impact the STI prevalence and services accessed by juvenile offenders. Figure 2.1 displays a modified version of the Ecological Model of Health Behavior.

Examining sexual health from an ecological perspective allows researchers to develop programs and policies that take into consideration cross-cutting levels of influence and how they

may impact the sexual health of juvenile offenders. Effective health promotion programs must examine how the organizational and policy levels of the socio-ecological model play a role in the sexual health of adolescent offenders.

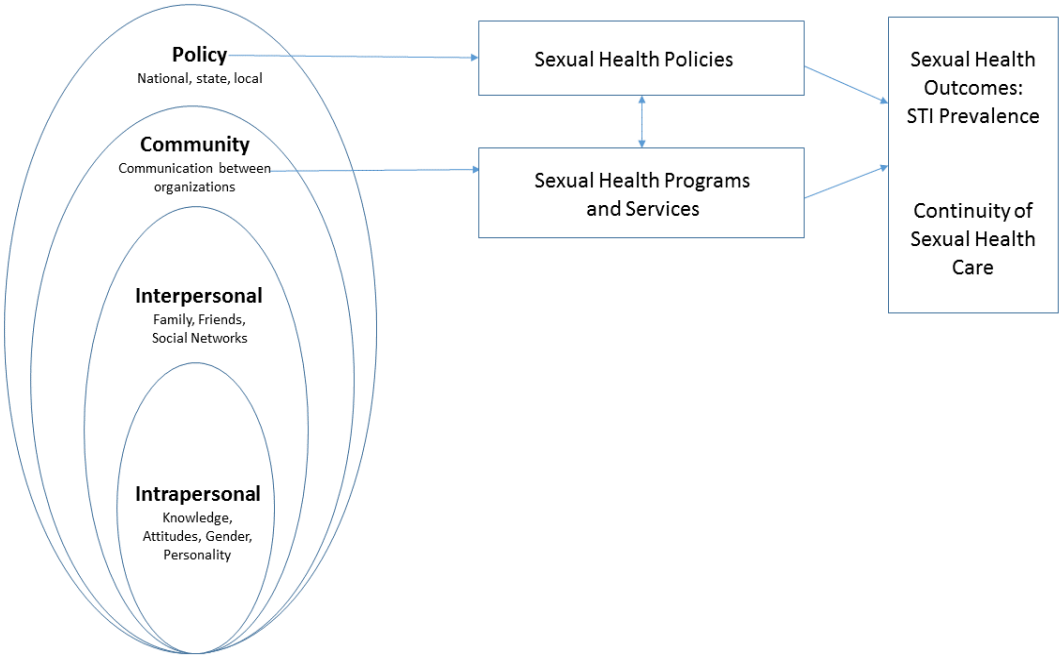

Figure 2.1. Theoretical framework examining organizational and policy factors impacting the sexual health of juvenile offenders. Adapted from "An Ecological Perspective on Health Promotion," by K. R. McLeroy, D. Bibeau, and K. Glanz, *Health Education Quarterly, 15*, pp. 351-377. Copyright 1988 by SAGE Journals.

Intrapersonal Factors

Intrapersonal factors prioritize biological and personal factors that may impact the sexual health of juvenile offenders (McLeroy et al., 1988). McLeroy and colleagues (1988) describe intrapersonal factors as knowledge, attitudes, gender and ethnicity, all of which are individual traits or behaviors that influence the sexual health of adjudicated adolescents. Research and subsequent interventions have focused on individual factors contributing to sexual health, however, the ecological model emphasizes that all levels of the model are interconnected (Glanz

et al., 2008). This section will examine the intrapersonal factors that impact the sexual health of juvenile offenders.

Gender. Gender is a critical variable among adjudicated adolescents, primarily as it relates to STI diagnoses and sexual risk behaviors. Individual behaviors as well as prevalence of disease is experienced differently for young males and females. Females were less likely to use condoms at last sexual encounter and males were younger than females at the time they received oral sex (Robillard, Conerly, Braithwaite, Stephens, & Woodring, 2005). Moreover, females were more likely to engage in unprotected vaginal sex than their male counterparts (Malow, Dévieux, Rosenberg, Samuels, & Jean-Gilles, 2006). Unprotected sexual activity for females may be confounded by other factors related to power dynamics. The ability for women to use condoms during sexual activity can be impacted by male dominance in sexual situations (Briere & Elliott, 2003).

Research with juvenile offenders indicated that more females than males were diagnosed with an STI (Biswas & Vaughn, 2011; Bryan, Aiken, & West, 2004; Dembo, Belenko, Childs, Greenbaum, & Wareham, 2010; Robertson et al., 2005). Higher STI diagnoses among females may be a result of more frequent interaction with the health care system through pregnancy or prenatal care (Centers for Disease Control and Prevention, 2009b). Research also indicates that males involved in the juvenile justice system had more lifetime partners than their female counterparts (Robillard et al., 2005). Lichtenstein (2000) found that African American men had a higher HIV/STI risk because they were having unprotected sex with high-risk partners more often than females and their Caucasian male counterparts. Although we see some gender differences in the risk-taking behaviors of juvenile offenders, both sexes are engaging in behaviors that put them at risk for contracting and transmitting sexual infections.

Ethnic identity. Ethnic identity is another nonmodifiable intrapersonal factor addressed among the general adolescent population and juvenile offenders. Ethnic identity is an important concept, especially among the adolescent population, as this is the time of identity formation and development (Beadnell et al., 2003). Ethnic identity is defined as having a set of customs, values and traditions experienced by a group of people. Research has demonstrated a relationship between ethnic identity and sexual risk, such that individuals with stronger ethnic identity are more likely to engage in less risky sexual behaviors (Beadnell et al., 2003; Belgrave, Van Oss Marin, & Chambers, 2000). A strong sense of ethnic identity can also protect against counterproductive thoughts and behaviors related to sexual risk (Belgrave et al., 2000). Research on ethnic identity and sexual risk has focused primarily on African Americans because this concept is believed to be stronger for this population compared to Whites (Phinney & Ong, 2007). Belgrave et al. (2000) found that among a sample of African American adolescent girls aged 10-13 years, a high sense of ethnic identity—defined by belongingness and affiliation—was associated with less risky sexual attitudes. Additionally, strong ethnic identity was associated with less risky peers and more perceived behavioral control, which was defined as an adolescents' ability to refuse unwanted sexual activity and efficacy using and negotiating condom use (Townsend et al., 2006).

For adjudicated adolescents, the relationship between ethnic identity and sexual risk differs from studies conducted by (Belgrave et al., 2000) and (Townsend et al., 2006). Voisin, Salazar, Crosby, and Diclemente (2013) examined the relationship between ethnic identity and gonorrhea and chlamydia infections among African American detained female adolescents. This study was unique in that it examined ethnic identity in relation to laboratory diagnoses of chlamydia and gonorrhea when the literature has consistently utilized self-reported data and

cross-sectional analyses to examine correlates of HIV risk. Results showed that girls who reported high levels of ethnic identity were 4.3 times more likely to have an STI diagnosis and girls with high sexual risk behaviors were 1.5 times more likely to test positive for gonorrhea and chlamydia (Voisin et al., 2013). Contrary to the study presented by Townsend and colleagues (2006), when examining ethnic identity among juvenile offenders Voisin et al. (2013) did not reveal ethnic identity as a protective factor against STI risk. These findings suggest that ethnic identity is complex and may not be as significant for certain youth, especially those who may be more likely to come in contact with the justice system (Voisin et al., 2013). The correlation between STI diagnoses and ethnic identity may be rooted in socio-economic status, neighborhood factors, and perceived discrimination. Further research is needed to accurately assess this variable in relation to the juvenile offending population and STI risk.

Attitudes, perceived behavioral control, and self-efficacy. Attitudes towards risky behaviors, perceived behavioral and self-efficacy can all impact the sexual health of juvenile offenders. Perceived behavioral control is defined as the belief in a one's ability to have control over a specified task and self-efficacy is defined as confidence in one's ability to perform a task (Azjen, 1991). All three variables are considered modifiable intrapersonal factors. This is different from the previously mentioned intrapersonal variables, which cannot be modified. The Theory of Planned Behavior (TPB; Azjen, 1991) provide a theoretical basis for understanding the importance of attitudes, perceived behavioral control and self-efficacy as they relate to sexual risk. TPB emphasizes that intention is the greatest predictor of behavior which in turn, is influenced by perceived attitudes, social norms and behavioral control (Azjen, 1991).

Intentions to use condoms and engage in safer sex behaviors among juvenile offenders has been examined in a few studies. For example, Bryan, Rocheleau, Robbins, and Hutchison

(2005) conducted a longitudinal study assessing the intentions of justice system-involved adolescents to engage in safer sex behaviors. At the six-month follow-up period, results showed there was a direct positive relationship between affective attitudes towards condoms and condom use behavior (Bryan et al., 2005). With male offenders, intentions to use condoms has also been positively correlated with attitudes and self-efficacy, such that as positive attitudes and confidence increase, intentions to use condoms also increase (Bryan et al., 2004). In this study, self-efficacy was defined as both the skill required to use condoms and the ability to negotiate condom use (Bryan et al., 2004). For females, Robertson, Stein, and Baird Thomas (2006) found that self-efficacy was positively correlated with vaginal condom use. Skills in the form of using condoms and negotiating its use are integral components associated with intention to use condoms.

Similarly, Kingree, Braithwaite, and Woodring (2000) found that among incarcerated adolescents in Georgia, those who had unfavorable attitudes about condoms reported greater intent to engage in unprotected sex. Broaddus and Bryan (2008) also reported that consistent condom users were more likely have favorable attitudes about condom use and a higher condom use self-efficacy compared to inconsistent condom users. TPB emphasize that the greatest predictor of behavior is intention (Azjen, 1991). Among the juvenile offending population, intentions to use condoms and engage in safer sex behaviors is influenced by attitudes, how much control an individual has over their behavior, and their level of confidence to engage in that behavior.

Based on the presented studies, attitudes, self-efficacy and perceived behavioral control are correlated with intentions to engage in safer sex behaviors, especially as it relates to condom use. Increasing condom use among adolescents will help decrease unplanned pregnancies and the

burden of STIs experienced by this age group. This is especially important among adolescent offenders as research indicates that rates of STIs are much greater among this sub-population than the general adolescent population.

Substance use. Adolescents involved in the juvenile justice system consume alcohol and drugs at higher rates than the general adolescent population. Detained youth report higher rates of marijuana use (Malow et al., 2001), alcohol (Malow et al., 2006), and methamphetamine use (Steinberg et al., 2011) compared to their nonoffending peers. The use of substances impairs judgement (Center for Behavioral Health Statistics and Quality, 2016), which limits an adolescent's ability to engage in safer sex choices, especially during highly emotional moments. Among justice system-involved adolescents, substance use and risky sexual behavior vary depending on the type of sexual partner (Rosengard et al., 2006; Valera et al., 2009). Substance use has been shown to be greater among juvenile offenders with casual partners compared to long-term sexual partners (Rosengard et al., 2006). This section will discuss the relationship between substance use and sexual risk among juvenile offenders.

Alcohol. Alcohol consumption interferes with normal adolescent brain development, minimizes impulse control and increases an adolescents' risk of developing Alcohol Use Disorders (AUD; National Institute on Alcohol Abuse and Alcoholism, 2006). According to the 2015 National Survey on Drug Use and Health (NSDUH), by age 15 about 33% of teens have had at least one drink and by age 18, the percentage is almost doubled (60%; Center for Behavioral Health Statistics and Quality, 2016). What makes this troublesome is that for young people aged 12-20 years, more than 90% of the alcohol they consume is through binge drinking—having more than 4 drinks for women and 5 drinks for men on one occasion within a few hours (Center for Behavioral Health Statistics and Quality, 2016).

Studies have examined adolescents involved in the juvenile justice system who are involved in drug court or treatment programs to determine how alcohol impacts their sexual risk. Among a sample of culturally diverse adolescents involved in juvenile detention or court-ordered treatment centers, Malow et al. (2006) found that severity of alcohol use was associated with greater risk of HIV infection as a result of an increase in risky sexual behaviors. High level alcohol users had a greater number of reported unprotected sex acts while under the influence of alcohol. Similarly, (M. Tolou-Shams et al., 2012) found that juvenile offenders who were classified as drinkers were more likely to be sexually active and had six times the odds of having vaginal or anal sex than nondrinkers. Although studies indicate a relationship with alcohol consumption and risky sex among this population, the results might be tainted because participants were already involved in juvenile drug court. This means that their offenses were related to substance use and could possibly mean that their rates of alcohol consumption might be higher than the general justice system-involved adolescent. Additionally, with a sample of all female offenders, results showed that those who frequently engaged in sex after drinking were less likely to engage in condom use (Rich, Robertson, & Wilson, 2014).

Alcohol impairs judgement and leads to increased risky sexual decision making for both males and females. For white female detainees who engaged in vaginal intercourse, alcohol was positively correlated with higher levels of depressive self-concept Lopez et al. (2010). Female detainees with higher levels of depressive self-concept were also more likely to believe alcohol will provide favorable sexual experiences (Lopez et al., 2010). Among a sample of black violent offenders, Richardson et al. (2010) found that alcohol increased the likelihood participants would not use condoms. This qualitative study was able to gather rich personal information from a small selection of black male adolescent offenders. The studies in this section contribute to the

discussion that alcohol consumption among juvenile offenders influences sexual risk-taking behaviors.

Marijuana. Marijuana is the most commonly used illicit drug in the United States and among justice system-involved adolescents (Johnston, O'Malley, Bachman, & Schulenberg, 2012). Adolescents involved in the juvenile justice system use marijuana at higher rates than the general adolescent population (Kingree & Betz, 2003; Valera et al., 2009). Marijuana use is linked to lower rates of condom use, STI diagnoses, and lack of condom use at last sex (Hendershot, Magnan, & Bryan, 2010). Studies have also shown that the link between marijuana and condom use is slightly moderated by whether or not the partner was short or long-term, where condom use was higher for short-term partnerships (Bryan, Schmiege, & Magnan, 2012). Moreover, higher marijuana use at baseline was associated with lower rates of condom use after the 2-year follow up period (Bryan et al., 2012). One study found that among a largely male sample of adolescent offenders, 46.1% of the reported using marijuana every time they had sex without a condom (Rosengard et al., 2006).

Age can influence marijuana use and subsequently impact sexual risk-taking behaviors. Kingree and Phan (2001) examined the relationship between marijuana use and STI risk among male and female adolescents in a short-term facility in Georgia. Results showed that marijuana use was associated with a higher occurrence of unprotected sex and STIs among younger adolescent offenders (Kingree & Phan, 2001). Different from the findings presented by Kingree and Phan (2001), Kingree and Betz (2003) found that, for older participants, as marijuana use increased, lack of condom also increased. Differences in the results of these two studies might be attributed to the gender of the samples. Kingree and Phan (2001) examined responses from both males and females whereas Kingree and Betz (2003) used only male participants. Risky sexual

behaviors might have been significant among younger adolescents in the sample because females were included. Females involved in the juvenile justice system experience higher rates of STIs compared to the general adolescent population (Voisin, DiClemente, Salazar, Crosby, & Yarber, 2006). This could quite possibly mean that they are engaging in riskier sexual behaviors at earlier ages than their male counterparts. Moreover, condom use is compounding and does not depend solely on the individual, especially for females. Power dynamics along with relationship factors can influence sexual decision making and it may take place at a much younger age for females than males.

Co-occurrence of substances. Even though marijuana and alcohol are commonly used at high rates among this population, the use of multiple substances is of great concern. A number of studies have combined the use of alcohol and marijuana with other highly addictive drugs. A longitudinal study examining adolescent offenders found that at the end of the twelve year period, 80% of females and 90% of males had developed a substance use disorder, which included AUD, any drug use disorder and marijuana use disorder (Welty et al., 2016). Castrucci and Martin (2002) examined the relationship between substance use and sexual risk behaviors of adolescents enrolled in any of the four training schools for delinquent youth in North Carolina. The substances assessed were marijuana, alcohol, cocaine and inhalants. Contrary to evidence provided in previous studies (Hendershot et al., 2010; Kingree & Betz, 2003; Kingree & Phan, 2001; Lopez et al., 2010; Richardson, Brown, Brakle, & Godette, 2010; M. Tolou-Shams et al., 2012), no one substance was found to be positively associated with risky sexual behaviors (Castrucci & Martin, 2002). However, regular use of two or more substances was positively associated with inconsistent condom use and multiple partners even after controlling for age, gender and race (Castrucci & Martin, 2002).

Evidence suggests a relationship between substance use, STI risk and delinquent behavior. After determining the DSM-IV criteria for substance use disorders (SUD), Rowe et al. (2008) classified participants into those with SUD and those without SUD. From the largely male (82%) and African American (58%) sample, results showed that delinquency and family conflict were predictors of SUD (Rowe et al., 2008). Continually, the number of days alcohol or drugs was used in the past 90 days predicted HIV/STI risk level (Rowe et al., 2008). Delinquency was the only predictor of both SUD and HIV risk related behaviors (Rowe et al., 2008). With a sample of drug court offenders, limitations must be noted. Similar to (M. Tolou-Shams et al., 2012) the increased incidence of substance use might be higher among the drug court population. We could quite possibly be seeing significant effects because these adolescents were involved in the juvenile justice system as a result of their substance using behavior.

Substance use disorders along with mental disorders can play a role in sexual risk taking. Teplin et al. (2005) set out to determine HIV risk behaviors among individuals with major mental disorders (MMD) and substance use disorders (SUD). Results showed that significantly more adolescents with co-morbidity—more than one condition—engaged in sex and unprotected sex while drunk or high (Teplin et al., 2005). Those participants with SUD only engaged in more HIV risk behaviors than any of the other comparison groups: MMD only, SUD+MMD, and none of the disorders (Teplin et al., 2005).

One particular substance used by the general adolescent and juvenile offending populations are methamphetamines. Lifetime methamphetamine use among adolescents ranges from 5% to 10% (Zapata, Hillis, Marchbanks, Curtis, & Lowry, 2008). Steinberg et al. (2011) discussed the associations between methamphetamine use and risky sexual behaviors among females incarcerated in three detention facilities in California. Only participants who were

diagnosed with an STI while incarcerated were included in the study. Methamphetamine users also used alcohol (36%) and marijuana (49%) at rates much higher than their nonmethamphetamine using peers (Steinberg et al., 2011). Rates of alcohol and marijuana use for nonmethamphetamine users were 34.1% and 18%, respectively (Steinberg et al., 2011). Methamphetamine users were less likely than nonmethamphetamine users to use condoms at last sex or consistently (Steinberg et al., 2011). This cross-sectional study is limited to information collected solely from incarcerated adolescent females diagnosed with an STI. Information from noninfected adolescents would be imperative in drawing conclusions about whether the relationship between methamphetamine use and risky sex is similar among those without an STI.

