How Ecological Systems Impact Black and Latine Youths' Health During Reentry After Confinement: Implications for Social Work

Edward Mei
Christopher Bondoc
Jocelyn I. Meza
John Bosco
Elizabeth S. Barnert

Abstract: *Reentry after confinement is a critical juncture for youth, and the environmental contexts they return to post-release play a crucial role in shaping their health. This qualitative secondary analysis explores the perspectives of Black and Latine youth and their parents/caregivers on how specific microsystems influence youths' health during reentry. We completed two-staged thematic analysis of longitudinal semi-structured interviews with recently released Black and Latine youth (n = 27) and their parents/caregivers (n = 34) to examine how the home, school, and neighborhood microsystems impact youths' health and well-being during community reentry. Participants described three environmental features across the identified microsystems as impacting the health and well-being of youth undergoing reentry: 1) relationships, 2) physical space, and 3) resources. Participant perspectives suggest that social workers can potentially leverage existing strengths within each microsystem to promote the health and desistance of Black and Latine youth during reentry. In addition, participants described health-detracting features within specific microsystems that social workers can aim to remedy to redress health disparities among Black and Latine youth undergoing reentry. Using participants' insights to optimize youths' environment for health promotion, desistance, and service utilization may facilitate long-term health and well-being for Black and Latine youth post-release.*

Keywords: *Reentry, juvenile justice, aftercare, qualitative research*

While the overall number of youth confined in the United States has declined in recent decades, racial disparities have continued to increase. Black and Latine youth account for a disproportionately high number of youth impacted by the juvenile legal system (Rovner, 2021; Sickmund & Puzzanchera, 2014). The experience of confinement also leads to worse physical and behavioral health outcomes (Barnert et al., 2017). As such, youth involved in the juvenile legal system have higher unmet health needs than their non-involved peers, with stark health disparities observed among Black and Latine youth (Braverman et al., 2010; Cocozza & Skowyra, 2000; Teplin et al., 2002). The same populations that are unjustly affected by the U.S. juvenile legal system, Black and Latine youth, also disproportionately live in environments with additional health barriers, such as neighborhood violence, poverty, limited providers, transportation difficulties, and lack of insurance (Crouch et al., 2000; Golzari & Kuo, 2013; Schwartz et al., 2022). The

Edward Mei, MD, Research Assistant, Department of Medicine, and Christopher Bondoc, MSW, Research Coordinator, Department of Pediatrics, David Geffen School of Medicine at University of California, Los Angeles [UCLA], Los Angeles, CA. Jocelyn I. Meza, PhD, Assistant Professor, Department of Psychiatry, UCLA, Los Angeles, CA. John Bosco, MD, Research Assistant, Department of Emergency Medicine, Harbor-UCLA Medical Center, Los Angeles, CA. Elizabeth S. Barnert, MD, MPH, MS, Associate Professor, Department of Pediatrics, David Geffen School of Medicine at UCLA, Los Angeles, CA

Copyright © 2024 Authors, Vol. 24 No. 3 (Fall 2024), 554-579, DOI: 10.18060/28082

environmental inequities that negatively impact the health of Black and Latine youth also increase their risk for confinement and recidivism, which then creates and exacerbates health problems—trapping Black and Latine youth in cycles of worsening health and increasing marginalization (Woods et al., 2013). Environmental differences interrelate with health disparities among Black and Latine youth involved in the juvenile legal system, signifying an important focus for social work (De Coster et al., 2016).

Youth Reentry and Health

Reentry, often defined as the 6 months following release from confinement , is a critical juncture for shaping youths' health trajectories (Altschuler & Brash, 2004). Youth experience high disease burden upon release, including high rates of sexually transmitted infections, psychiatric disorders, and substance use disorders (Altschuler & Brash, 2004; Teplin et al., 2002). Moreover, health behaviors or health-related behaviors post-release relate to risk for recidivism and adverse health (Freudenberg et al., 2005). Generally, health behaviors include individual actions that affect health, such as smoking, substance use, diet, physical activity, sexual activity, and treatment seeking (Armstrong, 2009). During reentry, youth often engage in behaviors that can harm their health and increase risk for recidivism, such as substance use, risky sexual behavior, and low service utilization (Freudenberg et al., 2005).

Like confinement, the reentry experience exacerbates health needs and widens health disparities (Barnert et al., 2016). Prior research has established a dose-dependent relationship between youth confinement and adult health such that more contact with the juvenile legal system and increased time in confinement relate to worse long-term health (Barnert et al., 2017). Thus, youths' desistance and risk for recidivism carry significant implications for their health trajectories. Notably, youth show high risk for recidivism during the reentry period with up to 46% returning to confinement within 2 years of release (Altschuler & Brash, 2004; Mendel, 2011). However, the extant literature indicates that health and social service interventions during reentry can improve youths' health and promote desistance (Bullis et al., 2004; Burns et al., 2000; Teplin et al., 2002). As such, supporting youth during the reentry period interrelates to their long-term health and well-being.

