



# Addressing the Specific Health Care Needs Of Female Adolescents

By Michelle Staples-Horne

**D**uring the past two decades, girls have entered the juvenile justice system in increasing numbers, at younger ages and with greater needs. In a traditionally male-dominated environment, girls have gender-specific health needs that the system may be ill-equipped to serve.

Female juvenile offenders — an adolescent subgroup that has been understudied and underserved — are at increased risk of adverse health outcomes relative to non-incarcerated adolescent populations. This may be due to their prior criminal activities, physical and sexual abuse, lifestyle, and high-risk behaviors. Poor academic performance and learning disabilities are also common in this group. Gender-specific programming must be adapted to fit their developmental stage and educational level.

## Health Issues Affecting Juveniles

Members of this subgroup may already be medically underserved because they are less likely to have access to routine health care. Juvenile offenders, in general, seldom seek preventive care or maintain routine medical visits. Their immunizations are not kept current, and preventive counseling and appropriate screenings are not completed. Most adolescents interfacing with the correctional system only access medical care in the community in acute situations, and then, usually through an emergency room rather than through a primary care provider. Many are uninsured and have parents who lack the financial resources to pay for medical care out of pocket.

Despite the popular belief that juvenile offenders are healthy because of their youth, they are not a group without medical problems. The public's perception is often that these youths are "well enough to get in trouble." Ironically, it is just that behavior of getting into trouble that places them at greater health risk. Smoking, alcohol and drug use, risky sexual behaviors with multiple sex partners and lack of condom use, weapon use, violence, and other risk-taking behaviors place these youths at increased risk of morbidity and mortality. Detention centers and other secure juvenile settings offer an opportunity to conduct health assessments, diagnose and offer treatment to girls who may otherwise not have received health care in their communities.

Although increasing numbers of female juvenile offenders create a challenge to the juvenile justice system, it is particularly important to address the health care needs of this population. Evidence suggests that incarcerated female adolescents are likely to have significant medical problems, including untreated sexually transmitted infections (STIs), pregnancies lacking prenatal care, chronic medical conditions, substance use and psychiatric disorders. Yet, most do not have a regular source of medical care, and more than half may not have families who are able or willing to help them seek medical care. Many have parents who are incarcerated themselves.

## Specific Diagnoses

Some of the most common categories of health-related issues found among female juvenile offenders in correctional settings include STIs, pregnancy, substance abuse and

mental health disorders. However, there are other acute and chronic medical conditions represented in this population as well. Mental health diagnoses, obesity, diabetes, hypertension and asthma show an increasing prevalence among female juvenile offenders and may be consequences of their other lifestyle factors.

Females detained for legal offenses represent a highly vulnerable population for the acquisition and transmission of STIs. Data from the Centers for Disease Control and Prevention indicate that rates of gonorrhea were 42 times greater among adolescent female detainees than female adolescents from the general population. Surveillance surveys have consistently indicated high rates of chlamydia, gonorrhea and trichomonas infection among detained adolescents. Studies have shown that between 10 percent and 28 percent of detained adolescent females tested positive for chlamydia. Likewise, studies have also shown that between 5 percent and 13 percent of detained adolescent females tested positive for gonorrhea. Trichomonas may also be a common sexually transmitted disease among detained adolescent females. Another study assessed the prevalence of genital herpes in a sample of detained female adolescents at 20 percent. Numerous studies have demonstrated that detained youths are more likely than adolescents from the general population to engage in risky behaviors that may lead to infection with HIV. And high rates of STIs further increase the risk of acquiring HIV infection. Detained youths were significantly more likely than youths attending school to be sexually active, initiate sexual activity before age 12, report having multiple sex partners and report injection drug use. Female juveniles may exchange sex for money or use sex as a survival tool for food and shelter. Despite these high-risk behaviors, condom use rates are low in this population.

Health-education programs designed to promote STI-protective behavior among female adolescents are feasible and beneficial in detention facilities. Early sexual experimentation and high-risk behaviors in this population should mandate sexuality education as a component of an effective program. Gender-specific educational programs should address anatomy and physiology, self-care, self-esteem and healthy partner relationships. Because so many girls who become delinquent have a history of sexual abuse, sex education can also help them separate past abuse from healthy sexual relating. Because girls are usually released to society more quickly than adults, these programs should emphasize the benefits and promote the use of condoms for STI prevention.