Two main substances used in conjunction with one another are marijuana and alcohol. Valera et al. (2009) examined the relationship between substance use and HIV risk among a sample of male adolescents involved in the criminal justice system. Results showed that both marijuana and alcohol use were significantly positively associated with multiple partners and unprotected sex with both short and long-term partners (Valera et al., 2009). Contrary to results presented in a previous study (Kingree & Phan, 2001), marijuana alone was not associated with unprotected sex with short or long-term sexual partners (Valera et al., 2009). One of the main differences between Valera et al. (2009) and Kingree and Phan (2001) deals with how marijuana use was measured. Previous studies identified marijuana use as both a short and long-term occurrence (Bryan et al., 2012; Kingree et al., 2000). Because levels of marijuana use were not specified in Kingree and Phan (2001), this might have been the reason why we did not see a positive correlation between marijuana use and unprotected sex. Additionally, Dembo et al. (2010) found that among male and female adolescents arrested in Florida, high risk youth had higher STD diagnoses and marijuana and cocaine use. High risk youth were classified as those

engaging in behaviors that make them vulnerable to contracting and transmitting sexual infections. The use of substances, including alcohol, marijuana and other drugs, limits judgement and increases risk for contracting and transmitting sexual infections among this population.

Personality traits. Personality traits have also been linked to STI risk among juvenile offenders. For example, Malow et al. (2007) examined the relationship between antisocial personality disorder characteristics and HIV risk behaviors among adolescent offenders who were court-mandated into treatment or detention and found that individuals with antisocial personality characteristics were more likely to use alcohol, marijuana and cocaine, have unprotected sex while using alcohol or marijuana, have less favorable condom attitudes and less favorable intentions to engage in safer sex behaviors. With this study, it is important to note that participants were not diagnosed with antisocial personality disorder, but rather asked to relate to certain characteristics of the disorder.

Sexual sensation seeking and impulsivity. Sexual sensation seeking (SSS) and impulsivity are two key personality traits that are linked to sexual decision making. SSS is defined as a fondness for optimal sexual stimulating and arousing experiences (Kalichman, Weinhardt, DiFonzo, Austin, & Luke, 2002). Voisin, King, Schneider, Diclemente, and Tan (2012) aimed to examine whether SSS was related to drug use and risky sex among a sample of detained youth in Georgia. Results showed that SSS was related to alcohol and ecstasy use (Voisin et al., 2012). Continually, SSS was related to more partners, having unprotected vaginal and oral sex, having sex while you and your partner are high and exchanging sex for drugs and money (Voisin et al., 2012).

Impulsivity and SSS are linked to one another, such that impulsive decision-making is more influential when SSS is high (Charnigo et al., 2013). Impulsivity is defined as engaging in

behavior without adequate forethought or planning (Donohew et al., 2000). Dévieux et al. (2002) found that among alcohol and other drug abusing offenders, those with higher levels of impulsivity reported higher levels of substance use and unprotected sexual behavior while under the influence of drugs or alcohol. Participants with higher levels of impulsivity reported less favorable sexual attitudes (Dévieux et al., 2002). Impulsivity has also been linked substance use and risky sexual behaviors. Found that those with high impulsivity were less likely to use condoms during sex and perceive these risk behaviors in a negative manner (Robbins & Bryan, 2004). This literature suggests that impulsivity and sensation seeking are strong predictors of sexual behaviors among adolescents. Understanding these variables and how they impact the thought process of adolescent offenders during sexual experiences is important to developing programs to address how and when to practice safer sex behaviors among this population.

Interpersonal Factors

According to the ecological model, interpersonal characteristics that influence behavior stem from relationships with others (McLeroy et al., 1988). Interpersonal relationships with friends and family members are integral components of establishing, maintaining and changing health behaviors (McLeroy et al., 1988). Interpersonal relationships draw on social support, which is established when people connect with one another (McLeroy et al., 1988). These connections are especially important when examining sexual risk behaviors. The relationships examined in this literature review focus on parental and peer influences on sexual risk-taking behaviors.

Parenting variables. Researchers have identified the importance of parental relationships in relation to STI risk behaviors among juvenile offenders. For example, Udell, Donenberg, and Emerson (2011) wanted to investigate the relationship between parenting

practices and HIV risk behavior among adolescents on probation. Parental permissiveness and monitoring along with parent-teen communication were negatively associated with sexual experience for girls (Udell et al., 2011). Parent-teen communication was not associated with condom use however, as parenting practices increased, alcohol and marijuana use before sex significantly decreased for boys (Udell et al., 2011). Among a sample of detained adolescents in Georgia, Crosby, Salazar, and DiClemente (2004) found that adolescents who had limited parental monitoring were more likely to be diagnosed with an STI. Perceived parental monitoring has also been negatively associated with gang membership and drug use (Voisin et al., 2008). Both gang membership and drug use impact the sexual risk-taking behaviors of adolescents involved in the juvenile justice system.

Robertson et al. (2005) found that when assessing predictors of chlamydia and gonorrhea diagnoses among incarcerated adolescents, more parental supervision was associated with a slightly lower STI rate. Moreover, participants living with both parents had the lowest rate of STIs (Robertson et al., 2005). The influence of parents on the sexual experiences of adolescents is important. Opening lines of communication between parent and adolescent can influence the sexual decision-making process of young offenders.

Gang norms. The social network theory has been used understand gang norms and risky sex among youth with a history of detention. This theory states that networks influence the behavior of members and encourage people to conform to group behaviors (Krohn, 1986). Gang norms were defined as having affiliation to a gang and engaging in certain practices like carrying a weapon and having sex with other gang members, to name a few (King, Voisin, & DiClemente, 2013). King et al. (2013) found that those with high risk gang norms were almost three times more likely to be high on drugs and alcohol and almost three times as likely to have a condom

malfunction compared to those with low risk gang norms. Gang norms were also correlated with having sex with a partner who is high and having sex with two or more people at the same time (King et al., 2013).

Peer influence. For juvenile offenders, relationships with peers influence engagement in safer sex behaviors. If adolescents believe that their friends are engaging in or not engaging in risky sexual behaviors, they may be more inclined to make those decisions as well (Voisin et al., 2006). Mosack, Gore-Felton, Chartier, and McGarvey (2007) found that for incarcerated girls, peer related factors were more important to risky sexual behaviors than family factors. For incarcerated males, family relationships and peer influences were associated with developing sexual relationships (Mosack et al., 2007). Among a sample of delinquents remanded to juvenile detention in Virginia, attitudes about safer sex were associated with being female (Chang, Bendel, Koopman, McGarvey, & Canterbury, 2003). Although not gender specific, Crosby et al. (2004) found that those who reported their peers did not use condoms, were twice as likely to report not using condoms. If peer influences can be positive and promote safer sex behaviors, this might promote behavior change among female adolescent offenders.

Community Factors

Historically, STI acquisition has focused primarily on individual behaviors (Adimora & Schoenbach, 2005), such as attitudes and self-efficacy; variables mentioned during the intrapersonal section of this chapter. However, as time has progressed, research has shifted towards understanding social and community factors, such as social networks, that play a role in the dynamics of STIs. Community level factors are described as relationships between organizations, institutions and networks (Glanz et al., 2008). The community level factors described in this section are sexual networks and witnessing community violence and trauma.

Sexual networks. Sexual networks impact the sexual health of adolescents. Sexual networks are defined as people who are directly or indirectly connected through sexual contact (Jolly, Muth, Wylie, & Potterat, 2001). Sexual networks involve examining the connections between people and how the quality of those connections impact STI acquisition (Doherty, Padian, Marlow, & Aral, 2005). Within a community, STI transmission occurs when groups people who engage in risky sexual behaviors form networks of people who are linked by sexual contact (Jolly et al., 2001). Sexual networks are determined by social norms and the places with which people are meeting partners (Doherty et al., 2005). Social norms are shaped by cultural factors and develop within networks to shape individual and partnership behaviors (Doherty et al., 2005). Individuals rely on social networks to gather information about sex primarily because this information is readily available and considered trustworthy (Youm & Laumann, 2002). Although research has not specifically addressed sexual networks within the context of juvenile offenders, it is important to understand how networks impact sexual risk. Contracting STIs extends beyond the behavioral choices of the individual, they also depend on the sexual behaviors of an individual's partner and social norms (Youm & Laumann, 2002).

Sexual networks are formed similar to social networks, whereby sex partners are recruited through activities and common acquaintances (Adimora & Schoenbach, 2005). Demographic variables, such as race, can play an important role in sexual networks and STI acquisition. Throughout the United States, African Americans experience higher rates of STIs than any other racial/ethnic group. A study conducted by Laumann and Youm (1999) found that there were differences in STI acquisition based on race. African Americans with low number of partners were more likely than their white counterparts to engage in sexual activity with other African Americans who had a greater number of partners (Laumann & Youm, 1999). As a result

of high-risk partner selection, African Americans experience a high incidence of STIs. Additionally, African-Americans are more likely than other racial groups to choose partners of the same race, which keeps their sexual networks more close-knit than other racial groups (Laumann & Youm, 1999). Researchers also found that among a sample of African American adolescents whose sex partners had sex partners outside of their local network, were more likely to encounter at least one sex partner in their network who had Gonorrhea and/or Chlamydia (Ellen et al., 2005). The likelihood than an adolescent within a high STI network will be exposed to an STI depends on the network connection between their sex partners and the community (Ellen et al., 2005).

Community violence and trauma. The National Survey of Children's Exposure to Violence (NatSCEV II), conducted by the Office of Juvenile Justice and Delinquency Prevention, is a nationally representative survey of the incidence and prevalence of children's exposure to violence (Finkelhor, Turner, Shattuk, Hamby, & Kracke, 2015). Researchers defined community violence as witnessing assaults and shootings. Results of the survey indicated that 30% of males and 24.9% of females have witnessed community violence across their lifetime (Finkelhor et al., 2015). Exposure to community violence among adolescents has been associated with high risk sexual behaviors, such as sex without condoms and multiple sex partners (Voisin, 2005; Voisin et al., 2007) and drug and alcohol use (Phillips et al., 2014; Voisin et al., 2007).

Witnessing community violence and trauma is also associated with sexual risk among juvenile offenders. One theory that explains the relationship between community violence and sexual risk is the Social Control Theory. One application of this theory suggests that social disorganization is a result of high rates of community violence, which limits the ability of social institutions within the community, such as schools and churches, to control youth (Farrington et

al., 1990). This results in adolescents deviating from societal norms and increased delinquency, which increases the chances of adolescents seeking guidance from deviant peers who may promote increased drug use and sexual risk behaviors (Petraitis, Flay, & Miller, 1995). Researchers examined a sample of detained adolescents from eight Regional Youth Detention Centers (RYDCs) in Georgia to determine the linkage between witnessing community violence and drug and sexual behaviors (Voisin et al., 2007). Approximately 76% of participants witnessed one or more acts of community violence 12 months prior to detainment. Results indicated that compared juvenile offenders who did not witness community violence, those who did were less likely to use condoms and more likely to be high on drugs or alcohol during sex (Voisin et al., 2007).

Community trauma has also been linked to sexual risk among juvenile offenders. Seth and colleagues (2017) defined community trauma as encompassing both emotional and physical acts of trauma such as robberies, gun violence and perceived muggings in the community. African American adolescents who had high exposure to community trauma were more likely than those who had low exposure to community trauma to have had unprotected sex in the past 30 days and have had sex with a partner in the past 90 days who had a previous history of detention (Seth et al., 2017). Community trauma and exposure to violence are correlated with

Policy Factors

Policy level factors within the Ecological Model of Health Promotion are local, state and national regulatory policies that have an effect on the health of populations (McLeroy et al., 1988). This section of public policy will examine the use of regulatory policies, laws and procedures to address the sexual health needs of juvenile offenders (McLeroy et al., 1988). For this review, we will examine policies set forth by the National Commission on Correctional Health Care (NCCHC)

addressing the sexual health of juvenile offenders. NCCHC provides position statements addressing the recommended requirements for the proper management of health care for juveniles under the care of the correctional system (National Commission on Correctional Health Care, 2015).

A number of policies and services impact the sexual health of juvenile offenders. Health care for detained adolescents is provided by the detention facility, which is under the jurisdiction of the Department of Juvenile Justice. Policies examining STI/HIV Testing, Immunizations, Contraceptives, and Sexual Health Education will be discussed in this section. Additionally, we will discuss the impact of the Medicaid Exclusion Policy on incarcerated youth. The NCCHC provides Standards for Health Services in Juvenile Detention and Confinement Facilities. These standards are provided to guide staff on administering health care to detained juveniles. NCCHC is committed to improving correctional health care services and helping detention facilities provide effective care for juvenile offenders (National Commission on Correctional Health Care, 2015). According to NCCHC, a *policy* is a facility's official position on a particular issue and a *procedure* explains how a particular policy should be carried out (National Commission on Correctional Health Care, 2015). Georgia juvenile detention facilities use these standards to establish health care policies for youth detained in secure facilities across the state.

STI/HIV testing policy for detained adolescents. STI and HIV testing policies, which identify specific diseases and indicated time-frame to administer testing upon entry into the facility, impact the sexual health of adjudicated youth. NCCHC provides position statements to express their opinion on issues that are not outline in their standards for juvenile correctional health care. STI testing is one of those issues. NCCHC recommends Chlamydia and Gonorrhea testing for women up to age 25 and pregnant women, regardless of age, at intake or as soon as

possible unless they were transferred from a facility where they were already tested (National Commission on Correctional Care, 2014). Additionally, NCCHC recommends testing of Gonorrhea and Chlamydia on all sexually active men. Syphilis testing should be determined based on "the active yield of syphilis screening within the institution" to determine if testing is needed (National Commission on Correctional Care, 2014). NCCHC recommends further STI testing (ex: HIV, Trichomoniasis) based on positive diagnoses of Gonorrhea, Chlamydia or Syphillis (National Commission on Correctional Care, 2014). Recognizing and treating STIs in juvenile facilities offers a way to prevent complications of the diseases and reduce transmission of STDs in juvenile detention facilities and the community (National Commission on Correctional Care, 2014).

Georgia Policy 11.30 outlines policies implemented by the Georgia Department of Juvenile Justice related to STI testing and infectious disease control. The Georgia Department of Juvenile Justice states that youth must be tested for gonorrhea and chlamydia within seven days of entering the facility (Georgia Department of Juvenile Justice, 2017a). Testing results cannot be disclosed unless asked in writing by the adolescent themselves (Georgia Department of Juvenile Justice, 2017a). Juvenile offenders can request HIV testing, however, for pregnant women and youth determined to be high-risk by medical staff, HIV testing can be administered without being requested by the adolescent (Georgia Department of Juvenile Justice, 2017a). Prior to administering the HIV test, adolescents must complete an HIV Test Consent Form (Georgia Department of Juvenile Justice, 2017a). Additionally, all infectious diseases must be reported to the Georgia Department of Public Health, as required by law (Georgia Department of Juvenile Justice, 2017a).

Vaccinations. Persons in correctional facilities bear a disproportionate burden of infectious diseases, including HPV, Hepatitis and other STIs. HPV infection causes cervical cancer, genital warts and various other cancers in both men and women (Meites, Kempe, & Markowitz, 2016). Currently, the HPV vaccine is approved for both young men and women, up to the age of 26 years. According to 2016 recommendations, adolescents who initiated the vaccination series between the ages of 9 to 14 years, are required to take two doses, while those who initiated the vaccination at 15 years of age or older, three doses are recommended (Meites et al., 2016). The HPV vaccine is offered at juvenile detention facilities in 39 states, however, the type of juvenile that is offered the vaccine varies. Juvenile offenders classified as detained, are only offered the vaccine in fourteen states and inconsistently in ten states, whereas adolescents who are classified as committed are offered the vaccination in all 39 states (Henderson, Rich, & Lally, 2010). Adolescents are classified as detained when they are awaiting trial, adjudication or placement at another facility; they are classified as sentenced or committed when they are placed in a facility as part of a court ruling (Sickmund et al., 2017).

According to the WHO, Hepatitis B is a condition that causes deterioration of the liver and can be transmitted both sexually and nonsexually (2017). Hepatitis B can be transmitted from mother to child during birth, through infected blood, through various body fluids such as vaginal secretions and semen, and through the reuse of needles and syringes (World Health Organization, 2017). The vaccine requires a three or four dose schedule and is approved for youth up to 18 years of age (World Health Organization, 2017). Similar to the HPV vaccine, the Hepatitis B vaccine is offered to detained adolescents in 26 states and offered to committed adolescents in 39 states. The first dose of the Hepatitis B vaccination is usually administered at

birth, however, the vaccination can be administered to youth and adults who are at risk for contracting the disease (Centers for Disease Control and Prevention, 2017b).

In Georgia, Policy 11.30 states that immunizations for juvenile offenders will be provided as indicated by the Advisory Committee on Immunization Practices (ACIP; Georgia Department of Juvenile Justice, 2017a) and when immunizations are not up to date, it is recommended that the facility provide all required vaccinations (Georgia Department of Juvenile Justice, 2017a; National Commission on Correctional Health Care, 2015). The ACIP recommends nine vaccinations for adolescents: Tdap, HPV1-3, Varicella1&2 and HepA1&2, and MCV4-Meningococcal. Prior to entering the detention facility, only 3% of adolescents completed all recommended vaccinations for their age group (Gaskin, Glanz, Binswanger, & Anoshiravani, 2015). These results indicate that there is not only a need for vaccination increase among juvenile offenders, but that the juvenile justice setting provides an opportunity to administer vaccinations to youth who otherwise may not receive them.

To gather insight into the immunization practices of juvenile correctional facilities, researchers have interviewed State Immunization Program Managers regarding Hepatitis B and HPV vaccination practices. Researchers found that some of the barriers to HPV vaccination among detained youth were parental consent requirements, cost, lack of refrigeration storage space, staff reluctance to administer the vaccination, and adolescent's fear of needles (Henderson et al., 2010). The most common reason mentioned for lack of vaccination for detained adolescents was the short length of stay (Henderson et al., 2010). Although cost was mentioned as a barrier to vaccination for juvenile offenders, most adolescents involved in the juvenile justice system qualified for free immunizations as a result of the Vaccines for Children (VFC) program (Sneller et al., 2008). A similar barrier to Hepatitis B vaccination was parental consent

(Tedeschi et al., 2007). Though vaccines have been proven to be effective at preventing disease, parental consent complicates the vaccination process (Tedeschi et al., 2007).

