

Tapping the “town and gown” potential for correctional health research collaborations

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ABSTRACT

Background: Collaborations between juvenile justice systems (town) and academia (gown) promise to significantly enhance what we understand about high rates of sexually transmitted infections (STIs) found among detained populations, particularly African American young women. However, research related to the sexual health of adolescent detainees has not occurred in proportion to the magnitude of issues found in the population. While there are many challenges to conducting research with this population, there are also lessons learned and best practices from other studies that may provide guidance.

Methods: In 2015, we implemented a pilot project with young women in a detention center to understand the association between STIs and relationship dynamics. Using a formative assessment-based approach, the team periodically compared expectations to actual milestones and outcomes. This approach has provided feedback, guidance and lessons learned that we will use to adjust our pilot project.

Results: Three challenges emerged from our review: concerns related to different agendas, bureaucratic difficulties and human protection. In addressing these challenges, we identified study procedures to revise and to incorporate into future works.

Conclusions: Juvenile justice and academic partnerships require extensive pre-research work to account for the many challenges to implementing and conducting projects with this population. However, “town and gown” approaches to understanding and improving the sexual health of detainees can result in a more complete assessment of these issues compared to either a solely academic or juvenile justice investigation.

Key words: adolescent sexual health; sexually transmitted infections; town and gown; juvenile justice; health research collaborations

INTRODUCTION

Sexual Health of Juvenile Detainees

Collaborations between juvenile justice systems (town) and academia (gown) promise to enhance understanding of STIs, which are prevalent among detained African American women aged 16 – 21. STIs in Georgia are problematic, since the state is among the top ten for rates of infection for several diseases. The Centers for Disease Control and Prevention found, based on 2013 data, that Georgia ranked first for primary and secondary syphilis, eighth for gonorrhea, and ninth for chlamydia (Braxton et al., 2014). Young women (aged 15 – 19) had a rate of 3,043 per 100,000 for chlamydia and a rate of 459 per 100,000 for gonorrhea (Braxton et al., 2014).

African American adolescents and women are at greater risk of acquiring STIs, including HIV, than any other racial or ethnic female population (Dolcini, Harper, Boyer, & Pollack, 2010; Hawk, 2013; Morrison-Beedy et al., 2013;

Painter et al., 2014; Sales, Brown, Diclemente, & Rose, 2012; Sales, DiClemente, Davis & Sullivan, 2012). Despite the disproportionate rate of STIs among African American young women with a juvenile detention history and their risk of acquiring STIs/HIV, few investigations (in proportion to their STI/HIV risk) have involved this population (Woodson, Hives & Sanders Phillips, 2010). Investigations involving the broader population of young African American women show that this group is more likely to engage in high-risk sexual behaviors than their non-high risk peers, have more lifetime sexual partners, engage in sex while high on drugs and alcohol, lack self-efficacy related to condom use, do not use condoms consistently, and are more likely to have STIs (Danielson et al, 2014; Herrman & Waterhouse, 2012; Morrison-Beedy et al, 2013).

A national survey found that 44% of young African American women had at least one STI compared to 24.1% for all young women (Raiford, Seth, & DiClemente, 2013).

Studies involving young women have linked high-risk sexual behaviors and increased risk of STIs/HIV to experiences of trauma, such as intimate partner violence and exposure to violence (Adelson et al., 2012; Raiford et al., 2013; Sales, DiClemente, et al., 2012; Voisin, Tan, & DiClemente, 2013; Wilson, Woods, Emerson, & Donenberg, 2012; Woodson et al., 2010). Young African American women with a detention history, relative to their non-detained peers, have higher rates of STIs and are diagnosed with more mental health issues, such as depression, that often can be attributed to trauma (Herrman & Waterhouse, 2012; Rosenberg et al., 2014).