Reentry and Health Disparities

The juvenile legal system disproportionately confines and impacts Black and Latine youth (Corbit, 2005; Kakade et al., 2012; Rovner, 2016; Sickmund et al., 2021; Starr & Rehavi, 2013). Black and Latine youth are also at a higher risk to recidivate and face additional environmental challenges post-release (Mendel, 2011). Given the dose-dependent relationship between youth confinement and adverse health (Barnert et al., 2017), racial disparities in rearrests and sentencing indicate that the juvenile legal system disproportionately harms the health of Black and Latine youth (Rovner, 2021; Starr & Rehavi, 2013). Additionally, Black and Latine youth involved in the juvenile legal system experience higher rates of physical health concerns, behavioral health challenges, and exposure to stressors, which are all exacerbated by confinement and increase risk for

recidivism (Boyd & Clampet-Lundquist, 2019; Teplin et al., 2002). Thus, differential treatment and racial inequities widen health disparities among Black and Latine youth that keep them in cycles of repeat confinement and worsening health (Rovner, 2021; Starr & Rehavi, 2013). While prior work indicates that environmental context influences the health of Black and Latine youth during reentry, the mechanisms behind how reentry environments influence health are not fully understood. Thus, it is crucial that social workers understand how environments shape Black and Latine youths' health during reentry.

Social-Ecological Perspective on Youths' Health During Reentry

Bronfenbrenner's Social-Ecological Model (SEM) provides a useful framework for conceptualizing the impacts of environment on the health of Black and Latine youth undergoing reentry (Bronfenbrenner, 1979; Eriksson et al., 2018). The SEM asserts that youth are rooted in multiple interconnected ecologies, or systems, which affect their health, well-being, and development. From the SEM's perspective, environmental factors and processes at multiple levels interact with Black and Latine youth directly and indirectly to shape their health during reentry. Interrelated factors can range from specific stressors in youths' immediate environments (e.g., food insecurity) to larger scale influences (e.g., systemic racism). After release, Black and Latine youth transition from confinement to interface with numerous settings that influence health and risk for recidivism. Prior qualitative studies indicate that youth face stressors in their environments that influence their health during reentry and that youth view their homes, schools, and neighborhoods as the primary contexts that impact their health and risk for recidivism post-release (Barnert et al., 2015).

Microsystem Influences on Health

The microsystem includes the individual and ties to their immediate surrounding people, places, and structures (Bronfenbrenner, 1979). Black and Latine youth involved in the juvenile legal system face challenges at the microsystem level from an early age, including high rates of adverse childhood experiences (ACEs), such as experiencing abuse, witnessing violence, or living with someone struggling with substance misuse (Baglivio et al., 2014; Felitti et al., 1998; Owen et al., 2020). The reentry period is no different in that Black and Latine youth return to microsystems fraught with difficulties (Baglivio et al., 2014). Black and Latine youth face additional environmental barriers to their health and desistance during reentry, including living in areas with fewer providers, encountering providers with limited cultural responsiveness, and having less access to resources (Centers for Disease Control and Prevention [CDC], 2020; Laub, 2014)

The current literature illustrates a robust understanding of environmental impacts on reentry from a socioecological perspective (Bronfenbrenner, 1979; Eriksson et al., 2018). Individual-level risk factors impacting reentry include mental illness, substance use, academic performance, and relationships (Bullis et al., 2002; Oembo et al., 2009; Sullivan, 2004). Features of youths' environments, such as neighborhood violence, have also been connected to reentry outcomes (Abrams & Freisthler, 2010; Alaniz et al., 1998; Freisthler

et al., 2008). Moreover, environmental features specific to the marginalization of Black and Latine youth can affect reentry. For example, compared to White youth, Black and Latine youth receive harsher punishments for similar behavior and are more often criminalized for mental health symptoms. Differences in school discipline impact rates of arrest that contribute to the school-to-prison pipeline (Crawley & Hirschfield, 2018; Lau et al., 2018; Laub, 2014; Mowen et al., 2020).

Current Study

While many environmental features likely affect health and risk for recidivism for Black and Latine youth undergoing reentry, the extant literature has not identified which environments or features exert the most influence (Abram et al., 2008; Altschuler & Brash, 2004; Udell et al., 2017). Moreover, research on the health of youth involved in the juvenile legal system often overlooks the important reentry period (Altschuler & Brash, 2004). While prior work has demonstrated that parents/caregivers help youth overcome adversity and access needed services during reentry, few studies on reentry have explored the perspectives of youth and their parents/caregivers (Barnert et al., 2020). The mechanisms underlying reentry's contribution to poor health remain largely unknown, despite the observed environmental impacts on youths' health during reentry (Freudenberg et al., 2005; Todis et al., 2001). Though Black and Latine youth are disproportionately involved in the juvenile legal system, experience high vulnerability to adverse health and recidivism, and face additional environmental barriers, few studies on reentry have centered and explored their perspectives. Stark health disparities and vulnerability to recidivism highlight the importance of exploring the perspectives of Black and Latine youth and their parents/caregivers on how microsystems impact youths' health during reentry (Freudenberg et al., 2005; Todis et al., 2001). Understanding and integrating perspectives from Black and Latine youth and their parents/caregivers may help social work improve the delivery of health and social services and ultimately promote positive health trajectories for Black and Latine youth post-release.