Contraceptives and family planning services. Contraceptive and family planning services provide adolescents with crucial information about pregnancy prevention. Although primarily focused on female offenders, providing information on contraceptives and family planning services is extended to all juvenile offenders. According to NCCHC standard Y-G-08, juveniles are provided with comprehensive family planning services, which includes pregnancy prevention and access to contraception services (National Commission on Correctional Health Care, 2015). NCCHC recommends a means through which adolescents can initiate contraceptives while in custody; females who are currently taking birth control are allowed to continue with that method (National Commission on Correctional Health Care, 2015). The NCCHC recommends emergency contraception be available at intake and at any time during incarceration (2015). Additionally, NCCHC recommends counseling services be made available to all adolescents addressing all aspects of sexuality, with referrals to appropriate community organizations for assistance, when necessary (2015).

Sexual health education. Policies related to the type of sexual health education administered to juvenile offenders are critical to their sexual health. According to NCCHC, health education is defined as "information on preventing illness, self-care for an existing health condition and maintaining a healthy lifestyle" (National Commission on Correctional Health Care, 2015, p. 107). Health education is provided from various sources, including staff, local health agencies, or volunteers through one-on-one encounters or group settings (National Commission on Correctional Health Care, 2015). Multiple entities both inside and outside the correctional setting can be used to implement health education programs to juvenile offenders.

Although sexual health education is not explicitly discussed in the standards, the NCCHC explains that HIV/AIDS infections along with STIs are suggested health education topics (National Commission on Correctional Health Care, 2015).

The type of sexual health education provided to juveniles in correctional facilities varies by state. However, different types of HIV/STI risk reduction interventions have been implemented with juvenile offenders. Below is a table outlining some of the more recent HIV/STI risk reduction interventions implemented with juvenile offenders. The table also outlines whether these interventions were implemented with incarcerated or nonincarcerated populations.

Medicaid Exclusion Policy. The Medicaid Exclusion Policy is a federal policy indicating that federal benefits cannot be used to fund health services for incarcerated adolescents (Acoca et al., 2014). Adolescents can be enrolled in Medicaid while incarcerated; however, states are not able to claim federal matching funds for these youth (Cuellar, Kelleher, Rolls, & Pajer, 2005). There are certain circumstances where exceptions apply. For instance, funds are available when youth are transferred to a medical facility or inpatient service, or are sentenced to community-setting, such as probation, and are awaiting release from the correctional facility (Acoca et al., 2014). Although not suggested, some states drop juvenile inmates from the Medicaid program, which prevents youth from receiving care abruptly, once they are released (Cuellar et al., 2005). Federal policy for the Medicaid program emphasizes that states "suspend" rather than "terminate" coverage for youth (Cuellar et al., 2005). Suspension allows coverage to be reinstated much more quickly than terminating youth from the program (Cuellar et al., 2005).

Table 2.1

HIV/STI Risk Reduction Interventions with Juvenile Offenders

Citation	Population and sample size	Target level of socio-ecological model	Research design	Summary of findings
DiClemente et al., 2014	Incarcerated, *N* = 183	Individual Interpersonal (peer)	Experimental (RCT)	Intervention participants (Imara) reported greater condom use self-efficacy and HIV/STI knowledge than control participants at 3-month and 6-month follow-up.
Goldberg et al., 2009	Incarcerated, *N* = 389	Individual	Experimental (RCT): Education, Education with Booster and No Intervention	Booster sessions shown to sustain effects for HIV knowledge for both males and females, prevention attitudes for males, and use of condoms by females.
Kelly, Owen, Peralez-Dieckmann, & Martinez, 2007	Incarcerated, *N* = 539	Individual Interpersonal (peer)	Pre-post comparison group; longitudinal	At 6 mo. follow-up, intervention group more likely to have used a condom at last and more likely to use communication to defuse violence.
Lauby et al., 2010	Incarcerated, *N* = 289	Individual	Nonrandomized concurrent comparison group	Intervention group significantly more likely to report using condom at last sex with a nonmain female partner at follow-up (6 mo.) compared to comparison group.
Mouttapa et al., 2009	Incarcerated, *N* = 48	Individual	Quasi-experimental; pre-post comparison group (2 sequential cohorts)	Intervention participants had greater knowledge scores, lower endorsement of false attitudes and beliefs, decreased stimulant use, significant increase in self-efficacy of being drug free compared to control group.
Mouttapa et al., 2010	Incarcerated, *N* = 64	Individual	Quasi-experimental; pre-post comparison group	Among sexually active youth, intervention group increased rates of condom use over time. Intervention group had 13.9% increase in abstinence. Neither group increased knowledge of HIV transmission.

Table 2.1 Continued

Citation	Population and sample size	Target level of socio-ecological model	Research design	Summary of findings
Rowe et al., 2016	Incarcerated; *N* = 150 MFT delivered post-incarceration	Individual Interpersonal (family)	Experimental (RCT); intent to treat design	Rates of STIs across conditions decreased from intake to 9 months and remained relatively stable over the course of 42 months. No differences in abstinence of sex across groups.
Robertson et al., 2011	Incarcerated, *N* = 246	Individual	Experimental (RCT); longitudinal	Girls in both conditions significantly decreased frequency of unprotected sex and sex while under the influence of alcohol and other drugs. Girls in intervention demonstrated better condom application and social competency skills.
Schlapman & Cass, 2000	Incarcerated, *N* = 69	Individual	Descriptive; 4 educational sessions over 7 months	Increased ability to label and recognized risk behavior. No evidence shown of commitment to change behavior.
Schmiege, Broaddus, Levin, & Bryan, 2009	Incarcerated, *N* = 484	Individual	Experimental (RCT); random assignment at session level: Motivational Enhancement therapy (MET)+theory-based intervention (GPI), theory-based intervention (GPI) and info only.	GPI+GMET lower risky sexual behaviors compared to info only group. GPI+GMET significantly better at influencing attitudes, norms and intention to practice safer sex behaviors than two other groups.
Son et al., 2017	Incarcerated, *N* = 134	Interpersonal (peer)	Pre-post; qualitative interviews	Confidence using a condom with a partner significantly and STI knowledge increased post-intervention. Self-efficacy in contraception use did not differ post-intervention.

Cuellar and colleagues (2005) conducted a study assessing Medicaid policies, at both the local and state level, addressing financing of health screenings and services, Medicaid enrollment and disenrollment policies and practices at entry and at release of juveniles from detention facilities (Acoca et al., 2014; Cuellar et al., 2005). Researchers indicated that 24% of local and 17% of state justice agencies reported submitting Medicaid applications on behalf of youth upon entry into the detention facility (Cuellar et al., 2005). This is particularly important because having a source of payment for services upon release could remove a significant barrier to youth accessing health care (Cuellar et al., 2005). This may provide a unique opportunity to impact access to sexual and reproductive health care services for juvenile offenders.

Facility policies for detained female adolescents. Although national standards exist outlining certain policies and procedures related to sexual health, not all facilities abide by these standards. Gallagher and colleagues conducted a study examining 1,255 facilities across the nation, which included group homes and short and long-term detention facilities (Gallagher, Dobrin, & Douds, 2007). Results indicated that 70% of facilities administer sexual health services (gynecological exams and HIV and other STI testing) on an as needed basis rather than opting to provide those services to all female youth (Gallagher et al., 2007). Moreover, about 16% and 3% of facilities test for STIs and HIV, respectively, after
youth arrive at the facility (Gallagher et al., 2007).

To assist with STI testing and other unmet needs of female offenders, some facilities in California have adopted the Girls Health Screening (GHS). GHS is a computer-based screening instrument designed to identify immediate and nonurgent medical needs of female offending youth (Golzari, Mollen, & Acoca, 2014). The assessment tool also identifies whether female

adolescent offenders have medical services and prompts probation officers and social workers to proactively enroll youth in care (Acoca et al., 2014). Currently, the assessment tool has been expanded to juvenile facilities in Los Angeles County and is now being administered as the primary assessment tool for female adolescent offenders upon intake (County of Los Angeles Probation Department, 2017). As a result of mandating that this screening measure be used upon intake for some of the juvenile detention centers in the Los Angeles area, the health needs of incarcerated female youth are being diagnosed and treated in a timely manner (Acoca et al., 2014). GHS provides an example of a policy that is impacting the sexual health of juvenile offenders. Detention facilities across Los Angeles County are adopting the screening and, in turn, linking female offenders to appropriate health care services.

Summary

This chapter examined the history of juvenile courts, the demographics of detained youth, juvenile detention in Georgia, and the sexual health of juvenile offenders, both broadly and within the state of Georgia. A vast literature base exists outlining the individual and interpersonal factors influencing the sexual health of juvenile offenders. The interpersonal factors include gender, ethnic identity, attitudes/perceived behavioral control, substance use, and personality traits such as sexual sensation seeking. At the interpersonal level, parenting variables, gang norms, and peer influence play a role in the sexual health of juvenile offenders. However, research is limited in addressing community and policy level factors impacting the sexual health of juvenile offenders. Community level factors addressed in the literature review are sexual networks and witnessing community violence. The policy level factors outlined in this literature review are STI/HIV testing, vaccinations, contraceptives and family planning, Medicaid

exclusion, and general facility policies for detained female adolescents, which are specific to detained adolescents.

Research examining how the sexual health needs of nonincarcerated juvenile offenders are addressed is minimal. More research is needed to examine the organizational and policy level factors impacting the sexual health of juvenile offenders, for both incarcerated and nonincarcerated populations. This research study provides an opportunity to fill the research gap by taking an organizational and policy approach to examining the sexual health of juvenile offenders. The goal of this study was to develop a theoretical framework outlining the factors impacting the sexual health of incarcerated and nonincarcerated juvenile offenders. An overview of grounded theory methodology and the resulting theoretical framework are presented in Chapter 3.

CHAPTER 3: METHODOLOGY

The purpose of this chapter is to provide the methodology for this research study designed to explore the factors impacting juvenile offenders' access to and use of sexual health services. The specific aims of the study are as follows:

Aim 1: Identify how sexual health service needs are determined for adjudicated adolescents.

Aim 2: Identify the current sexual health services provided to adjudicated adolescents.

Aim 3: Identify the barriers and barriers and facilitators impacting the sexual health.

This study used a grounded theory approach to provide a thorough understanding of the experiences of service providers in addressing the sexual health needs of juvenile offenders and a way to develop a theoretical framework from the data. The methods used to conduct the grounded theory study are described in this chapter. The methods used to conduct the grounded theory study are described in this chapter. The recruitment and inclusion of participants, the design of the study, and the role of the researcher, data management, analysis, and trustworthiness implemented in the study are also presented in this chapter.

Study Design

Through The researcher conducted semistructured one-on-one interviews with key informants ($N = 6$). Semistructured interviewing is a flexible technique that begins with a structured set of questions but, allows the researcher to add or replace pre-existing questions as the interview progresses (Glesne, 2016). To examine how organizations are involved in

addressing the sexual health needs of juvenile offenders, the researcher interviewed individuals who work directly with juvenile offenders. The primary way to investigate organizations is by examining the individuals who make up the organization or carry out its processes (Seidman, 2013). The researcher conducted five in-person interviews and one took place on the phone. In-person interviews took place in a location—public library, conference room, or office—and at a time convenient for the interviewee.

The study protocol was approved by the University of Georgia's Institutional Review Board. To ensure participants' confidentiality several steps occurred. First, no personal identifying information was collected from participants. Second, participants provident verbal consent, which eliminated written documentation of their participation in the research study. Third, participants were identified by their pseudonyms. Lastly, the researcher explained to participants that they can withdraw from the study at any time and did not have to answer any questions(s) they did not feel comfortable addressing.

Role of the Researcher

As the primary researcher for this study, disclosing personal biases and relationship to the research topic and participants is critical. The researcher worked with juvenile offenders as a sexual health educator. She implemented a comprehensive evidence-based sexual health education program to incarcerated and nonincarcerated juvenile offenders, which initially sparked her interest in conducting further research on the sexual health of juvenile offenders. As a service provider, she felt her efforts to provide sexual health education to juvenile offenders were often too late. She also recalled how critical those conversations were with adolescents who were often unknowledgeable about sexual health prevention measures, which included birth

control options and condom use. As a sexual health educator, the researcher's understanding of sexual health prevention placed quite a bit of responsibility in the hands of the adolescent. However, the researcher wanted to learn more about the role of the service provider, an entity representing an organization, in addressing the sexual health needs of juvenile offenders.

It is important to note that the researcher had professional connections with two of the participants, which established the basis for snowball sampling. She conducted initial interviews and use the networks of those who participated in the study to recruit participants. None of her prior connections with research participants presented a conflict of interest. Often times in research, we must rely on our personal and professional networks to conduct research studies.

The researcher was also trained in conducting interviews through qualitative research courses at the University of Georgia. These acquired skills helped her probe participants into providing detailed responses to the interview questions. The goal of the researcher was not to work for communities, but rather, work alongside members within communities, whether individual entities or organizations, to address the sexual health needs of juvenile offenders. She also wanted to make sure the experiences of service providers were heard and valued. She understands her biases: previously working as a service provider and her desire to learn more about the sexual health of juvenile offenders and is stating them as they relate to her role as a researcher. Her attempt is to make them known, so they do not limit her ability to thoroughly interview study participants and/or analyze the data.

Recruitment and Inclusion Criteria

Prior to start of the study, the researcher compiled a list of eight potential participants at health departments, probation offices, and individuals within her personal and professional

networks. Once the study was approved, the researcher sent an initial email to her list of potential participants outlining the study with the attached recruitment flyer. The email also indicated how potential participants could arrange an interview. She contacted one potential participant via phone. Of that list of eight, she was able to interview two service providers. Two service providers did not respond to emails or phone calls. The additional four potential participants indicated that their supervisors would not allow them to participate in the study. The researcher conducted additional recruitment online through academic Facebook groups and Instagram pages. The recruitment flyer was shared through these social media networks.

Purposeful sampling, a nonrandom sampling technique was used to recruit participants. Contrary to random sampling, purposeful sampling allows the researcher to intentionally select participants whom they can gain an in-depth understanding of the phenomenon in question (Patton & Patton, 2002). One type of purposeful sampling is snowball sampling. For this study, snowball sampling, after interviewing initial respondents, was used to recruit participants. Snowball sampling obtains potential study participants from others who are interested or may have previously participated in the study (Patton & Patton, 2002). This sampling technique driven by those responding to the study and can be useful in reaching additional key informants across various organizations. After interviewing the initial two service providers, they reached out to individuals within their networks to assist with recruitment. Three additional participants were recruited in this manner. The researcher also identified potential participants by reviewing the websites of local community-based organizations. Individuals were contacted via phone and email. One participant was recruited in this manner.

To be included in the study participants must (a) be 18 years of age or older, (b) work for an organization that makes decisions about or serves adjudicated adolescents, and (c) be able to participate in an interview in English. The researcher interviewed individuals across various roles who interact with juvenile offenders within different organizations. These roles varied from mental health clinicians to social workers. Once participants contacted the researcher about the interview process, a suitable time and date to conduct the interview was scheduled. To provide anonymity, participants provided verbal consent on the phone or in-person prior to starting the interview. One interview took place on the phone and five interviews occurred in-person. All participants were provided with a $20 Amazon gift card for completing the study.

Data Management

All interviews were audio recorded and transcribed verbatim using a transcription service. The researcher reviewed the completed transcripts for clarity, checked for errors, and adjusted the document, if necessary. The researcher uploaded the transcripts to a computer assisted qualitative data analysis software (CAQDAS) called ATLAS.ti (version 8) into her password-protected computer. Once the committee deemed the study complete, audio-recordings were destroyed.

Data Analysis

Grounded theory methodology was used to analyze the data. Multiple researchers have contributed to the development of grounded theory and the data analysis for this study draws on processes outlined by several researchers Strauss and Corbin (1998) and Charmaz (2006). These researchers promote the use of grounded theory techniques as flexible strategies that can be adapted to the process being studied (Charmaz, 2006). The process being examined is the factors

that impact juvenile offenders' access to and use of sexual health services. Grounded theory methodology involves continuous data collection, categorization and comparison to develop theory about a specific phenomenon (Charmaz, 2006). Refer to Figure 3.1 for a visual representation of the adapted grounded theory methodology.

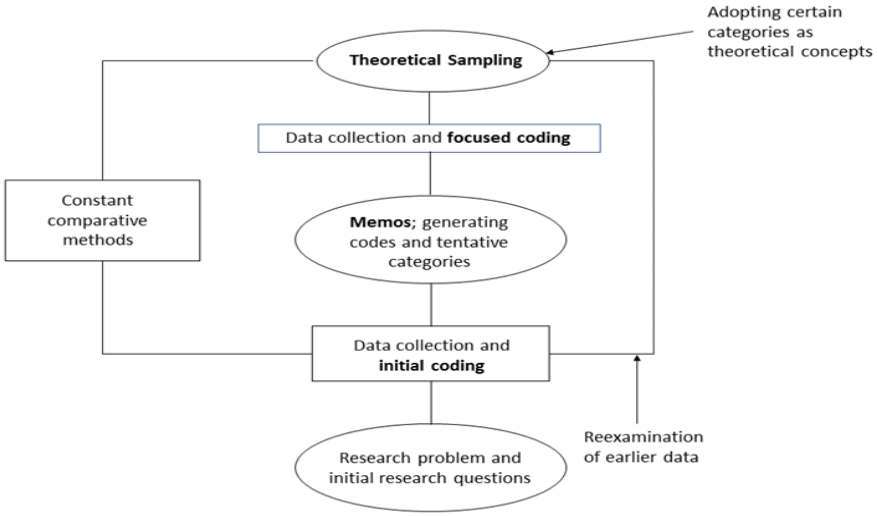

Figure 3.1. Grounded theory process. Adapted from *Constructing Grounded Theory: A Practical Guide Through Qualitative Research*, by K. Charmaz, and *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*, by A. Strauss and J. Corbin. Copyright 2006 and 1998 by SAGE Publications.

The first step in the data analysis, also identified as initial coding, was to review the transcripts and group lines, phrases, sentences, and/or paragraphs. Initial coding during this stage was very broad. The researcher reviewed the data relatively quickly, noting first impressions and important segments of the data. One of the defining aspects of grounded theory includes applying a constant comparative method whereby the researcher is constantly comparing data during each stage of analysis (Charmaz, 2006; Strauss & Corbin, 1998). Constant comparison involved multiple reiterations of simultaneous data collection and analysis throughout the

research process (Charmaz, 2006). The researcher coded the data and reviewed each transcript to determine similarities and differences. During the analysis, the researcher created memos throughout the process to outline definitions of codes and establish connections between interview data. Another round of coding, described as focused coding, generated codes more refined than the initial coding process and identified codes related to the three specific aims of the study.

As codes and categories were established, theoretical sampling took place. According to Charmaz (2006), theoretical sampling involves constructing ideas about the data to develop a theoretical framework. For this study, the researcher relied on memos as the basis for creating theoretical constructs. During the theoretical sampling process, I used categories related to barriers and facilitators to develop the theoretical framework. The generated theoretical framework aligned closely with elements within the socio-ecological model.