Pregnancy and its associated parenthood represent two health care issues that are unique to female offenders. Management of these issues requires attention to adolescents' current needs (e.g., the need for prenatal and postpartum care) and future needs (e.g., the need to avoid

repeat pregnancy, contraceptive information and parenting skills). These programs may be most effective if they address multiple aspects of the female adolescent's life, including examination of her potential motivations to purposefully conceive.

Data from a variety of sources suggests that substance abuse is highly prevalent among incarcerated adolescents in general. In 2000, the federal Arrestee Drug Abuse Monitoring (ADAM) program released its first public report that detailed findings from drug tests conducted among incarcerated adolescent females. Data for five drug assays (marijuana, cocaine, methamphetamines, opiates and PCP) administered to female juvenile offenders were reported from six cities throughout the United States (Denver; Phoenix; Portland, Ore.; San Antonio; San Diego; and Tucson, Ariz.). Marijuana was the most commonly detected substance, with 20 percent testing positive across the six sites. Cocaine use was the second most prevalent substance detected, with rates as high as 17 percent (Tucson). Methamphetamines were the third most commonly detected substance. Compared with male offenders, females were much more likely to test positive for methamphetamines. Opiate use was rare, and PCP was not detected among

females at any of the six sites. Females are also more likely to inject drugs, posing risk factors for the acquisition of hepatitis B, hepatitis C and HIV infection. Substance abuse, including binge drinking, among adolescent female offenders creates its own morbidity and may predispose them to a variety of other risk behaviors such as injection drug use, unprotected sex with multiple partners and further delinquent behavior.

In most cases, girls were victims of physical and sexual abuse before they became offenders. Internalization of

feelings associated with this abuse may present as self-harm through prostitution, substance abuse, eating disorders, self-mutilation or other self-harm behaviors. Other internalizing disorders may manifest themselves as depression and/or anxiety disorders. As a result of the abuse, some will even lash out violently at the perpetrator or others, exhibit oppositional or defiant behavior, or develop a conduct disorder.

Girls are three times as likely to have been sexually abused as boys. In some detention facilities, the incidence of abuse for girls is close to 90 percent. Most are victimized by family members or close family friends perceived as trusted adults. Girls are even more likely to have been physically abused. A considerable body of literature has firmly established the relationship between adolescents' reports of physical/sexual abuse and multiple forms of subsequent mental illness. A history of traumatic stress may lead to a definitive diagnosis of post-traumatic stress

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disorder or at least interfere with a girl's ability to learn and function appropriately in society. Screening for trauma (including physical and sexual assault, illness and injury, witnessing violence, and loss) is recommended along with subsequent treatment. Female juvenile offenders are considerably more likely to have a history of mental health issues such as major depression and bipolar disorder. Many of these problems may manifest or progressively intensify during periods of incarceration.

## Where to Start

A health screening and examination is essential for adequate assessment of the health status of all youths entering juvenile correctional facilities. The purpose of the medical screening is to determine if any current or past medical, mental, dental or allergic conditions exist; whether drug intoxication or use is present; whether communicable diseases are present; and if there is a need for medication and treatment. Also essential are mental health questions relating to previous mental health diagnoses, previous hospitalizations, and suicidal ideations or intent.

A full health assessment for youths should include screening information and a review of body systems for current and past complaints, vital signs, and laboratory and diagnostic tests to meet the community standard of health care. Screening recommendations include a dipstick urinalysis and pregnancy test, hemoglobin count, STI screening, and a skin test to determine exposure to tuberculosis. A determination of the adolescent's immunization status should also be determined as part of the health assessment. Immunization updates should be provided as clinically indicated. Vision and hearing screenings should be conducted because many youths have unrecognized and undiagnosed difficulties in these areas. Dental screening and the availability of dental care and treatment are necessary in this population because many have never had a dental visit. The hands-on physical assessment should be specific to the adolescent female population and should include age-appropriate screenings such as a scoliosis test, a breast examination and a gynecological assessment.