In addition to the immediate and direct impact that STIs have on the health of young women, these diseases also have long-term effects. According to the U.S. Department of Health and Human Services, Office on Women’s Health, STIs in women can lead to cancer, infertility, pelvic inflammation, infections in other areas in the body, and organ damage ("Sexually transmitted infections (STI) fact sheet," 2012). Further, the Office on Women’s Health indicates that chlamydia and gonorrhea in pregnant women can lead to low-birth-weight babies and babies with blindness, deafness, and/or brain damage ("Sexually transmitted infections (STI) fact sheet," 2012). These findings are compelling with respect to the need and urgency to investigate STIs among a population most affected. We propose that collaboration between the juvenile justice system and academia provides an effective approach in which academics contribute expertise, such as research methods, and juvenile justice provides knowledge related to corrections and the population.

Academic and Juvenile Justice Research Collaboration

Although the Georgia Department of Juvenile Justice (DJJ) – Institute of Public and Preventive Health is not the first “town and gown” partnership to deal with STIs and detained populations, we propose that more collaboration is necessary to reduce the disparities in rates of STIs for this vulnerable population, as evidenced by the limited number of intervention studies and their lack of effect on detained populations.

Three STI/HIV risk reduction interventions (*Safe on the Outs*, *Young Women Get Real Program* and *IMARA*), involving adolescent detainees and juvenile justice – academic collaborations, were identified (See Table 1). *Young Women Get Real Program* and *IMARA* were piloted with young women in juvenile detention. The *Young Women Get Real Program*, which was unable to demonstrate effectiveness, did not focus on relationship dynamics or attend sufficiently to the cultural needs of the population (Herrman & Waterhouse, 2012). *IMARA* had no effect on condom use of the population but increased self-efficacy for condom use (DiClemente et al., 2014). The three interventions, which were implemented in detention settings, shared limited effectiveness and had only a short-term impact, suggesting the need for additional research into the factors associated with the high prevalence of STIs among adolescents involved in the juvenile justice system and the need to develop interventions with long-term effects.

Table 1: HIV Risk Reduction Interventions with Adolescent Detainees

Intervention	Gender	Race/Ethnicity	Framework	Goals*	Effects
<i>Safe on the Outs</i> (Bryan, Schmiede, & Broaddus, 2009; Schmiede, Broaddus, Levin, & Bryan, 2009)	Male (83%) Female (17%)	White (37%) Latino (28%) Other (15%) African Amer. (13%) Amer. Indian (5%) Asian Pacific Is. (3%)	•FRAMES structure •Motivational Enhancement Therapy •Social Cognitive Theory •Theory of Planned Behavior	2,5	Increased condom use. Decreased alcohol problems.
<i>Young Women Get Real Program</i> (Herrman & Waterhouse, 2012)	Female (100%)	African Amer. (100%)	•Health Belief Model •Social Self-regulation Theory •Theory of Reasoned Action •Social/cognitive Learning Theory	1,3,4,5,6	No changes in knowledge, attitudes or behaviors.
<i>IMARA (SiHLE adapted)</i> (DiClemente et al., 2014)	Female (100%)	African Amer. (100%)	•Social Cognitive Theory •Theory of Gender and Power	1,3,5	Increased self-efficacy for condom use, skills and HIV/STI knowledge. No change in consistent condom use.

*Goals: 1. Skills building regarding risk behaviors. 2. Substance use treatment/management. 3. Knowledge about HIV risks. 4. Healthcare/resource navigation. 5. Protective behaviors (condom use). 6. Parenting.

Addressing Juvenile Justice Health Research Challenges

The purpose of this report is to share our experience in investigating one aspect of health among juvenile detainees; other researchers may find it valuable for planning or implementing studies with this population. Investigators who have worked in juvenile justice systems understand that there are challenges in regard to implementing research projects with detained populations. In developing the concept for this project, we identified three challenges that we expected to encounter but would be able to address: (1) mutual misperceptions between juvenile justice systems and academia with respect to different agendas and level of transparency (e.g., research findings); (2) collaboration, even when juvenile justice systems and academic institutions desire to do so, can be bureaucratic and difficult to navigate; (3) and daunting requirements and reluctance of Institutional Review Boards to sanction research involving two protected populations (children and prisoners). Due to the collaborative nature of the project, these challenges were addressed.