Saturation is loosely defined as the criteria for discontinuing data collection and/or analysis (Glaser & Strauss, 1967). Saturation is heavily rooted in theoretical sampling, a level of analysis within grounded theory (Glaser & Strauss, 1967). The researcher begins to see similar concepts throughout the data, which occurs through sampling, collecting, analyzing data in a continuous manner (Saunders et al., 2018); a technique within grounded theory known as the constant comparative method. For this study, saturation was reached as no new codes emerged from the data. Starks and Brown Trinidad (2007) suggest that saturation occurs when the constructs within the theoretical framework are completely represented in the data. The researcher found that there were a number of codes that consistently emerged in the data, however, by the sixth interview no new codes resulted. Some grounded theorists (Glaser &

Strauss, 1967) suggest that small sample sizes are not problematic because the purpose of grounded theory is to develop constructs within a theoretical framework and the data collection process is focused on developing the properties of constructs and the relationships between those constructs (Charmaz, 2006). In other words, grounded theory methodology data collection, sampling, and analysis are central to the development of theory and that can occur with a small sample size.

Trustworthiness

Within qualitative research, trustworthiness is achieved through credibility, dependability, confirmability, and transferability (Ulin, Robinson, & Tolley, 2005). Credibility is defined as providing an interpretation of the data that is consistent with the data collected and represents the perspectives of the study population (Ulin et al., 2005). The researcher presented findings from participants who work directly with juvenile offenders in a variety of capacities. Differences and similarities in their perceptions of assessing the sexual health needs of this population and barriers and facilitators to addressing their access to and use of sexual health services were also examined. Member checks were also used to establish credibility. Member checks occur when researchers share data with participants to ensure accurate representation of their thoughts and ideas (Merriam & Tisdell, 2016). The researcher provided participants with a summary of the results of the study and gave them the ability to provide feedback.

Dependability is defined as providing enough details to replicate the process of obtaining the results of the study, rather than replicate the study itself (Ulin et al., 2005). To increase dependability, the researcher met with committee members to review the coding scheme for clarity and interpretation. Committee members served as a support team; constantly challenging

the researcher to reflect on their role in the research process. ATLAS.ti also served as a means to establish dependability. The researcher created memos, which outlined detailed steps outlining data collection, software management, and analysis phases of the research process.

Confirmability examines the researcher's central role in the data collection and analysis process and how that might influence research findings (Ulin et al., 2005). The researcher explained her position and relationship to the data collected. This allowed her to monitor her biases during the research process and allows the reader to better understand her findings and conclusions. Ulin et al. (2005) describes audit trails as a strategy that can be used to establish confirmability. The researcher provided detailed descriptions of interview data, an interview guide, and diagrams indicating relationships across data, which allows the reader to determine whether the presented finding were grounded in data.

Lastly, transferability is defined as making inferences to other populations. The purpose of qualitative research is not necessarily to apply research findings to a different study population (Merriam & Tisdell, 2016). However, this can be the case if the basis of the research is theory development (Ulin et al., 2005). Although the intention is not to generalize the study findings to other populations, the researchers' goal is to develop a framework grounded in data that advances our understanding of the systemic factors impacting juvenile offenders' access to and use of sexual health services.

Summary

The goal of this chapter was to describe the methods used to examine the specific aims of the study. The researcher explained the study design, including ethical obligations, role of the researcher, recruitment and inclusion criteria, data management, analysis, and trustworthiness. A

grounded theory approach was used to develop a theoretical framework outlining the factors impacting juvenile offenders' access to and use of sexual health services from the perspective of the service provider. Participants shared their rich experiences working with juvenile offenders to contribute to the development of the theory. Chapter 4 will provide the research findings and the resulting theoretical framework.

CHAPTER 4: FINDINGS

The purpose of this study is to examine the organizational and policy level factors that impact the sexual health of juvenile offenders. The three specific aims for this study are to identify: (a) how sexual health needs are determined, (b) the current sexual health programs, and (c) the barriers and facilitators impacting the sexual health infrastructure for juvenile offenders. The sexual health infrastructure refers to the access to and use of sexual health services and programs. This chapter contains the results of a grounded theory study conducted with service providers working directly with juvenile offenders. Multiple levels of analysis occurred with axial coding, open coding, and selective coding. As a result of this coding, participant responses were framed through a socio-ecological lens, which examines the individual, interpersonal, community, organizational, and policy level factors that impact the sexual health of juvenile offenders. This analysis is structured to address each specific aim. Included in this chapter are descriptions of participants, a table outlining codes and themes, and a visual representation of the resulting conceptual framework developed from grounded theory.

Overview of Sample

Semistructured interviews were conducted with six participants ($N = 6$) who provided services directly to juvenile offenders. Table 4.1 provides a brief overview of participants, their associated pseudonyms, years working in the profession, and their job titles for the study. Pseudonyms were provided to maintain confidentiality. Although each service provider is distinctly classified in Table 4.1, some of their job responsibilities, as mentioned in participant

descriptions, may overlap with one another. Interviewees reported a wide range of experience working with juvenile offenders, ranging from 1 to 33 years. The minimal amount of professional information necessary was collected.

Table 4.1

Service Providers' Job Descriptions

Participant	Pseudonym	Years in profession	Job title	Organization type
1	Alex	1	Sexual health educator	GA
2	Daniel	2	Case worker	JC
3	Rebecca	3	Therapist	JC
4	Victoria	12	Care coordinator	CBO
5	Chloe	10	Social work supervisor	CBO
6	Elizabeth	33	Mental health clinician	CBO

Note. The organizational type has been abbreviated to include: GA=government agency, JC=juvenile court, CBO=community-based organization.

Description of Participants

All participants' characteristics are self-reported at the time of the interview. Each description outlines the role of the service provider and their duties within their organization. The six service providers interviewed for the study represent five different organizations. The types of organizations within the sample include two different community-based organizations (CBO), one government agency (GA), and two organizations collaborating with the juvenile court system (JC). Table 4.1 identifies each participant's organizational affiliation.

1. Daniel served as a **case worker** directly interacting with a broad range of juvenile offenders; from those committing status offenses, such as truancy, to felonies, such as rape. He worked in this role for two years. His duties consisted of addressing the

mental and emotional health needs of his clients, which usually occurred at pre-disposition; the stage prior to sentencing. During pre-disposition, Daniel worked with several sources to assess the needs of the juvenile offender. He provided individual, in-home, and court assessments, deliberated on solutions, and prepared adolescents for the realities of sentencing.

2. Rebecca was in her third year as a **therapist** working with both incarcerated and nonincarcerated juvenile offenders. She worked with juvenile offenders who have committed their first offense leading to probation to those who have been detained for violent crimes. Her duties consisted of working with juvenile offenders on criminally-oriented thinking, developing social skills, and reacclimating into the community with better strategies to address conflict. Rebecca conducted intake assessments and led individual and group therapy sessions in both detention centers and various community locations.
3. At the time of the interview, Alex was a **sexual health educator** who had been working with juvenile offenders for one year. He taught evidence-based sexual health education classes and conducted workshops. He provided juvenile offenders with general sexual health knowledge related to prevention and treatment, different types of STIs, symptoms, and recognition. Alex also provided juvenile offenders with information on local community resources to assist with learning more about birth control methods and testing services.
4. Victoria served as a **care coordinator** for an organization where a large portion of her clients were classified as juvenile offenders. She worked with youth for

approximately twelve years. She built a support team for her clients through coordinating services related to stabilizing placements and assessing health needs. She served as a communication liaison between the entities of law enforcement and other agencies. Victoria conducted home visits, contacted providers, made referrals for various health services, and documented all interactions with her clients.

5. Chloe operated as **social work supervisor** for various organizations that work with youth with challenging behavioral and mental health needs. She worked with juvenile offenders for approximately ten years. She served as both an administrator and service provider. She facilitated one-on-one therapy sessions and conducted comprehensive family and child intake and trauma assessments. Chloe also provided support for other clinicians in her organization through coordinating and facilitating meetings.
6. Elizabeth worked with juvenile offenders as a **mental health clinician** for an organization that provides mental health services for adolescents in the community. At the time of the interview, she worked with adolescents involved in the juvenile justice system for over thirty years. Specifically, she oversaw a program that provided mental health services to juvenile offenders. Her duties included trauma and substance abuse assessments, along with sexual assault care. She conducted intake assessments and provided diagnoses for clients. Elizabeth also provided prevention, intervention, and resource connection services for juvenile offenders.

Research Findings

Specific Aim 1: Determining Sexual Health Needs

The sexual needs of juvenile offenders are determined in a number of ways. Service providers (a) conduct assessments, (b) communicate with the juvenile offender about their sexual behaviors and history and (c) examine trends in regional data.

A variety of assessments are used as a means to determine the sexual health needs of juvenile offenders; from psychological to trauma assessments. For those service providers who mentioned conducting assessments, those assessments took place during the intake process. For example, Daniel described when juvenile offenders meet with him, they are provided with several assessments. He stated:

> I mean, they go through formal psychological assessments. There is a psychosexual assessment that they'll get. Of course, the problem with those is that you can only assess as much as they will tell you. So, they know not to answer certain things, certain ways."

Although clients may minimize the information they disclose, having formal criteria to address their sexual health needs is crucial. It could be the sheer act of conversation that may create an avenue for juvenile offenders to disclose their concerns.

These assessments are completed by the service provider and they use the acquired information to determine what additional information to provide to the juvenile offender. Daniel stated that "a lot of it is homework on your own, really crafting individually that particular person and what's going on." Daniel also felt as though "the people who have the most profound impact and help the kid really, I guess, understand but also continue to do their own work

beyond them." He believed that addressing the sexual health aspects related to the difficulties some of his clients were experiencing created an overall impact on their offending status.

Part of Elizabeth's role as a clinician involves providing trauma assessments for juvenile offenders. Elizabeth gathered sexual health information from her clients during these assessments. She discussed what is included in those assessments. She stated:

> And so, a full-on assessment of not only their experiences with their feelings, their needs, their social norms, their beliefs, what's important to them, understanding their perspective on what sex is and appropriate sexual health is, how they would define that and then also bringing in the values that they have…

Elizabeth mentioned how her range of questioning extends beyond sexual assault because she thinks "it's extremely important so that we can have an understanding that is not quite so cut and dry." Elizabeth also mentioned that no matter how youth are assessed, it is important their clinicians are discussing aspects related to "healthy decision making, promoting problem solving skills, and so there tends to be with adolescents, really important day to day conversations, friendships, connections, sex, drugs, school performance, family." Adolescent sexual health encompasses all of these entities and it would be doing the client a disservice to only discuss elements related to STIs and sexual trauma.

Assessments and communication are equally important when assessing the sexual health needs of juvenile offenders. Victoria explained how critical this is when interacting with her clients. She stated that, "we do a few like documentation and document gathering, and interviews, and like assessments and things like that when they enter into our programs." Although assessments are the norm in her organization, Victoria gathered information about her

clients' behavior and history to determine how to address their sexual health needs. She stated, "So, just from like learning about their history, learning about like if they have any history of sexual abuse or sexual behaviors and knowing more information about that we can kind of tailor how we work with them." Determining sexual histories creates topics for conversation and a potential introduction to other sexual health services, such as STI testing.

Similar to Victoria, Chloe also used assessments along with direct communication to understand the sexual health needs of the juvenile offenders she worked with. Chloe mentioned a specific assessment used to elicit sexual health information from her clients. She explained that:

> …we have this thing called strengths, needs, culture discovery and it's where we just gather information about the person…that would be something that we would ask during that…What is the young person sexual like preference? Are they straight or gay or are they having sex or do they want to have sex, stuff like that…

Along with a structured assessment, Chloe used direct communication to elicit sexual health information. Chloe evaluated the sexual health needs of her clients through conversation. She stated that, "It's just kind of me talking to them so, there's no like formal way to find that information. I think it varies I guess between clinicians. Unless I knew that there were some kind of sexual trauma coming in and then, we will talk about that." In other words, Chloe explained that service providers address the needs that come up in conversation, unless they are privy to other information related to the sexual health of their client.

Alex used a combination of examining trends in the data and communicating with adolescents to determine their sexual health needs. Alex specifically examined statistical trends in the data to determine the needs of youth in the community. He focused on general trends

because specific sexual health data for juvenile offenders in the community is not easily accessible. He stated that he determined the needs of juvenile offenders by "looking at youth purpose data to get an idea of what the community looks like in a snapshot." However, he also spoke to youth directly. He indicated that:

> I had to do a few informal classes at the career academy, and I'll do a sexual health class for them. And they, there's a lot of basics that they just do not know or they've never been told before. So, kind of gauging by that, it's really, give them the short simple basic things that they need in order to make whatever decision they want to make because they're going to have sex, that's just reality of it. But I'm trying to give them strategies to either how to say no if they don't want to or if they do make the decision to have sex, they do it safely.

Based on Alex's assessment of the sexual health knowledge of the juvenile offenders he worked with, he provided information on the areas of sexual health that may be lacking for them.

Daniel explained how assessing the sexual health of juvenile offenders also included communicating with other service providers whose expertise may have been different from his own. He stated:

> …when it's more of an intense case where your sexual world of continuum has been significantly altered trajectory wise it's a little more kind of looking at, are there any specific counselors that are sexual therapists or looking at this area that can really hone in on things and that encompasses across trauma, paraphilia, fetish so that way, again, at the end of the day it's trying to make them understand and go, okay, do you understand what may be healthy, what may be unhealthy and then how do they identify that…

Daniel not only relied on his own knowledge, but he reached out to available community resources, when necessary.

Even though examining trends in data is important, determining the sexual health needs of juvenile offenders is primarily done on an individual basis. Rebecca further emphasized that sexual health among this population is addressed in a reactive manner, primarily in response to pregnancy or STI symptoms. She explained that:

> …mostly the determining factor there was does the kid have a baby…Okay. So obviously, they weren't using protection, obviously, there's a chance with an STD. Obviously, this should be a conversation, but, in my opinion, that's reactive rather than proactive.

Rebecca declared that taking a reactive approach to addressing the sexual health needs of juvenile offenders was problematic. Even though juvenile offenders may be pregnant or have an STI, addressing their current sexual health needs, not just their pregnancy status or STI diagnoses, can impact their future decision making.

Specific Aim 2: Current Sexual Health Services

Service providers spoke about their awareness of the sexual health services provided to juvenile offenders, which includes (a) sexual health education programs and (b) testing services. If organizations were not equipped to provide certain sexual health services, they communicated with other organizations to help provide those services.

As a sexual health educator, Alex discussed the program he implemented with juvenile offenders at the detention center. He stated that he used "evidence-based programs recommended by the Office of Adolescent Health under Health and Human Services." His choice of curriculum

was based on demographic variables, such as setting and target audience. He mentioned that he used the "reducing the risk curriculum because it is evidence-based, number one, and it has been used in a setting with juvenile offenders. It is one of the few that specifically looked at that group." Not only was sexual health education provided to both incarcerated and nonincarcerated juvenile offenders, Alex also mentioned testing services were provided by his organization.

Alex also explained working closely with the epidemiologist to provide testing for HIV, TB, and Hepatitis C. He stated, "we do rapid testing ourselves, so we can go ahead and do it then and there." However, Alex stated that there are only a few tests that can be done rapidly. "As far as referring them or getting them for other bacterial infections, we have to refer them to the health department."

Elizabeth explained that her organization does not provide specific sexual health programming or services for her clients. As a result, she worked with other community agencies to address the sexual health needs of juvenile offenders. She explained that they have connections with local hospitals, health clinics, and domestic violence shelters that can provide "sexual health services that we would not necessarily provide here." Elizabeth described communication with other organizations as a means to provide sexual health services her organization may not be equipped to handle.

Specific Aim 3: Barriers and Facilitators

Service providers' perceptions of the barriers and facilitators impacting the sexual health infrastructure for juvenile offenders were examined. The sexual health infrastructure is defined as the access to and use of services. Service provider responses were organized through the lens of the socio-ecological framework. Barriers are described as the factors hindering access to and

use of sexual health services and facilitators are defined as the factors that support the sexual health infrastructure for juvenile offenders. Barriers and facilitators were identified at the individual, interpersonal, community, organizational, and policy levels. Table 4.2 provides a short description of the barriers and facilitators at each level of the socio-ecological model. This table will be used to frame the discussion of Specific Aim 3.

Individual level barriers. Individual level barriers were classified as characteristics that influence behavior, such as knowledge, awareness, and other personal traits. Individual level barriers were divided into two categories: service provider and juvenile offender. At the individual level of the service provider, three factors were mentioned: expectations of provider demeanor, limited time, and lack of knowledge. Characteristics at the individual level of the juvenile offender were identified as transience, lack of knowledge, and lack of mobility.

Service provider: Demeanor of provider. One participant mentioned being expected to act in a certain way to appease parents and his organization. Daniel described his own demeanor, as a service provider, impacting his ability to provide services to his client. How Daniel presented details and expectations of the youth's case created a state of conflict with the parents of his client. He stated:

> I got taken off a case because I wasn't nice enough about the situation and to me the kid was facing, there were two girls that were accusing him of raping them and so I mean he's facing eight felony counts and he's going to be considered high and aggravated which means in a Georgia scale, they're very considerable, very serious. So, it's not like a slap on the hand, hey, so in those kinds of cases I'll be supportive in the direction of

like, here's what you need to prepare for, here's what you need to be thinking about but trying to be nice about it is almost a disservice…

Service provider: Limited time. Service providers mentioned numerous job duties, all competing with the demands of addressing the sexual health needs of juvenile offenders. Chloe said, "we have so much other stuff going on that kinds of thing gets shuffled into the background unless like someone thinks they have an STI or someone is pregnant or some emergency situation." Elizabeth also agreed with this statement. She stated that, "sexual health is so often a tertiary concept of people's minds as far as priorities that we're not really talking about it…until it's too late." Both of these service providers shared evidence suggesting that addressing sexual health among juvenile offenders tends to be a reactive rather than proactive process.

The limitation with time for service providers extended beyond just competing priorities to include learning new information. Victoria explained:

> …a lot of the things with my youth I may not be educated on myself, so before I can help them I kind of have to learn. I would need to learn what is appropriate to talk to them about, or what I should be talking to them about with sexual health…And so, when you have 18 other things on your to-do list it is hard to set aside time just to kind of do some research and self-education.

Finding the available resources in the community and educating herself on the discussions that should take place with her clients, were described as time-consuming tasks.