Girls often enter juvenile correctional facilities with undiagnosed medical conditions or problems that were identified earlier but did not receive proper follow-up. Sometimes conditions, such as congenital heart defects, are detected but not followed up with until the adolescent reaches a juvenile correctional setting and receives an adequate health assessment.

A sick-call process must be established to meet the acute health care requirements of incarcerated females and to ensure unimpeded access to health care. The process should allow youths to directly request sick-call

visits without permission or intervention by security staff. Chronic medical conditions should be monitored in a manner consistent with the community standard of care.

While important, the provision of health care to female adolescents in an environment of incarceration may present a challenge to health care providers as well as to administration and security staff. To begin, the health care model may be perceived by security staff as foreign and even contradictory in a correctional setting. Fulfilling security requirements remains the correctional facility's primary goal. Assuring that the juvenile offender receives unimpeded access to health care is the primary goal of the institution's medical provider. On the surface, it may seem that these two goals are in conflict with one another. But it is indeed possible for both goals to be met simultaneously. In order to do so, it is critical to involve medical staff and security staff in the development and implementation of the health

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care program, following prescribed health care standards. Issues that impact the operation of the medical program in the context of operating a secure facility should be discussed in joint meetings. Common ground must exist for correctional and health care staff in the development of policies and procedures that will meet the goals of both areas.

Providing health services to female juvenile offenders requires an interdisciplinary approach to staffing and program development. The inclusion of licensed health professionals is important in staffing a juvenile correctional facility, but line staff also must be well-trained and attend educational programs relating to medical needs specific to the population served. Facility and community staff should participate in the development of a treatment plan continuum for the juvenile offender upon her return to the community.

A female offender's history of victimization may make compliance with simple medical regimens an issue. Emotional reactions may trigger somatic responses such as a herpes outbreak or gastrointestinal upset. Sometimes this leads to the perception by staff that the offender is being manipulative or pretending to be ill. All staff should be trained to take all medical complaints seriously and respond appropriately. Medical staff should be aware of the health problems that are more likely to affect black girls, who are disproportionately represented in the juvenile justice system. Cultural sensitivity on the part of medical, administrative and security staff is mandatory and should go beyond just creating cultural diversity through staff hiring.

In a juvenile facility, greater health care expenses should be anticipated when providing health services to females. Females, in general, experience a higher use of medical care in the community. Staffing patterns and ratios at facilities serving females should reflect this increased use. The greater prevalence of chronic diseases, including

mental health diagnoses and the provision of prenatal care and delivery, also tend to accelerate expenditures for female juvenile facilities. Medicaid exclusions for the provision of health care to incarcerated youths and the uninsured status of most incarcerated youths can create a financial burden on facilities and correctional agencies that provide quality health care. Despite financial constraints, the community standard of care must be maintained, if not exceeded, for this medically underserved population that has a constitutional right to health care while incarcerated. Also, society benefits when infectious diseases are identified and treated in a population that will eventually return to society. An improved health status and medication compliance may also impact recidivism and reduce the number of girls returning to the system.

## Conclusion

The vast majority of female juvenile offenders have been underserved by their families, schools and communities. Indeed, periods of incarceration may often comprise the only opportunity these adolescents have to receive medical and dental care and preventive services. The detention period also offers the opportunity to present disease-prevention and health-promotion messages to female offenders engaging in high-risk behaviors. Gender-specific prevention and treatment programs, tailored to the unique needs of female juvenile offenders, constitute an essential starting point for addressing these missed opportunities.

Indeed, the Juvenile Justice and Delinquency Prevention Act specifies that programs should be established that meet the full range of health needs (e.g., mental health, substance abuse, and physical and sexual assault) experienced by female offenders.

Effective programs provide girls with comprehensive health services that promote physical and mental wellness, good nutrition, exercise, reproductive health, disease prevention, and stress management. Other health-education programs should address smoking, alcohol and drug use, with resources for treatment programs available. Behavioral management programs are essential, because most juvenile offenders have difficulties with anger management and nonviolent conflict resolution.

There is a critical need for advocates to provide health services to this special population of adolescents. Greater involvement by the medical and legal community may assist in this effort. The impact on the health and wellness of these youths during their period of incarceration will have a direct effect on the health and wellness of them as emerging adults as well as the community to which they return.

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