“Town and Gown” Approach to Promote Shared Agenda

Conferences and workshops, the juvenile justice – academic relationship for this project was developed over several years. During these meetings, the academic and juvenile justice colleagues fostered and developed a trusting relationship, particularly in regard to conducting research in the interest of detainee health and collaborating as equal partners. The relationship is comprised of the DJJ Central Office, a DJJ facility, and academic researchers at the Institute of Public and Preventive Health (IPPH) at Georgia Regents University. The lead investigators at DJJ and IPPH, along with colleagues from both institutions, developed and implemented the study.

With this collaboration, academic and issues were considered, and a vision for the objectives, implementation, analysis, and reporting was developed. A willingness of both parties to negotiate and revise the proposed study design based on existing and emerging issues was essential. Initially, the academic partners were primarily interested in a study of HIV risk reduction. However, the prevalence of HIV infections among this population was low, but rates for chlamydia and gonorrhea were high. After evaluating DJJ data, the focus was shifted to STIs and psychosocial factors, as they relate to HIV risk reduction.

In building the relationship, the academic partners, although having experience in collaborating with correctional personnel, acknowledged a lack of expertise in correctional management, operation and limited day-to-day exposure to aspects of the juvenile justice system. The experience of the team suggests that clarifying the research goals, expectations, and limitations of both organizations with respect to management and operational issues enhanced the relationship, minimized concerns about trust, established transparency, and provided guidance on minimizing the research footprint.

Navigating the Juvenile Justice System

The juvenile justice system, a large bureaucratic and complex organization that serves multiple functions, varies from one jurisdiction to another in regard to health services, operations, and structure. In Georgia and in other jurisdictions, the juvenile justice system is comprised of community placement, such as group homes, and secured settings. Community placement typically involves probation/parole or some type of supervision. Secured settings require the highest level of supervision, for adolescents are detained in an enclosed environment where the juvenile justice system provides and controls most aspects of their lives.

Georgia has two types of secure settings: regional youth detention centers (RYDCs, typically for short-term confinement pre- or post-adjudication) and youth development campuses (YDCs, for long-term confinement for serious offenses) (“Facilities and Programs Overview,” 2015). The population is housed in an RYDC, which allows investigation of STIs and psychosocial factors in a fluid population. Psychosocial factors may be more salient for this population, which has more recent *free-world* experiences than YDC populations. The academic partners were familiar with the structure of the juvenile justice system, but there was a need to understand juvenile justice operations.

As strategy was mapped and plans were made to implement the project, we attended to the competing interests that juvenile justice systems address, such as balancing health and security, maintaining the safety of staff and juveniles, and providing basic living needs, including social and recreational ones, while providing a secure environment. Juvenile justice systems must meet stringent accreditation standards, adhere to shifting governmental edicts (legislative, executive and judicial), attract and retain staff, and manage tight budgets. We also considered the context (e.g., detainees, health care, counselors, officers, education, and programs) in regard to when and how to integrate the project.

In a highly structured and organized way, juvenile justice systems provide for the health, education, social, and safety needs of detainees. Research projects can be unintentionally intrusive and interruptive. The aim was to have a small footprint and not expand the responsibilities of facility staff or require resources beyond normal operations. In collaboration with the DJJ staff, health education classes were identified as the most appropriate and least intrusive venue in which to recruit participants and seek assent. How and when to interact with detainees and parents/guardians required discussions between juvenile justice and academic participants. Prior to discussions with facility staff, we had planned to mail consent forms to parents. The facility staff suggested, however, that we could, during visitations, use the lobby unobtrusively to request parental or guardian consent.

Throughout the planning and implementation phases, exchanges of ideas and negotiations between partners characterized the project and helped to maintain

commitment to the shared goal. We suggest that the commitment from the DJJ can be attributed largely to our relationship with their Central Office and to the potential impact our research project on reducing STIs, which is relevant to their operations, goals, and mission. Such commitment likely could not have been earned without our colleagues in the Central Office, who worked with facility staff and understood operations and issues. We aim to maintain a small footprint, sharing findings and collaboratively proposing recommendations.