Table 4.2

Service Providers' Perspectives on Barriers, Facilitators, and Recommendations

Socio-ecological level	Barriers to access and use of sexual health services	Facilitators to access and use of sexual health services	Recommendations
Individual – service provider	Expectations of provider demeanor: Not abiding by parent/guardian expectations Limited time: Multiple competing demands; limited time to learn new information Lack of knowledge: Not familiar with regional or local community sexual health resources	Assessing needs: Determining how to address the sexual health needs of juvenile offenders Communicating with youth: Creating opportunities to talk about different aspects of sexual health	Continuing education: Mandate continuing education courses geared toward sexual health communication with youth
Individual – juvenile offender	Transient: Constant movement in/out of system; hard to track down in the community Lack of knowledge: Lack of general sexual health information (ex: how to use condom, resource availability) Lack of mobility: Incarceration limits youth's mobility; cannot receive resources	Confidentiality: Not having to disclose personal information to parents/guardians Willingness to engage: Wanting to engage in conversations with service provider	Probation officer inclusion: Incorporate community resources to increase youth participation in services
Interpersonal	Parental/guardian involvement Parental/guardian involvement limits conversations providers have with youth (sexual identity, orientation, etc.)	Realistic sex education: Open and honest conversation; providing realistic scenarios and give youth opportunity to share personal stories	Educate parents/guardians: Policies should include developing and providing education for parents/guardians on how to discuss sexual health topics Consent education: Policies should include teaching youth about consent

Table 4.2 Continued

Socio-ecological level	Barriers to access and use of sexual health services	Facilitators to access and use of sexual health services	Recommendations
Community	Religious: Regional limits on resources provided and (health protection) conversations; can influence feelings youth have about sexual experiences Talk sex=have sex: Talking about sex increases likelihood youth will have sex Taboo to discuss sex: "Just don't talk about sex"; service provider is unsure about what to include in conversations; thus, avoid altogether	Leverage local resources: Using connections with local resources to communicate with youth about sexual health	Community collaboration: Service providers collaborate with community organizations to provide sexual health services (testing or education) to incarcerated and probate youth
Organizational	Financial: Providing resources dependent upon financial barriers Training: Service provider sexual health training Lack of organizational cohesion: Policies and procedures not followed in same way by everyone in organization	Communication with organizations: variance in inter-agency communication based on needs ongoing resource development: Creating a system for service-providers to access community resources	Exit programs: Policies should promote and provide an exit program for juvenile offenders that includes sexual health information and community resources Training: Policies should promote training to service providers conducted by local organizations well-versed in sexual health education
Policy	Geographic area: Type of information provided depends on region (abstinence-only policy in GA) No policy: No specific agency policies related to sexual health education	Comprehensive, evidence-based programs: Using programs with proven effectiveness to implement sexual health education	Mandate sex education: Policies should include mandating sexual health education for juvenile offenders Probation requirements: Policies should incorporate sexual health education into probation requirements

Service provider: Lack of knowledge. Lack of knowledge deals with service providers not being aware of regional or local community resources. This comment by Victoria explains some of the overlap between limitations with time and lack of knowledge. She stated that, "It takes time to learn about the services that are available in your community or in their community. A lot of times the kids are in a community that's like an hour away from me, so I don't know what's available there." When providers are not aware of the sexual health services in their community or the communities of their clients, it limits their ability to link juvenile offenders to the proper resources.

The three individual barriers at the level of the service provider are demeanor of the provider, limited time, and lack of knowledge. Service providers mentioned how their demeanor impacted their interaction with their client and the parents as it relates to discussions surrounding sexual health. Service providers also discussed limited time, as sexual health was not necessarily considered a priority when interacting with their clients. Additionally, lacking knowledge surrounding how to access sexual health resources in the community was also viewed as a barrier impacting juvenile offenders' access to and use of sexual health services.

Juvenile offender: Transience. At the individual level for the juvenile offender, service providers mentioned transience as a major barrier impacting the sexual health infrastructure for this population. Participants felt that because juvenile offenders were constantly in and out of the system, either through probation or incarceration, it limited their ability to access sexual health services. Alex, the sexual health educator, specifically spoke about this in relation to STI testing. He stated:

> …as soon as they're checked into [the detention center], they're automatically screened for different STIs. The problem or the disconnect that comes with that is that sometimes

> by the time we get the information here through Epi [Epidemiology], they've been released. So, we know that they're infected, but we can't treat them because they don't really treat onsite for that.

When juvenile offenders enter the detention facility, they are screened for STIs. However, often times once the health professional is made aware of the diagnosis, youth have already been released from the facility. Alex discussed how treatment becomes a difficult process as a result of this movement. Most of the time "contact is made without success, so they just remain an open case until they come in again for symptoms." Even though testing has taken place, notification of diagnoses, treatment, and partner notification are lacking.

The transient nature of some of the adolescents involved in the juvenile justice system makes addressing sexual health needs challenging. Chloe, the social work supervisor, mentioned that the youth she worked with may be moving from group home to hospital to various other residential placements. As a result, sexual health is not considered a priority. She stated:

> I think that sexual health can be lost in that because it's not usually an immediate thing. It's like people are more focused on making sure they have somewhere to stay and making sure they're going to school and making sure they're not like hitting people and trying to kill people.

Service providers are focused on creating a stable environment for their clients and not their sexual health. Based on Chloe's explanation, when interests compete, immediate physiological needs must be met first.

Juvenile offender: Lack of knowledge: Lack of general sexual health information negatively impacts the sexual health of juvenile offenders. This includes knowledge about birth control usage, testing services, and knowledge of available community resources to access sexual

health services. Alex explained how this is particularly troublesome for post-incarcerated adolescents. He stated, "Access to services, once they get out, can be tricky just because they don't know where to go. They don't understand that there's a sliding scale/free services offered…at the health department." Alex mentioned that as he taught sexual health education courses to juvenile offenders, the female participants were especially interested in learning more about birth control. Some were unaware "about the different methods they have to offer and…the reduced cost" offered through the health department (Alex). Alex also mentioned that juvenile offenders do not know where to get tested. He stated:

> So, a lot of them don't know that they can get tested here or really anywhere and that it's confidential. They didn't know that if they come here and get tested and treated that it would remain confidential even from the parents because their parents don't have a legal obligation to know unless the child gives us consent to disclose to the parents…

Knowledge of hours of operation, location, and resources for sexual health services are limited for many juvenile offenders, especially with regard to testing services. Minimizing rates of STIs among this population begins with adequate knowledge about community resources for birth control methods and testing services.

Victoria also explained how some of her clients lacked information about birth control. She expresses that "a lot of them don't know that there are birth control options that are free to them, they don't…they may have some old information about like the side effects that they may cause and things like that." This lack of information contributes to adolescent offenders not seeking care. Not knowing accurate information about side effects and where available resources are limits juvenile offenders' use of sexual health services.

Moreover, Rebecca discussed how she felt her clients lacked an understanding that sex is a biological process often resulting in offspring. She explains that, "…sex is obviously pleasurable, but it's also for the purpose of reproduction when you are ready, and like, they're just like, sex is just something that you do, because everyone is doing it." This lack of knowledge translated to an incarcerated teenager, experiencing her third pregnancy, with minimal understanding of how she continued to get pregnant. Rebecca retold this story the way her client explained it to her. She stated, "…the first time we used to pull-out method, but I still got pregnant. And the second time…he came in me, and then I got in the shower afterwards and I washed it off, so I thought I wouldn't get pregnant." Rebecca's client lacked a fundamental understanding of reliable methods of birth control, which led to her successive pregnancies.

Juvenile offender: Lack of mobility. Incarcerated adolescents are restricted in their mobility, which limits their ability to receive sexual health services. These youth cannot be sent to outside organizations for sexual health education or testing. As a result, organizations must enter the detention facilities. Rebecca, the therapist, discussed the difficulty with this. She stated:

> So, with detention centers, the kids can't leave. It's not like you can send them to an outside agency. The agency would have to come into the facility and that means they need to get background checks, they need to be willing and able to do it, that means they need to be flexible. They need to go through all of these trainings…

Having outside organizations enter juvenile detention facilities is not just about need. Organizations providing services to juvenile offenders are impacted by facility regulations and protocol that must be followed before entering the detention facility.

Transience, lack of knowledge, and lack of mobility were classified as barriers at the level of the juvenile offender. Transience, the constant movement of juvenile offenders, inhibits

their access to and receipt of sexual health services. This is particularly troublesome when service providers are unable to notify juvenile offenders of their STI status because they have been released from the detention facility. Lack of knowledge is also considered a barrier because juvenile offenders are often unaware of what sexual health services are provided and how to access those services in the community. Lack of mobility inhibits impacts service delivery for juvenile offenders in two ways. First, juvenile offenders cannot leave the detention center to receive services and second, multiple provisions must be followed before individuals can enter the facility to provide services.

Interpersonal level barriers. Interpersonal level barriers are defined as processes related to relationships with parents, friends, and peers that impact the sexual health of juvenile offenders. One specific variable deemed as a variable by service providers was parental/guardian involvement.

Parental/guardian involvement: Participants defined parental involvement as a relationship dynamic that limits the types of sexual health conversations that service providers are able to have with their juvenile offending clients. Elizabeth described this process from first-hand experience and observations with other clinicians. She stated:

> I think there's a lot of shyness that people have talking to under age youth in general about sex. I would imagine just from the conversations and the observations that I've had, and this is more anecdotal, that people think they can't, they think it's illegal. They're not sure what they're allowed to say with a parent in the room. They're scared they're getting into trouble and upset a parent.

On top of the uneasiness some service-providers felt when discussing sex, their conversations are limited to what is perceived as acceptable by the parent. Daniel described how helping his client

was a constant battle between what he perceived as important information and what was considered acceptable by the parent. He stated:

> I mean, for me, it's like, I know this is a losing battle to try and, you know, argue against this. All I can do is essentially kind of lay out my platform of what I may suggest and if they decide to take it up or ask more questions that's good but, I mean, I really know and a lot of times they're very adamant and they're very articulated about, we don't talk about this, this doesn't exist.

In this example, Daniel is specifically referring to conversations about sexual health topics. Even though Daniel perceived discussing sexual health as important, those conversations were limited with his clients.

Although service providers had the best interest of their clients in mind, their clients' status as a minor prevented them from keeping all discussions confidential. Chloe specifically referred to an example of a client requesting to be tested for STIs. She mentioned:

> If a young person approached me and said, "Hey, I think I need to get tested," then, I'd say, okay, we're going to figure out how to get that set up and I would approach that person's parent or foster parent and ask hey, let's go get a doctor appointment set up, after making sure with the young person if that's okay.

Chloe cannot accompany the minor for these services, so she must try to arrange testing with their parent/guardian. Disclosing the need for testing or that the juvenile offender is sexually active to the parent may put the juvenile offender at risk of repercussion from the parent/guardian. Daniel provided a clear example of how discussions about sexual identity may impact the safety of the child. He stated:

> …let's say a kid who's like, in that kind of questioning [their] sexuality, it's clear to me that they're acting out because they're trying to figure out stuff… let's say if that kid were, like, to work with me and then felt emboldened then come out, the parents could be ridiculously mad to the point where it would put that kid in danger. So that's where it's also, on our end trying to figure out, like, what – what can we pose, what can we do but also isn't going to put that kid in a compromising position with the family.

Daniel described conversations related to sexual identity as sometimes being re-directed to minimize or alleviate the risk of negative consequences from clients disclosing their status. Furthermore, Daniel stated that because parents "can look at the records, especially if it's juvenile justice," he must "take caution, small steps, [and] tread lightly" because he does not want to put the child in a compromising position or risk being reprimanded at his job because he has upset the parents.

Parent/guardian involvement is considered an interpersonal barrier to access and using sexual health services for juvenile offenders. Including parents/guardians in discussions with juvenile offenders prevented service providers from asking questions that made the parent/guardian uneasy. The interviews revealed that service providers asked questions they thought the parents deemed as acceptable. Service providers also mentioned that having to disclose information about sexual activity or testing may put the juvenile offender at risk for repercussions from their parent/guardian.

Community level barriers. Community level barriers are formal or informal norms or standards of groups or individuals. Three barriers were examined at the community level: religion, talk about sex leads to having sex, and the taboo nature of discussing sex.

Religion. Religion serves as a barrier impacting the sexual health of juvenile offenders. Daniel indicated that knowing whether families have religious affiliations impacts the types of conversations he has with clients. He stated, "one of the biggest considerations and when I go into a case is, identifying, like, are you religious because that will help me identify, like, basically kind of choose the methods best appropriate to approach and talk through." Furthermore, Daniel mentioned how religiosity impacts how sexual health is viewed. He explained feeling limited in his ability to converse about available sexual health resources. He exclaimed:

> It's really hard and for me because one of the things that we run into was a lot of the religious aspect which can provide a huge blockade even with things we know the kid is sexually active to a degree where they should be concerned but to get tested or to consider any of those things, you can run into kind of more conservative or religious ideas that don't want to deal with it. So that's where it makes it hard because you can't override.

Views about religion may also influence how juvenile offenders feel about their sexual experiences. Daniel further explains how he felt client's religious affiliation impacted that particular client's feelings towards having sex. Daniel stated:

> …because of the family's background being very devoutly fundamentalist Christian, he harbored an extreme amount of guilt and shame, which trying to talk to him, you know, I understand that part at the same time people have sex, this is not the most horrible thing in the world…so this kid is going to have his own mental anguish and torture, feeling bad for something that a number of teenagers do…

As a result, Daniel struggled with determining the best care for his client. Since Daniel's client harbored certain feelings towards engaging in sexual activity, having conversations about sexual health was not easy.

Talking about sex means having sex. The idea that having a conversation with a minor about sex means that will encourage engagement in sexual activity serves as a barrier for service providers. As a clinician, Elizabeth described generally how service providers in her line of work try to steer clear of sexual health topics. She stated that "they're scared that by saying something they're condoning behavior that could be considered inappropriate or risky and so they just avoid it." Daniel also mentioned this idea in further detail. He stated that, "a lot of what we're still dealing with and we're, I mean, it was the same in the schools was this idea that if we provide condoms for free in the counselor's office somehow that is an encouragement to go ahead and have sex." By avoiding conversations about sexual health altogether, service providers are not having discussions that could potentially minimize risk for juvenile offenders.

Taboo to discussing sex. Participants mentioned a culture of not discussing sex. Chloe felt as though many of the service providers she worked with did not want to talk about sex with their clients. She explained, "I am pretty open about things, but I think a lot of people don't want to talk about sex." Not only do service providers not want to talk about it, "but it seems like no one's ever bothered" (Chloe). Victoria further demonstrated how discussing sex considered taboo. She stated that she "could hear certain providers or case workers saying just don't have sex." Victoria also examined this idea within the context of being a service provider in Georgia. She stated:

> There's a lot of rural areas in Georgia [and] sex is still a very taboo subject. And so, I think that hinders us from having honest and accurate information and conversations.

> You still hear about a lot of areas preaching about absence only and that's just not realistic for anybody.

When a topic is considered taboo, it becomes acceptable not to talk about it. As a result, health discussions are overlooked and that detaches expectations from the provider. More emphasis can then be placed on what behaviors the juvenile offender is engaging in rather than discussing the role of the service provider in engaging the adolescent in conversations about their sexual health.

Three community level barriers to accessing and using sexual health services for juvenile offenders were religion, talking about sex means having sex, and the taboo nature of discussing sex. Religious affiliation may impact the types of conversations service providers have with their clients and impact their internal feelings towards sexual activities. Service providers mentioned that the sheer idea of talking about sex was seen as encouraging sexual activity. This idea had an impact on what types of conversations service providers had with their juvenile offending clients. When discussions around sex are considered taboo, it creates a climate where not discussing sex is the norm. This provides a great disservice to the juvenile offending population because they are not able to learn about the sexual health resources and services available to them.

Organizational level barriers. Organizational barriers are defined as factors within the system of the organization that impact juvenile offenders' access to and use of sexual health services. Four factors became apparent in data analysis: financial, training, lack of organizational cohesion, and nonmandatory services.

Financial. Providing sexual health resources to juvenile offenders is highly dependent upon the availability of financial resources. For some organizations, financial resources are acquired through grant funding. Victoria explained how this process is challenging, especially as it relates to sexual health.

> …a part of the program with the teen parent connection is…education classes. And those can revolve around sex education, healthy boundaries in relationships, parenting skills, and development skills, things like that. But they often don't have enough funding to provide a lot of – like they have funding to provide some classes but it's not enough for – it's not as much as it should be. And sometimes, I was talking to the director who writes a lot of the grants for the program and then she was saying like you can't – sometimes you have to be creative with your wording because a lot of the grant providers won't provide a lot of funding for something called family planning. So, even like grant funding that you're dependent upon, they may have different ideas of what you should be focusing on as a program.

Providing sexual health education classes for her clients, some of which are juvenile offenders, is based on organizational funding. Acquiring this funding can be challenging in an environment where abstinence-only is the central focus. These entities play a role in sexual health services being provided to juvenile offenders and their access to and use of these services.

Training. Providing training to address the sexual health needs of juvenile offenders is considered a barrier. Funding and training often overlap with one another. In this discussion of training service providers to provide sexual health education to juvenile offenders, it is important to not overlook the financial component. Rebecca clearly explained how funding and training are intertwined. She emphasized how evidence-based and comprehensive sexual health programs for juvenile offenders require specialized training, often from an outside agency. Rebecca stated:

> So getting training, so then there's the financial component of that, is it – who is going to pay for the training, or is it a grant that's going to get – that's going to allow them to pay

> for the training, or if it's a grant, well, then who's going to write the grant, or getting accepted in the grant.

Often, organizations must lean on grant funding as a means of financial support. Finding someone to write the grant, factoring in training into the grant, and the grant award and final reporting can be a tedious task.

When training service providers, Elizabeth mentioned much of it has to do with emphasizing the importance of having conversations about sexual health with clients. She stated how this is one challenge her organization faces when addressing the sexual health needs of juvenile offenders. She emphasized:

> One part is practitioner comfort. I think that people accidentally silo what services are needed and having an understanding as to how one, sexual health is an enormous factor in their overall well-being comes down to how well have they're trained, how comfortable are they, how experienced are they, and proximity to the knowledge that's out there.

Elizabeth described how training service providers on how to address the sexual health needs of their clients is not mandatory. Although sexual health is not necessarily the main focus during the client-practitioner interaction, it is an important aspect of their overall health. Victoria contributes to this discussion by emphasizing the need for training service providers, in all capacities, on how to communicate with juvenile offenders about sexual health topics. She elaborated:

> …more access and funding to training people and providers on how to communicate with the youth and that's any provider, I think, that worked with the youth whether it's someone from juvenile justice or at the RYDC facilities, group home providers, case

> managers, therapists…specifically of what kinds of conversations and how to talk to kids about that. And just making sure that they all have accurate information.

Victoria has previously mentioned how discussions with her clients can be challenging, however, providing resources and accurate information to this population is critical to addressing their sexual health needs.

Lack of organizational cohesion. Another barrier impacting the sexual health of juvenile offenders is the lack of organizational cohesion. This barrier explains how policies and procedures may not be followed in the same manner by individuals within the same organization. When addressing the sexual health needs of juvenile offenders, Rebecca mentioned how much of this is done on an individual basis. She stated:

> So, if I realize that my client was having unprotected sex, and then I took that to my supervisor, then that's when it would determine the need. Do you know what I mean? But it wasn't just a general, Okay. We need to all be in a conversation around sex, we need to all be implementing this group, or this intervention specifically related to sexual health. That wasn't happening as an organization, it was more on an individual basis.

Although Rebecca discussed her assessments and requested assistance from her supervisor, there are no set procedures used to provide resources, testing, or education to her clients. Chloe further mentioned that within her organization, sexual health is handled on a case by case basis and at the discretion of the service provider. She explained, "it's like one of those things like you can do what you want at the individual level if you feel like it or if you think it's important, but what if you don't feel like everything is important…" Because of the lack of cohesion at the organizational level, service providers are not obligated to address the sexual health needs of their clients.

At the level of the detention center, Elizabeth described how much of the sexual and mental health needs are not provided directly by the facility. She explained, "DJJ has contracted organizations that they work with. So, they don't offer a lot when it comes to sexual health, mental health, behavior health in house. That is of their own administrative control." As a result, there is no clear picture of the sexual health services actually provided to juvenile offenders and what similarities or differences exist across detention centers. Elizabeth also felt as though as a result of outsourcing, DJJ places a lot of emphasis on outside organizations to meet the sexual health needs of juvenile offenders. She explained:

> I think that the assumption is that if we get a counselor on board, they are going to take care of everything. That doesn't necessarily mean that the sexual health piece is being rolled out appropriately because where are the medical providers, where are the nurses, where the people who actually have some training? Not every therapist has training nor does every therapist carry a value system that inherently encapsulates what it is to take care of sexual health…

Elizabeth's description provides an example of the expectation that all needs of the juvenile offender will be met by one outside source. As mentioned previously, if sexual health is not viewed as a priority for the service provider, it can often be overlooked.

Organizational barriers. Organizational barriers were identified as financial, training, and lack or organizational cohesion. Providing sexual health education to juvenile offenders was primarily dependent on funding provided from grants. Financial barriers also inhibited service providers from receiving sexual health training. Additionally, service providers are not being trained on the importance of having conversations about sexual health with their clients. The lack of training on how to have conversations with juvenile offenders about sexual health topics stems

from a lack of organizational cohesion. There is no clear understanding of what policies and procedures exist around sexual health discussions, treatment, and education provided to juvenile offenders at the organizational level.

Policy level barriers. Policy level barriers include local, state, and national policies that may impact the sexual health of juvenile offenders. These variables exist on a larger scale than organizational barriers. Two specific barriers emerged from the data regarding policy level variables: geographical area and no policy.

Geographic area. Policies that are reflective of the geographic area can impact the sexual health of juvenile offenders. With regard to sexual health education, Georgia is an abstinence-only state. This means policies and programs focus on preventing adolescents from engaging in sexual activity altogether. For instance, a few participants described how being in Georgia impacts how service providers approach sexual health. Victoria said that "you will hear a lot about abstinence-only and that's just not realistic for anybody." Although the state focuses on abstinence-only education, especially within the school system, Alex has deviated from this norm. He stated,

> Georgia's an abstinence-only by state law but there's only one evidence-based abstinence-only curriculum that the Office of Adolescent Health under HHS [Health and Human Services] even recommends. So, most of the studies show that abstinence-only education is ineffective. So, it's a lot of barriers for these kids because the ones that I teach are not abstinence-only. So, it's real world, actual demonstrations with things like condom use but all -- it's more about risk mitigation and risk reduction strategies.

Alex described how regardless of the state policy, he provided juvenile offenders with a curriculum that presented a realistic approach to sexual health. This curriculum included

information on how to use a condom and the location of sexual health resources in the community.

The type of sexual health information provided to juvenile offenders varies at the national level. Elizabeth explained her sentiments around this. She stated,

> I think on the national level we have a lot of inconsistency as to having to address sexual health and proceed in conversations about sexual health, so not having a standardized approach is a blessing and a curse at the same time.

Having a standardized approach to sexual health at the national level ensures certain information is discussed. However, it does remove autonomy at the state level.

No policy. Service providers described not having any local or state policies to guide their understanding of how to implement sexual health programming or address the sexual health needs of juvenile offenders as being problematic. Alex stated that "there are no district policies or really other initiatives focused towards that specific subset." By subset, Alex is specifically referring to juvenile offenders. He further stated that "they really don't have anything in writing as far as policy." Chloe also spoke about there being no set policy regarding the sexual health education provided to juvenile offenders. She explained,

> I think that it's very again, kind of in terms of providing education, there's no like set way to do it, so, I think that that probably varies a lot in terms of how comfortable you are doing that and how, you know, whether or not it even occurs to you, so it should probably be more standardized.

Lack of standardized policy related to sexual health education, leaves the choice to include this information in discussion up to the discretion of the provider. There is no way to know what information is being introduced, to which youth, and in what capacity.

Service providers considered geographic area and no policy as policy level barriers impacting juvenile offenders' access to and use of sexual health services. Geographic area primarily focused on service providers positioned in an abstinence-only state and how that limited their discussions around sexual health with minors. Service providers mentioned there was no standardized policy related to sexual health education. This means there is no way of knowing what information is or is not being provided to juvenile offenders.

Service provider level facilitators. Facilitators were defined as variables that support the service provider's ability to impact the access to and use of sexual health services for juvenile offenders. Two individual level facilitators were identified at the level of the juvenile offender and service provider. At the level of the service provider, those factors included assessing the sexual health needs of juvenile offenders and communicating with other organizations. Facilitators examined at the level of the juvenile offender were confidentiality and willingness to engage.

Service provider: Assessing needs. Service providers discussed assessing the needs of juvenile offenders as being seen as a way to promote access to and use of sexual health services for juvenile offenders. This category was expanded on in Specific Aim 2. The ways in which service providers determined the sexual health needs of juvenile offenders included conducting assessments, communicating with juvenile offenders, and examining trends in data.

Service provider: Communicating with youth. Communicating with youth is defined as service providers creating opportunities to speak with juvenile offenders about sexual health topics. Daniel clearly explained how he does this as a case worker. He indicated that:

> So part of it that I kind of work with kids is more the communicative and negotiating, so they understand, like, the parts of them that they have questions about, who can they go

> and talk to and that's probably, I guess, kind of the, back to your original question, there's a lack of, like, there's a vulnerability and risk in talking to somebody especially some of the things I have to talk to kids about involving, like, fantasies and trying to get an idea of like, where their head is. It can be embarrassing, and they don't want to say…we want you to grow and continue in a healthy way not one that may cause issues later down the line because you never learn that something was okay or needed to be corrected.

Daniel attempts to create a welcoming environment, so clients feel comfortable discussing sensitive topics. Much of that involves establishing a sense of trust and using that energy to guide conversations.

Individual level facilitators. Assessing needs and communicating with youth were the two facilitators identified at the individual level of the service provider. Service providers determined the sexual health needs of juvenile offenders through assessments, communicating with youth directly, and examining trends in the data. A few service providers mentioned combining assessments and examining trends in the data with communicating with youth directly as ways in which the sexual health needs of juvenile offenders were assessed. Both facilitators mentioned require that the service provider and juvenile offender collaborate and determine the next steps for addressing their sexual health needs.

Juvenile offender: Confidentiality. Service providers mentioned confidentiality as a way to promote juvenile offenders' access to and use of sexual health services. Participants explained that juvenile offenders were more likely to request sexual services when they knew that information would not be disclosed to their parent/guardian. Alex stated that:

> I've known a few of them that have come and got tested because of that because they only have to be 13 in order to get tested and the parental consent. We can even do the HIV 60 second test on 13 and over and we don't need parental consent…

Juvenile offenders requested services when they understood service providers were not legally obligated to mention their inquiries to their parent/guardian. Another service provider, Elizabeth also mentioned confidentiality with sexual health as being important for her clients. Elizabeth states that she "can't disclose to a parent if a child is sexually active [or] has requested service information." She also explained how she "is not obligated to contact their parent and can provide anybody with information at their request." Juvenile offenders were more easily able to communicate their needs with the service provider when the pressure of disclosure was minimized.

***Juvenile offender: Willingness to engage*.** Another facilitator described by service providers was willingness to engage, which was defined as the openness of the juvenile offender to engage in conversations with the service provider. For example, Elizabeth described how when juvenile offenders are mandated by the court to participate in sessions with her, they often shut down during interactions. However, she explained that once they see a consistent face, they become more willing to engage in conversation. She stated:

> They're wonderfully grumpy 90% of the time because they're being mandated and yet they're extremely engaged because once they realize there is actually someone they can talk to that is going to be a consistent presence in their life and they realize that they probably don't want to end up where they are currently again, they tend to be really willing…

According to Elizabeth, the willingness of the juvenile offender to engage in conversation stems from consistent interaction with a service provider. Those consistent conversations may lead to extended conversations about sexual health matters specifically.

Confidentiality and willingness to engage are considered facilitators at the level of the juvenile offender. Both facilitators involve interactions with the service provider. As explained by service providers, when confidentiality regarding sexual health services is explained, juvenile offenders are more willing to seek services. When service providers are consistently interacting with juvenile offenders, their willingness to engage in conversation increases.

Interpersonal level facilitators. Interpersonal level facilitators are defined as factors that involve relationships with peers, family members or service providers that promote juvenile offenders' access to and use of sexual health services. Service providers identified one facilitator at the interpersonal level, which was realistic sex education.

Realistic sex education. Interpersonal interactions between the service provider and juvenile offender create opportunities for conversations around sexual health topics. Realistic sex education was defined as having conversations that are open and honest and give youth the opportunity to share their personal stories. Rebecca mentioned how she felt youth are respectful of sexual health services when they are more realistic. She advocated for "hard and fast rules and regulations" that focus on prevention and protection. From her perspective realistic sexual health education involves "being realistic about their sexual encounters and engaging them in ways that are allowing them to share their personal stories…rather than coming down on them as like this is right and this is wrong but more of this is reality and we're here to help." This comment provides an example of how interpersonal interaction can impact the sexual health of juvenile offenders. Focusing on understanding the individual experiences, prevention, and providing

opportunities for open and honest conversation can have a significant impact on juvenile offenders requesting sexual health services or expressing their concerns about their sexual health.

Community level facilitators. Factors that promote the sexual health infrastructure for juvenile offenders at the community level involve interacting with other community agencies. One particular service provider mentioned leveraging local resources as a community level facilitator.

Leveraging local resources. One service provider defined leveraging local resources as using connections with local resources to communicate with juvenile offenders about sexual health. Alex identified a number of community agencies he interacted with to promote sexual health education with this population. Alex explained that as a sexual health educator, he felt it was necessary for him to seek out community agencies that work with juvenile offender to provide his educational expertise. He specifically mentioned this in response to limitations with financial resources. If an organization does not have the ability to finance sexual health education, there may be community entities that can provide those services for free.

Organizational level facilitators. Facilitators at the organizational level were classified as factors supporting the access to and use of sexual health services for juvenile offenders on a larger scale. The organizational level dealt with entities that occurred within and between organizations. Communicating with other organizations and ongoing resource development were the two factors addressed at the organizational level.

Communicating with other organizations. Service providers reaching out to community resources occurred at not only the individual, but the organizational level. Participants mentioned opportunities to include other organizations in addressing the sexual health needs of juvenile offenders. Because there is often a network of individuals that work with this population, making

sure everyone is aware of and understands how the sexual needs of their clients are being addressed is important. Chloe explained how taking a holistic approach to care is important. She stated:

> …our whole thing is like team process, so, we try to be as open as possible and talk about hard things in our group, which usually involves DFCS [Department of Family and Children Services] and probation officer, therapist, sometimes school, always like the parent or foster parent, always the young person and other people like us that may or may not be involved…

Chloe mentioned how all service providers are kept in the loop through group meetings. This provides a space for group members to express any concerns and contribute to the overall care of the client.

Communicating with other organizations connects juvenile offenders to necessary sexual health services. Elizabeth described how most services are provided "in-house" and the process of connecting with outside resources is done on a "case by case" basis. She stated that:

> We do have a therapist and clinical supervisor within our organization that is also housed at the…health clinic so that we can have a direct conversation with medical professionals who we know are the primary health provider for adjudicated youth in the area.

Having those established connections with organizations that provide services for juvenile offenders makes interacting with outside organizations during times of need easier.

Ongoing resource development. Another organizational level facilitator identified by one service provider was ongoing resource development. This was defined a creating a system for service providers to access community resources. Ongoing resource development was a strategy used to provide knowledge on available community resources for service providers. Elizabeth

mentioned how her organization is working on a "trauma informed library system so that we can help to again intervene early…to provide prevention, intervention, postvention supports and resource connection." Creating a space where service providers have access to resources available in the community provides them with knowledge on how to link juvenile offenders to resources outside of their organization.

The two organizational level facilitators mentioned by service providers were communication with other organizations and ongoing resource development. Communicating with other organizations served as a means to connect juvenile offenders to the necessary sexual health services. Ongoing resource development provided a tangible resource for service providers to access community resources and in turn link juvenile offenders to prevention and intervention services. Both facilitators are ways in which service providers can promote juvenile offenders' access to and use of sexual health services.

Policy level facilitators. Facilitators at the policy level are defined as systemic factors that promote the sexual health infrastructure for juvenile offenders. Local and state policies and procedures are classified within this category. One service provider mentioned comprehensive, evidence-based programming as a facilitator impacting the sexual health of juvenile offenders.

Comprehensive, evidence-based programs. Alex described comprehensive, evidence-based programming as the criteria for how his organization chose sexual health education programs. The program he chose indicated proven effectiveness among juvenile offenders and provided a thorough overview of sexual health. Alex stated that the program "goes from everything from basic anatomy, correct terminology, to risk reduction strategies, refusal strategies, appropriate prevention methods…everything from condoms to other barrier methods to birth control methods…" He further describes the program he administered to juvenile

offenders as providing an extensive overview of sexual health, not just focusing on anatomy. As an addition to the general curriculum, Alex mentioned a unit where program participants identified sexual health resources in the community. As explained by Alex, comprehensive, evidence-based programs provided sexual health knowledge to juvenile offenders. These programs also promote juvenile offenders' access to and use of sexual health services by incorporating knowledge of community resources into the curriculum.

Conceptual Framework

Figure 4.1 displays the conceptual framework developed by grounded theory. The framework presents the relationship between service provider and juvenile offenders' access to and use of sexual health services. Using the socio-ecological model as a basis for this framework, the barriers and facilitators to accessing and using sexual health services for this population are displayed. Barriers and facilitators are categorized by each level of the socio-ecological model. Individual level barriers are divided into factors impacting the service provider and the juvenile offender. This diagram shows that majority of the factors in this relationship are barriers rather than facilitators. Most importantly, there is one facilitator at the organizational level, however, this is minimally addressed in the data.

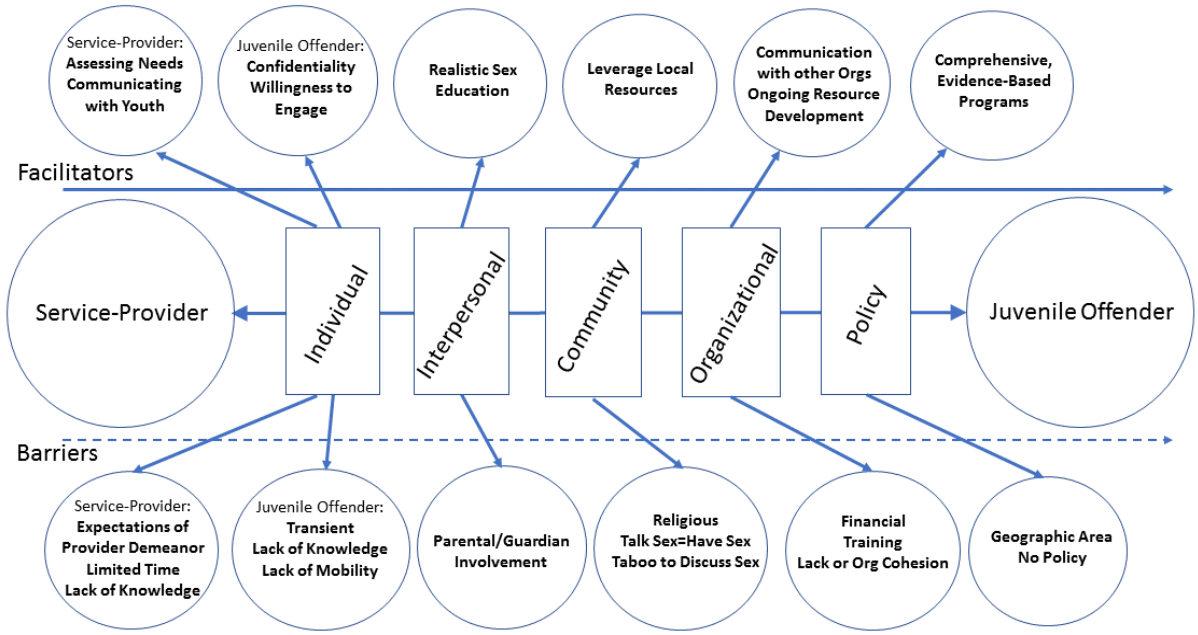

Figure 4.1. Conceptual framework examining service providers' perspectives on the barriers and facilitators impacting juvenile offenders' access to and use of sexual health services.

Policy Recommendations

Service providers were asked to offer recommendations on policy for juvenile offenders, specifically as it relates to their sexual health. Recommendations were categorized using the socio-ecological model. Table 4.2 includes a breakdown of the policy recommendations at the interpersonal, organizational and policy level. Even though these recommendations are listed as policies, their differences occurred with implementation.

Individual level policies. Individual level policies were identified at the level of the service provider and the juvenile offender. At the level of the service provider, the policy level recommendation identified was continuing education. The policy recommendation at the level of the juvenile offender was probation officer inclusion.

Service provider: Continuing education. At the level of the service provider, one interview participant mentioned the importance of discussing sexual health topics with juvenile

offenders and how little these conversations happened. As a result, one policy recommendation was having service providers participate in a continuing education courses geared towards sexual health communication with youth. Elizabeth described this in more detail. She stated that:

> Any therapist is required to continue to explore and expand their knowledge basis…and so I don't know how many people actually promote the development of understanding of sexual needs, sexual health, sexual reactivity into their practice because if you're not interested in it then you're not going to pursue that continuing education.

Elizabeth described ambiguity associated with expanding knowledge for service providers within her organization. A few service providers also mentioned a general cautiousness about discussing sexual health topics with youth. Having a continuing education course specifically addressing how to communicate with youth about sexual health topics, may minimize some of the hesitance experienced by service providers and create a sense of consistency on a larger scale.