Obtaining Sanction to Work with Detained Juveniles

Since detained juveniles are a doubly protected population, we expected scrutiny from our institutional review board (IRB) and the DJJ review committee to ensure that their rights were protected. For our IRB, detainee populations were a new consideration and required the members to learn more about juvenile justice systems. Having experience with other IRBs and other correctional projects, we anticipated and addressed concerns prior to submitting the protocol. The concerns included the following:

- **Recruitment method.** Defining our inclusion/exclusion requirements; how we would identify potential participants; the process for obtaining consent and assent; a follow-up process for consent; and identification of project roles for each stage of recruitment.
- **Procedures.** The administration of the instrument including when, where, and the duration; what data we would collect and how it would be collected; a data management plan; how we would reduce risk; and an explanation of how our procedures would adhere to regulations, particularly 45 CFR 46.303(d), which governs research with prisoners, and Subpart D, which pertains to children.
- **Confidentiality.** Since we were collecting data from multiple sources, it was necessary that we collect protected health information data, i.e., institutional identification numbers. These numbers allowed us to link the different data sources. We explained our process for collecting data from multiple sources, linking data and de-identifying data at the conclusion of the data collection phase.

We drafted an IRB protocol that required only minor modifications, such as revising the assent document to emphasize the right of detainees to participate or not to participate in the study.

Lessons Learned

Despite our best efforts, at two months into our study, we realized that we underestimated the difficulty of contacting parents, even though we expected parental/guardian consent to be a challenge. We were surprised, however, by the willingness of the detainees to participate and provide assent. Our experience has been that adult offenders are often willing to participate in research projects and to talk with visitors. Anecdotally, adult offenders have told us that contact with outsiders disrupts the monotony of their day. However, our experience with juvenile detainees did not lead us to expect the same willingness to interact with

outsiders. It is likely that receptivity to participate in a project on multiple factors, including the subject, type of study, and possible benefit to the participant. Thus far, 71% of the young women have assented to participate; however, we have consented only 29% of the parents/guardians. This low percentage is attributed to the small number of parents/guardians who visit their children; however, the percent of parents/guardians we have consented represent over 90% of those who were visitors.

Parents/guardians do not visit their children for the following reasons: (1) visitations are primarily on Saturdays and Sundays from 2:30 – 4:30 pm, and some parents work weekends; (2) detainees come from all regions of the state, and distance is an issue for some, particularly as it relates to financial resources to travel; (3) the emotional strain of having a child in a detention center may be too great for some parents; (4) strained relationships may exist between parents and their child; and (5) parents with incarceration histories may not be eligible to visit. We are not aware of data that explain why parents in Georgia do not visit their detained children. Thus far, only one detainee has not assented when we obtained parental consent, and only one parent declined to talk with us regarding our project. These results regarding acceptability of our study are encouraging.

Laboratory results for confirmation of STIs were not always received in a timely manner due to the use of a free program for laboratory testing provided through Public Health. Young women detainees were occasionally treated symptomatically for STIs, resulting in an underreporting of the actual rate for diagnosed infections. Further, a mission of the juvenile detention center pertains to public safety, rehabilitation, and reentry. Population-level health research often is secondary, if a goal at all. Finally, project visits will inevitably be interrupted due to institutional needs, such as special programs and events at the facility or due to security needs, such as ceasing movement for census counts. While interruptions have not occurred frequently, there were occasions when visits for data collection had to be cancelled or rescheduled.

CONCLUSIONS

For effective collaborations, academic and juvenile justice research partnerships require pre-research work. There are challenges in regard to conducting health research, difficulties in planning, and logistical issues that add to the complexity of studying this population. However, studies with and in regard to detained populations relate to public health and can be accomplished. Former detainees eventually have contact with groups who have no history of detention. While our data regarding the association between STIs and psychosocial factors for the juvenile detention population are still emerging, investigations involving both detainees and their families can enhance understanding of the health and social well-being of the detained population. Although family dimensions and other psychosocial factors may not completely explain detainee behaviors, particularly ones that contribute to unhealthy outcomes, such as having an STI, we propose that, despite the complexity, the public health impact on detainees and their families warrants

research with this population. For research into detainee health, we propose a “town and gown” approach, which combines the expertise of juvenile justice with the research

competency of academia and results in a more complete understanding of health issues.

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