Juvenile offender: Probation office inclusion. The policy recommendation at the level of the juvenile offender was probation officer inclusion. This was defined as using resources within the community to increase youth participation in sexual health services. Rebecca explained how probation officers were used in the community when she worked with juvenile offenders. She stated that "we literally had to have the probation officer pick them up from school and bring them to the probation office." Rebecca also mentioned that there were times the probation officer had to go to the house of the juvenile offender and bring them to the associated program. Incorporating community resources can be one policy recommendation to increase the use of sexual health services for juvenile offenders. To combat the barrier of transience, having probation officers pick up juvenile offenders from home or school and transport them to a

desired location to obtain services can be integrated into the current system. When the probation officer is interwoven into the process of providing services for this population, juvenile offenders begin to understand the importance of the activity.

Two individual level policy recommendations were mentioned by service-providers. At the level of the service provider, participants mentioned mandating continuing education courses aimed at communicating with youth about sexual health topics. At the level of the juvenile offender, participants mentioned including community resources, such as probation officers, to increase juvenile offenders' participation in sexual health education programs and services. Although classified as policies, both policy recommendations would be implemented at the individual level.

Interpersonal level policies. Interpersonal level policy recommendations include ways in which personal interactions, such as those with parents and service providers, have impacted the sexual health of juvenile offenders. Two specific interpersonal level variables were mentioned: educating parents/guardians and providing consent education.

Educate parents/guardians. Policies should include developing and providing resources for parents/guardians on how to discuss sexual health topics with juvenile offenders. Rebecca stresses that "parents should be the primary people talking with their kids about sex." However, Rebecca explained that this is not an easy task. She indicated:

> …not all parents are prepared to, maybe, maybe not. Some parents may not, you know, even though they should be having those conversations with their kids because no one had the conversation with them. Some parents may not know as much as they should know in terms of what to say or how early to have those conversations…

Rebecca presented a pressing need for parents/guardians to be educated on how to have conversations about sexual health. She also described what information should be provided to the parent/guardian. She stated:

> They should be giving them information about you know how people get pregnant, what STDs are out there, like how you catch an STD, what is an age of consent, so that kids are already prepared with that knowledge prior to being in those vulnerable situations.

To combat the parental/guardian involvement barrier service providers mentioned, educating parents is critical policy recommendation. Rather than antagonizing service providers for the conversations they are having with their child, parents/guardians are taught how to initiate and sustain sexual health conversations with their child outside of their interactions with the service provider.

Consent education. Policies should include teaching youth about consent. Service providers repeatedly mentioned consent being a very important aspect of sexual health for juvenile offenders. Chloe mentioned the importance of consent. She stated:

> I think that people need to know about issues like consent that we haven't talked about traditionally, but now, it's coming up a lot more. It's like hey, you need to talk about that. We need to know what that means and what that looks like and how you can make sure that the person you're having sex with wants to have sex with you.

Additionally, Daniel specifically described how consent, for some adolescents, has led to their offending status. He stated:

> …for example, a lot of the issue, like, in the rape cases, goes back to consent. So, you have an overt consent where she clearly said yes or no and then where it gets muddled is like the implied consent. So, that's where it gets tricky with the kids because you end up

> in a, well, you know, she was dressing like she wanted it, she was drinking drinks like she wanted it, so I was going to give it to her…

Determining whether consent is overt or implied can be confusing. However, Daniel stated that if the conversations begin with "principles of understanding consent, checking in at the base level, those would be, if they could be instituted, they would, I think, cut down on cases where, I thought things were good and then she backs out of it later on…" Learning boundaries, establishing clearly defined lines of yes and no, and having those conversations with juvenile offenders is critical. This level of understanding lays the foundation for future conversations with potential partners.

Chloe further described the importance of offering consent education for juvenile offenders. She also provides some suggestions as to how consent education could take place. She mentioned that:

> I think just that education piece about sexual health and consent in relationships and I don't know how we do that exactly, but it's -- I think if every kid could get that, it'd be pretty amazing. Maybe something that their probation officer could do or a doctor at an appointment or I know they have like these counselors through DJJ, maybe something that they can kind of just do as part of their daily or not daily, but their routine process.

Chloe's stated that consent education should be provided by organizations linked directly to the Department of Juvenile Justice (DJJ). She emphasized but rather youth who interact with the justice system should be provided with consent education through those entities.

The two policy recommendations mentioned by service providers at the interpersonal level were educating parents/guardians and providing consent education. Policies should include developing and providing education on how to discuss sexual health topics with their youth.

Educating the parent/guardian is important, however, creating policies geared toward teaching youth about consent is equally as important. Both of these policies would be implemented at the interpersonal level.

Community level policies. Policies at the community level were defined as those dealing with norms or standards for groups of individuals. At the community level, service providers identified community collaboration as a policy recommendation.

Community collaboration. One service provider recommended creating policies designed for service providers to collaborate with community organizations to implement sexual health education services to incarcerated and probate youth. Community collaboration was defined as essential partnership building and working towards promoting access to and use of sexual health services for juvenile offenders. Victoria explained how when a sexual health need is established with her client, she works to create a strong support system. She stated that if a child is engaging in risky sexual behaviors, she "has conversations with the team, gets them specific therapy sessions, gets them on birth control…" Although Victoria's organization does not provide counseling or testing services specifically, she explains that she would link youth to organizations that provide those services.

Organizational level policies. Organizational level policies include procedures that can be implemented within an organization. The two organizational level policy discussed was an exit program for juvenile offenders and training for service providers.

Exit program. Policies should promote and provide an Exit Program for juvenile offenders that includes sexual health education in the form of programs and community resources. One suggestion provided by Alex included providing education and resources as part of a final component before departure from the detention centers. He stated:

> Educating them on linkages would be a really big one before they get out. I'm sure it's difficult since their turnover rates are all over the place, but definitely letting them know what community resources are available in the area, especially to stop them from coming back into the system or to keep them out of the system, that would be a big one. But it would be very difficult to implement, I'm sure, but there should still be some sort of policy procedure for like an exiting program.

Alex expressed providing juvenile offenders with knowledge of community resources for testing, birth control, and other sexual health needs is important. Implementing this at the organizational level, primarily within the detention centers or probation department, may reduce reasons for them to re-entering the system.

Training. Policies should promote training for service providers conducted by local organizations well-versed in sexual education. One service provider recommended providing training to combat the lack of training experienced as a barrier at the organizational level. Rebecca mentioned providing free training to service providers by local agencies. She explained that organizations may not be aware of the availability of community resources for these purposes, so the local agencies should reach out to entities like the detention centers and other organizations to provide these trainings. Providing free trainings from local agencies would combat both the financial and training barriers experienced at the organizational level.

Providing an exit program and training were the two organizational level policy recommendations mentioned by service providers. Providing an exit program for juvenile offenders would ensure they would receive baseline sexual health information, which included knowledge of community resources. Policies should also include free training for service providers implemented by organizations knowledgeable about sexual health education.

Policy level policies. Policy level recommendations are those that occur at the state or national level. These policies impact the sexual health of juvenile offenders at the highest level. Two policy recommendations provided by service providers were mandating sexual health education and probation requirements.

Mandate sex education. Policies should include mandating sexual health education for juvenile offenders. Establishing mandates involves creating provisions where all juvenile offenders in the state of Georgia receive sexual health education. Rebecca advocates for this policy. She declares, "the moment that a kid is detained, they should need to go through some type of sexual health orientation, some type of sexual health education, some type of sexual health training." Rebecca bases her advocacy off of her experience visiting a detention center in Texas. She describes how for youth there, sexual health is considered a priority. She stated:

> Texas had different units that were focused on different areas of improvement for the kids. And I believe every kid went through every unit depending upon some of their needs, or their time at the facility. But one unit was solely focused on sexual health. And they were constantly trained, and like educated on sex, and educated on protection, educated on different STDs, and educated on having babies, and what not. And like how to protect themselves, and how to avoid, or like how to avoid having sex.

These provisions, as described by Rebecca, create opportunities for open and honest conversations about sexual health with juvenile offenders along with the educational component. This provides an example of responses to mandated sexual health education can look like within the detention centers.

Alex mentioned that, "there are not a lot of policies that dictate sexual health because even for the DJJ, they fall under the Department of Ed[ucation]" and they are restricted in terms

of the formal education that can be provided to juvenile offenders." However, Alex explained that impacting "DJJ policies would be the most bang for your buck." Working to emphasize the importance of sexual health on a policy level has the potential to influence the individual level. Mandating juvenile offenders to learn more about their sexual health may influence their future decision making.

Chloe mentioned that one of the major unmet needs is that there is a lack of standardized sexual health education that can be implemented by service providers, regardless of the organization with which they work. Service providers working with juvenile offenders should be discussing sexual health topics. She stated:

> I think some kind of like standardized education program so that it's not something you have to figure out how to do by yourself. And I think some kind of expectation for checking. So, like I'm thinking of we check in to make sure our kids had dental appointments every six months and medical appointments every year and so, it seems like it would make sense that there'll be some kind of checking for sexual health too. Making sure the kids have access to things that help them be safe like birth control and condoms.

Along with a standardized educational component, there should be a system of checks and balances. This will help ensure that the education discussed is being retained and youth are being made aware of and seeking sexual health resources when necessary.

Probation requirements. One service provider's policy recommendation was to incorporate sexual health education into probation requirements. Alex stated that he knew juvenile offenders had certain mandates while on probation, however, he was unaware of how the process worked. He felt that juvenile offenders' access to and use of sexual health services could be impacted on a larger scale if sexual health education was incorporated into their

probation requirements. Mandating sexual health education through probation increases opportunities juvenile offenders can become acquainted with sexual health resources in the community.

The two policy recommendations provided by service providers at the policy level were mandating sexual health education and incorporating sexual health education in probation requirements. Making sexual health mandatory allows for more standardization and structure or guided discussions with service providers and their juvenile offending clients about sexual health topics. Incorporating sexual health education as a part of probation requirements allows juvenile offenders to become aware of sexual health services provided in the community. Both policy recommendations address the barrier of the lack of policy mentioned by several providers interviewed in this grounded theory study.

Summary

This chapter contains the specific aims of the study, the research findings as they relate to each specific aim, and a conceptual framework developed from grounded theory. Six service providers were interviewed for the study. All service providers were gathered from a range of professions that work directly with juvenile offenders. Interview questions were formed to uncover the factors impacting the sexual health of juvenile offenders, with a primary focus on organizational and policy level factors. Service providers mentioned completing assessments, examining trends in regional data, and communicating with their clients, as ways in which juvenile offenders' sexual health needs were assessed. Additionally, service providers described current sexual health services or programs provided to juvenile offenders were evidence-based sexual health education curriculum and STI testing services. If their organization could not

provide sexual health services, one service provider mentioned communicating with other organizations to provide any necessary sexual health services for their clients.

Barriers and facilitators impacting the access to and use of sexual health services for juvenile offenders were framed through a socio-ecological lens. Barriers, facilitators and policy recommendations were identified at the individual, interpersonal, community, organizational, and policy level. After identifying the barriers and facilitators, selective coding was used to develop a conceptual framework depicting service providers' perspectives on the organizational and policy level factors impacting the sexual health of juvenile offenders. It is evident in the research that there are opportunities to impact the sexual health of juvenile offenders at the organizational and policy level. Chapter 5 will outline the discussion of each specific aim, present avenues for future research and practice, and present policy recommendations.

CHAPTER 5: DISCUSSION

The purpose of this study was to explore the policies and procedure that impact the sexual health of juvenile offenders using grounded theory methodology. The data collection method used was semi-structured interviews, which provided a thorough examination of the experiences of service providers as they discussed a sensitive topic: the sexual health of juvenile offenders. This chapter discusses the interpretations of findings from the three specific aims of the study: (a) Identify how sexual health needs are determined for juvenile offenders, (b) Identify the current sexual health services provided to juvenile offenders, and (c) Identify the barriers and facilitators impacting the sexual infrastructure for juvenile offenders. Also included in this chapter are the strengths and limitations, implications for research and practice, policy recommendations, and a final summary.

Discussion

The first specific aim of the study was to identify how sexual health needs are determined for juvenile offenders. Service providers mentioned three specific ways in which the sexual health needs are determined for juvenile offenders: conducting assessments, communicating with juvenile offenders about their sexual behaviors and history, and examining trends in regional data. One service provider specifically indicated that assessing the sexual health needs of juvenile offenders was traditionally done in a reactive manner as a result of pregnancy, STI symptoms or STI diagnoses. Although each of these strategies are listed separately, several service providers mentioned engaging in at least two of these strategies. Service providers discussed conducting assessments and examining trends in data along with having conversations with juvenile offenders about their sexual histories, relationships, and behaviors.

The interview data suggests that service providers were communicating with juvenile offenders about their sexual health and tailoring the services provided based on the results of certain assessments. One important aspect to note is that none of the assessments discussed were specific to sexual health needs. Some of the assessments focused on trauma, but there was limited indication that sexual behaviors, sexual health education, and discussions around STI testing services were taking place. Sexual health needs should be addressed consistently, rather than in response to what the service provider might perceive as a problem. Incorporating a short sexual history and behaviors scale into routine assessments can create opportunities for pertinent conversations with juvenile offenders about their sexual health.

The second specific aim of the study was to identify the current sexual health services provided to juvenile offenders. One service provider, who was a sexual health educator, described the sexual health education programs and STI testing services provided for juvenile offenders. The sexual health education curriculum was comprehensive and evidence-based as outlined by the Office of Adolescent Health. Testing services consisted of rapid HIV testing, while other bacterial STI testing was conducted by the health department. Another service provider explained that their organization did not specifically implement sexual health services, but in the event their clients needed them, they would link them to the proper care. The results from this study reveal that the sexual health services provided to juvenile offenders are focused on incarcerated juvenile offenders. This study also suggests that there is a service delivery gap. For public health professionals, emphasis should be placed on implementing comprehensive, evidence-based programs (Office of Adolescent Health, 2017) with juvenile offenders; a subgroup of adolescents heavily impacted by STIs.

The third specific aim was to identify the barriers and facilitators impacting juvenile offenders' access to and use of sexual health services. Barriers and facilitators were identified at each level of the socio-ecological model. The coded interview data were used to develop a theoretical framework using grounded theory methodology. Service providers indicated several policy recommendations at varying levels of the ecological model.

Policy Recommendations

Figure 5.1 displays a visual representation of the conceptual framework developed from grounded theory and resulting policy recommendations. Using the socio-ecological model as a lens for this framework, the barriers and facilitators to accessing and using sexual health services for this population are displayed. Barriers and facilitators are categorized based on the levels of the socio-ecological model. Individual level barriers are divided into factors impacting the service provider and the juvenile offender. Included in the diagram are policy recommendations outline by service providers to impact the sexual health infrastructure for juvenile offenders. Although recommendations were presented at each level of the socio-ecological model, service providers mentioned impacting the sexual health of juvenile offenders on a large scale through organizational and policy level recommendations.

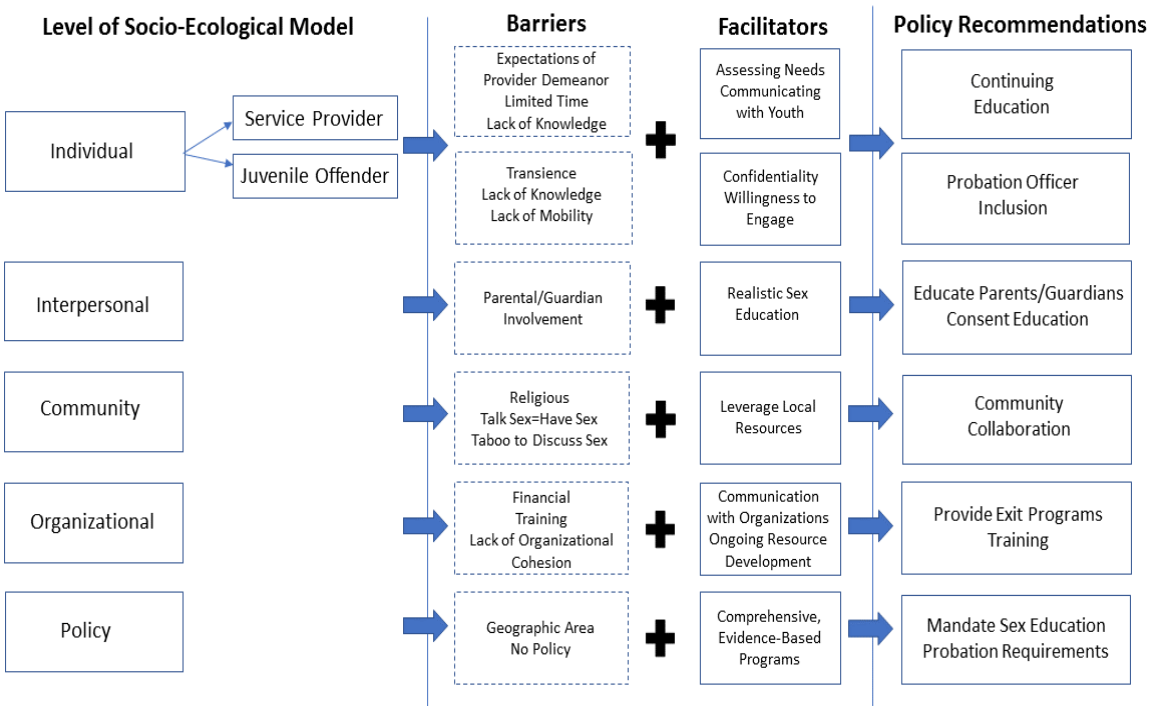

Figure 5.1. Barriers, facilitators, and associated policy recommendations. This figure illustrates the barriers, facilitator,s and policy recommendations described by service providers.

Continuing Education

Advocating for service providers to seek continuing education courses examining their communication with youth about sexual health topics is important. The results of this study indicated that service providers were hesitant about having conversations with youth about their sexual health. Hesitance was a result of not knowing what to discuss and how detailed those conversations should be. Participating in continuing education will provide service providers with information on sexual health topics to address during sessions with their clients. Furthermore, implementing this policy may minimize the lack of knowledge identified as a barrier by service providers.

Probation Officer Inclusion

Youth do not seek services on their own; they tend to be directed to services by parents, juvenile justice authorities, and other adults (Stiffman, Pescosolido, & Cabassa, 2004). Stiffman and colleagues (2004) describe these individuals as "gateway providers," who are knowledgeable about the youth and availability of services. Probation officers can be classified as "gatekeeper providers." Although probation officers are not implementing sexual health services, they can serve as a means of support, linking juvenile offenders to the appropriate health services. Probation officers are knowledgeable about the available community services and have an established relationship with juvenile offenders. As a policy recommendation by service providers, probation officers can serve as entities involved in transporting youth to sexual health education programming. If juvenile offenders must meet with probation officers, another way to promote delivery of sexual health services is to provide those services at the probation office. Transportation issues are minimized, and service delivery can take place in a location the juvenile offender is familiar with.

Educating Parents/Guardians

As a policy recommendation, one service provider advocated for educating parents/guardians on how to communicate with their child about sexual health topics. Research suggests that the sexual health knowledge and comfort of parents predicts sexual communication with their child, such that as knowledge and comfort increase, conversations surrounding sexual health are more extensive (Jerman & Constantine, 2010). Parents/guardians should be the initial point of communication with juvenile offenders about their sexual health. Providing educational resources and/or training can alleviate some issues related to lack of knowledge and comfort at the level of the parental/guardian. As a result of parental/guardian involvement, service providers

felt limited in their ability to have thorough sexual health conversations with their juvenile offending clients. Educating parents/guardians on how to have these conversations with their child increases the number of individuals interacting with juvenile offenders and discussing their sexual health needs.

Consent Education

As a policy recommendation, sexual consent education should be provided to incarcerated and nonincarcerated juvenile offenders. Consent is the foundation for how individuals make decisions about their sexual experiences, which may also be a key point for intervention and prevention (Borges, Banyard, & Moynihan, 2008). One service provider mentioned consent as a critical topic, which often resulted in adolescents becoming involved in the juvenile justice system. Juvenile offenders grappled with situational circumstances around consent, which can be addressed with sexual health education.

Wrap around services provide coordinated and individualized community-based services for juvenile offenders (Department Services Group, 2017). According to OJJDP, wrap around services are designed to divert youth away from detention and address the gaps in care for juvenile offenders (Department Services Group, 2017). Programming includes counseling and treatment services (Department Services Group, 2017). One of the areas lacking within wrap around services is the ability to provide sexual health education for this population. Within wrap around services, a policy recommendation would be to include consent education as part of the services provided to juvenile offenders. Education can be provided by trained service providers or health care professionals.

Community Collaboration

Recognizing how organizations within the community can contribute to addressing the sexual health needs of juvenile offenders is imperative. Policies advocating for partnership building between service providers and other community agencies may consist of community networking events and tangible resource development. Working with organizations to create tangible resources outlining sexual health services or programs provided within the community is necessary. Service providers can use this information to advocate for their clients and link them to proper sexual health care services.

Title X of the Public Health Service Act is a federally funded grant program provided by the Office of Population Affairs (OPA) within the Department of Health and Human Services (HHS). This program provides family planning services, such as contraceptives, confidential testing, STI/HIV education, and services to adolescents (Napili, 2016). This program is implemented through health departments, community health organizations and other nonprofit agencies (Fowler, Gable, Wang, & Lasater, 2018). In 2015, approximately 4 million people were served under this grant and 18% of clients were 19 or younger (Napili, 2016). Adolescents rely on these services for STI/HIV testing, pregnancy testing, contraceptives, and various other family planning services. Title X funding also makes community outreach and education on reproductive health issues possible (Napili, 2016). Through community collaboration, serfvice providers can become more knowledgeable about the organizations that provide sexual health services and education. Service providers can leverage local resources by identifying organizations that receive Title X funding and collaborating with them to provide sexual health education programming for juvenile offenders.

Sexual Health Education Exit Program for Incarcerated Youth

As a policy recommendation specific to incarcerated youth, sexual health education should be provided prior to juvenile offenders leaving the detention facility. The Department of Juvenile Justice is responsible for supervision and detention along with providing educational, mental, and behavioral health services for juvenile offenders (National Commission on Correctional Health Care, 2015). Sexual health must be included within this existing policy. Exit programs should consist of abbreviated versions of general sexual health education and community resources available for adolescents. These short sessions, approximately 30 minutes, can be administered by detention center staff, prior to the juvenile offenders' release from the detention center.

Sexual Health Training for Service Providers

Service providers mentioned training as an important factor impacting juvenile offenders' access to and use of sexual health services. A study conducted by Karimian et al. (2018) examined sexual health training modules provided to health care professionals. The study revealed that the sexual health training modules assessed were primarily designed for physicians (58%) and the remaining for nurses, midwives, and other allied health professionals (Karimian et al., 2018). Training programs for service providers outside the health care sector are lacking. Health care professionals may not be the first ones to discuss sexual health topics with juvenile offenders. Developing a training module for service providers, potentially adapted from health care provider resources (Altarum Institute, 2019), can offer the educational component service providers indicated was lacking.

Training offered to service providers should promote positive aspects of sexual health, rather than focusing on the assumption that adverse sexual health is a result of socially

unacceptable behaviors (Ford, Barnes, Rompalo, & Hook, 2013). Ford et al. (2013) emphasizes taking a sexual health approach, whereby service providers are trained in comprehensive sexual health education, as opposed to solely addressing disease prevention. Educating service providers on how to discuss sexual health topics with juvenile offenders may increase their level of comfort and create an environment where sexual health conversations are common and prioritized. Education for service providers should be implemented by public health professionals well versed in sexual health education. These individuals stem from community organizations, such as local health departments and clinics. Public health professionals are equipped to provide sexual health training from a comprehensive, medically accurate perspective.

Mandated Evidence-Based Sexual Health Education for Juvenile Offenders

Evidence-based sexual health education should be mandatory for incarcerated and nonincarcerated juvenile offenders. Service providers mentioned abstinence-only sex education in Georgia as impacting the types of conversations they had with their juvenile offending clients. Although much emphasis is placed on abstinence-only education, the results of a meta-analysis suggest that abstinence-only programs do not delay the initiation of sexual intercourse or reduce the number of sexual partners for teens (Kirby, 2007). Research indicates that effectiveness at reducing sexual risk behaviors for youth has not been demonstrated with abstinence-only programs (Kirby, 2007).

The CDC recommends implementing evidence-based sexual health education programs (Centers for Disease Control and Prevention, 2009a). Evidence-based programs demonstrate proven effectiveness in reducing sexual risk behaviors. Addressing program effectiveness is important because with high rates of unplanned pregnancies and STIs in the South, finding a

program that works is critical (Malone & Rodriguez, 2011). Additionally, with limited funding available, policy makers are uninterested in providing funding for programs that do not work (Malone & Rodriguez, 2011).

Further examination around Title X finding is warranted, especially when discussing providing sexual health education to juvenile offenders. Current Title X funding is 40% of what is needed to meet family planning needs in the United States (August et al., 2016). Critics of this funding fear financial resources are being contributed to abortions. However, Title X funds are closely monitored to ensure funds are allocated appropriately and not used for prohibited services such as abortions (Napili, 2016). Reducing this funding limits the ability of organizations to provide health education services to the adolescent population, which includes juvenile offenders.

Providing evidence-based sexual health education programs for juvenile offenders in Georgia is one strategy to help reduce the high rates of STIs and unplanned pregnancy experienced by this population. Making participation in this program mandatory, allows juvenile offenders to be provided with this knowledge regardless of whether they have conversations with their parents or service providers. Offering sexual health education to this population provides them the tools they need to engage in healthy decision making.

Probation Requirements Include Sexual Health

As a policy recommendation, sexual health education should be included as a probation requirement for juvenile offenders. Similar to juvenile offenders with drug offenses being required to participate in substance abuse programs, sexual health education should be incorporated into these requirements. However, requirements to participate in the program

should not be solely based on the juvenile offenders' offense but be mandatory for all juvenile offenders on probation.

Implications and Recommendations for Researchers and Practitioners

This study contributes to the literature by exploring the policies and procedures impacting juvenile offenders' access to and use of sexual health services, an understudied area of public health research. Interviewing service providers provided further insight into the experiences of a range of service providers working to address the sexual health needs of juvenile offenders. The research study also demonstrates the need for sexual health training among service providers outside traditional health care settings. Additionally, this study provided the foundation for developing policy recommendations that can be implemented at each level of the socio-ecological model.

Qualitative methods allowed the researcher to gather rich data from service providers working directly with juvenile offenders. Although the researcher identified qualitative methodology as the best choice data collection, future research should include designing a similar study incorporating quantitative methodology. Now that there is an emergent grounded theory framework, future research should examine the barriers and facilitators from a quantitative research perspective. Using existing or developed scales, future research could further explore the barrier(s) and/or facilitator(s) making the largest contribution to juvenile offenders accessing and using sexual health services.

Future research should also include a larger number of service providers in the study sample. Additionally, the types of service providers should include law enforcement officials. Law enforcement, including probation officers and judges, may provide a different perspective on juvenile offenders' access to and use of sexual health services. A similar study could be

completed within one specific organization. Focusing on the different types of service providers within an organization can allow the researcher to examine the provision of sexual health services for juvenile offenders.

For public health and health promotion professionals, it is imperative to address the sexual health needs of juvenile offenders. This can be done by using our extant knowledge to provide sexual health education resources to juvenile offenders through service providers or community organizations. Furthermore, implementing evidence-based sexual health education programs should be offered to both incarcerated and nonincarcerated juvenile offenders. For service providers, initiating conversations about sexual health topics is necessary for this population.

Strengths and Limitations

The strengths and limitations of the study must be noted. First, the main strength of the study was the methodological approach. Conducting a qualitative study using semistructured interviewing allowed the rich experiences of service providers to be highlighted. Semistructured interviewing also allowed the researcher to make changes to the interview protocol as a result of the responses of participants. Using a grounded theory approach allowed the researcher to organize and analyze data in such a way that the comments presented by the service providers would lead to the development of a conceptual framework. Second, the researcher was able to interview a range of service providers to gain insight into how the sexual health needs of juvenile offenders are addressed, current sexual health services, and barriers and facilitators impact access to and use of sexual health services for this population.

A few limitations existed with this qualitative study. First, accessing service providers that work directly with juvenile offenders was difficult. As a result, the sample size for the study

was limited. However, the small sample size did not derail the quality of the study. The interview data was rich, which resulted in the development of a theoretical framework. Second, researcher bias is more prominent within a qualitative study. To minimize biases, measures of validity and reliability, also known as trustworthiness, were carried out throughout the research study. Third, data collection from individuals within various organizations that provide services to or whose work impacts adolescents involved in the justice system is limited to those who respond to the study. As a result, not all organizations that work with juvenile offenders were represented during the interview process. Lastly, this sample did not consist of service providers within the law enforcement sector. Their perspectives could have provided insight into the responsiveness of the justice system in addressing the sexual health needs of juvenile offenders. The service providers who did participate in the study represented community-based organizations, government agencies, and organizations collaborating with the juvenile court system. Perhaps the fact that the study sample was not directly connected to law enforcement allowed for their unrestricted participation in the research study.

Summary

This study provides insight into how service providers identify sexual health needs for juvenile offenders and in turn provide or link them to the necessary services. Additionally, this research presents the barriers and facilitators impacting juvenile offenders' access to and use of sexual health services from the perspective of the service provider. The overarching goal of this study was to develop a framework that can be used by organizations to understand the barriers and facilitators impacting service providers' ability to address the sexual health needs of juvenile offenders. This study provides evidence for the need for training for service provider to discuss sexual health topics with juvenile offenders. Emphasis should be placed on service providers

seeking continuing education to enhance their comfort and knowledge base around discussing sexual health topics with juvenile offenders. Additionally, the qualitative data collected during semistructured interviews reveals that service providers need support from public health professionals and policy makers to address the sexual health needs of juvenile offenders. The presented policy recommendations address some of the barriers experienced by service providers at each level of the socio-ecological model. It is up to service providers, public health professionals, and policy makers to create a system where addressing the sexual health of juvenile offenders is considered important and necessary.

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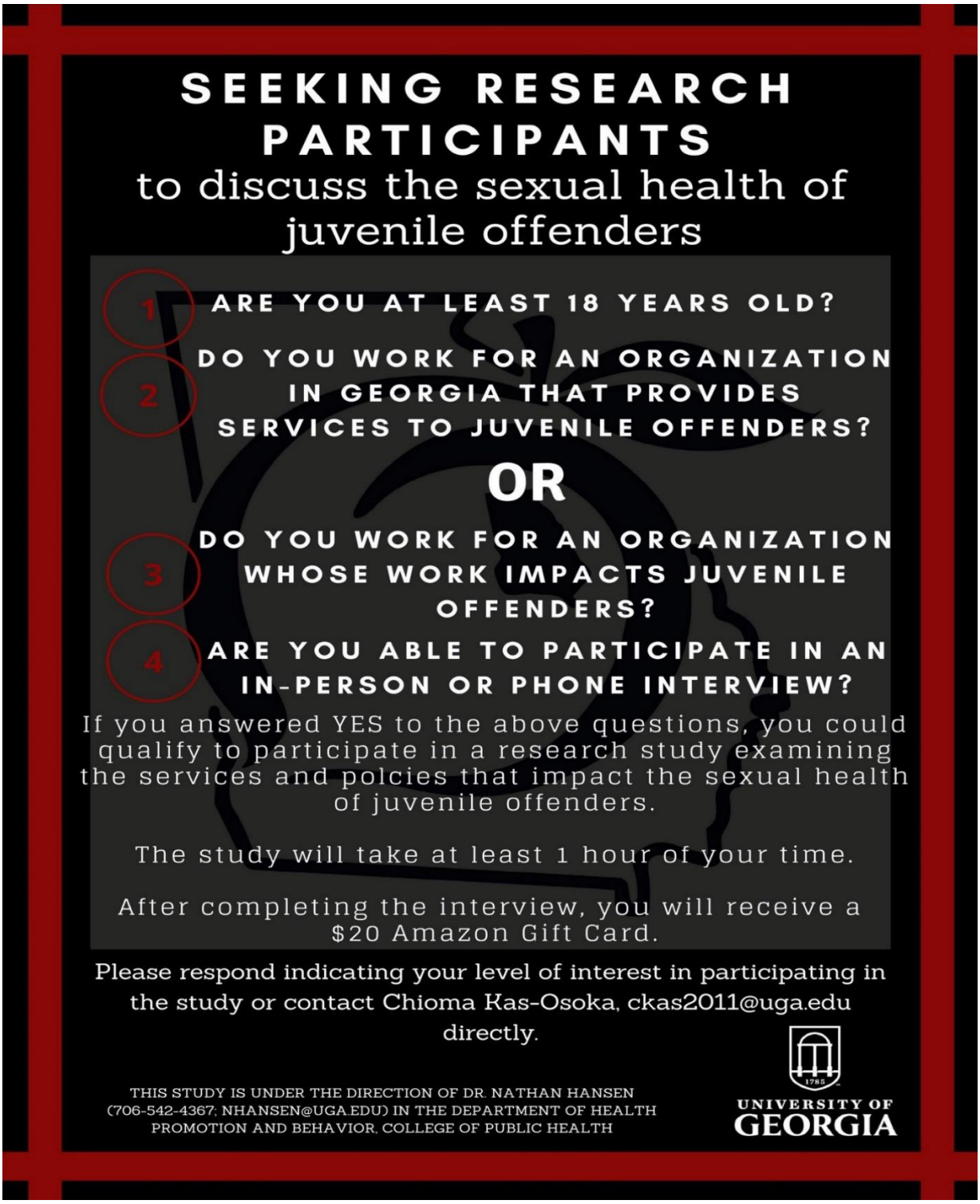
APPENDIX A: RECRUITMENT FLYER



APPENDIX B: INTERVIEW PROTOCOL

Hello! My name is Chioma and I am PhD Candidate at the University of Georgia. I wanted to thank you for agreeing to participate in this interview. I will be talking with individuals like you who provide services to or conduct work that impacts the sexual health of juvenile offenders. It is our hope that this information will be used to create and strengthen sexual health services provided to juvenile offenders.

Before we start, I need you to verbally consent to participating in the study. This will give you an opportunity to learn more about the research project. After you review the consent form, you can decide if you would like take part in the interview or not.

(Review consent form and ask for verbal consent before continuing.)

Our session today will last 30-60 minutes and will be recorded. This will help me recall what you said and accurately portray your responses. Only researchers who are part of the study will have access to this information and the information you provide will not be shared with others without your permission. Everything we discuss is confidential. Your ideas will be described generally, and no names will be linked to specific comments. Do you have any questions?

I would like to get a better understanding of your role in relation to juvenile offenders and what services and policies may impact the sexual health of these youth. I will begin by asking you questions about your current position and then addressing the organization you work for.

1. How long have you been working with adolescents involved in the juvenile justice system?
2. Tell me a little about your agency.
    a. Tell me about your position within your agency.
3. How is it that you became involved in the work that you do?
4. How do adolescents end up coming in contact with you?
5. What does a typical work day look like for you?
6. What are some of the sexual health needs of the adolescents you serve?
7. I'd like you to think about a time when sexual health has been an important topic for the adolescents you work with.
8. How does your organization determine the sexual health needs of adjudicated adolescents?
9. Who is involved in determining the sexual health needs of adjudicated adolescents?
10. Tell me about communication between your organization and other organizations? (Probes: sexual health education, notification of testing, etc.)?
11. What sexual health services does your organization provide to adjudicated adolescents?
12. What standards does your organization use to determine what programs are offered to adjudicated adolescents? (Probe: metrics, standard policy, etc.)

13. What are some of the challenges your organization faces in providing sexual health services to juvenile offenders?
14. What would you say are unmet needs in your agency service delivery?
15. Do you have any recommendations regarding sexual health for people who make policies for juvenile offenders?
16. What are some of the organizational challenges to linking adjudicated adolescents to sexual health services?
    a. How did the organization manage this challenge?
    b. What are ways it was not managed?
17. What are some suggestions to improve the way juvenile offenders use services?

APPENDIX C: CONSENT FORM

Dear Participant,

My name is Chioma Kas-Osoka and I am a doctoral student in the Department of Health Promotion and Behavior at the University of Georgia. how organizations address the sexual health needs of juvenile offenders.

I am looking for participants who are currently serve in organizations that provide services for or whose work impacts the sexual health of juvenile offenders. If you agree to take part in the study, you will be asked to participate in a one-on-one interview either in person or on the phone to discuss your experiences addressing the sexual health needs of juvenile offenders.

Participation is voluntary, and you do not have to answer any question you do not feel comfortable answering. You can also stop participating at any time without penalty. Your decision to participate will have no impact on your employment status.

Your responses may help us better understand how organizations address the sexual health needs of juvenile offenders. Your responses will help us develop recommendations for creating and implementing sexual health services and policies for this population.

The interviews will be 30-45 minutes, will be voice recorded, and conducted in a location of your choosing. Names will not be recorded. No identifying information will link your responses to your employment agency. The recordings will be destroyed once the study is analysis is complete. You will receive s $20 Amazon Gift Card for participating in the study.

If you are interested in participating or have questions about the study, please feel free to contact Chioma Kas-Osoka, (408) 646-6797, ckas2011@uga.edu or my major professor Dr. Nathan Hansen, (706) 542-3313, nhansen@uga.edu. If you have any questions or complaints about yo0ur rights as a research participant, contact the Chairperson, University of Georgia Institutional Review Board (IRB); telephone (706) 542-3199; email irb@uga.edu.