Method

Study Design

We performed an in-depth qualitative secondary analysis of longitudinal semi-structured interviews from a larger mixed methods study conducted with agencies from the Los Angeles County juvenile legal system, the largest county juvenile legal system in the United States (Barnert et al., 2020). Our university Institutional Review Board and the focal county juvenile courts approved the study procedures.

Recruitment and Enrollment

Between November 2016 and March 2018, the larger study's research team recruited youth newly released from confinement. Other eligibility criteria included age greater than or equal to 12 years, fluency in English or Spanish, and no severe cognitive delay. Initial

recruitment was conducted by distributing study flyers to youth exiting confinement and inviting youth and their families to contact the study team via telephone if they were interested in participating. In addition, the study team received the names and contact information of recently released youth from county probation weekly and subsequently telephoned families for study recruitment. During encounters, the research team iterated to youth and families that participation was confidential, voluntary, and would not impact youths' probation status.

The larger study experienced a 44% youth response rate, comparable to other work with youth involved in the juvenile legal system recruited in the community (Abrams, 2010). Fifty youth agreed to participate in the larger study, which included completing a close-ended survey 1-month post-confinement to assess youth sociodemographic information, family factors, physical and behavioral health status, and utilization of healthcare and social services during reentry. Participants received a $30 gift card for completing the survey.

Qualitative Interviews

All 50 youth who completed quantitative surveys in the larger study were invited to complete longitudinal interviews. Youth who agreed to additional interviews were invited to interview at 1-, 3-, and 6-month post-release. Parents/caregivers of youth were also invited to complete interviews at the same intervals. Youth whose parents/caregivers declined interviews were still able to complete interviews. Similarly, parents/caregivers whose children declined interviews could still participate in interviews.

Prior to interviews, assent and consent were obtained from youth and parents/caregivers, respectively. Youth and parent/caregiver interviews were completed separately, such that youth and parents/caregivers were not present during each other's interviews. All participants chose the language of interviews (English or Spanish) and how interviews were conducted (i.e., in-person or via telephone). Interviews were conducted in a private location and lasted 30 to 60 min. Researchers recorded audio during the interviews and then used a professional service to create the transcripts. Participants received a $30 gift card for each interview completed.

Qualitative Sample

Twenty-seven unique youth completed longitudinal semi-structured interviews, resulting in 40 total youth interviews: 25 at 1-month post-confinement, 10 at 3-month post-confinement, and five at 6-month post-confinement. Table 1 presents the sociodemographic characteristics of 26 of the 27 interviewed youth; one youth participated in interviews but did not complete a close-ended survey in the larger study. Youth were aged 15-19, mostly male (85%), and born in the United States (92%). Despite not purposively sampling by race or ethnicity, all interviewed youth were Black or Latine, reflecting the demographics of the focal county and the overrepresentation of Black and Latine youth in the juvenile legal system (Herz et al., 2015).

Table 1. *Youth Demographic Characteristics (n = 27)*

Demographic Characteristics	*n* (%)
Age[a]	
15-17	15 (57.7%)
18-19	11 (42.3%)
Gender	
Male	23 (85.2%)
Female	4 (14.8%)
Race/Ethnicity[b]	
Latine	23 (85.2%)
Black	4 (14.8%)
Country of Birth[a]	
United States	24 (92.3%)
Mexico	2 (7.7%)
Number of Times Confined[a]	
Once	5 (19.2%)
Two or three times	10 (38.5%)
Four or more times	11 (42.3%)
Highest Grade Completed[a]	
8th or less	1 (3.8%)
9th	2 (7.7%)
10th	7 (26.9%)
11th	10 (38.5%)
12th	6 (23.1%)
Language Spoken at Home	
Only English	8 (29.6%)
English more than my other language	5 (18.5%)
Both equally	9 (33.3%)
My other language more than English	4 (14.8%)
Only my other language (Spanish)	1 (3.7%)

[a] Twenty-seven unique youth were interviewed. However, one youth interviewee did not participant in close-ended surveys and thus did not report data for the following variables: age, country of birth, number of times confined, and highest grade completed.
[b] One Latine youth identified as Latine and White.

Thirty-four unique parents/caregivers participated in longitudinal semi-structured interviews, resulting in 51 total parent/caregiver interviews: 33 at 1-month follow-up, 13 at 3-month follow-up, and five at 6-month follow-up. Twenty-nine parent/caregiver interviews (57%) were conducted in Spanish by a Spanish-speaking researcher; transcriptions were subsequently translated into English by a Spanish-speaking member of the research team. Table 2 summarizes sociodemographic data on parents/caregivers. For simplicity, we will herein refer to parent/caregiver participants as "parents."

Table 2. *Parent/Caregiver Demographic Characteristics (n = 34)*

Demographic Characteristic	*n* (%)
Caregiver Role	
Mother	28 (82.4%)
Father/Stepfather	5 (14.7%)
Grandmother	1 (2.9%)
Race/Ethnicity	
Latine	19 (55.9%)
Black	11 (32.4%)
Race/ethnicity unavailable[a]	4 (11.8%)
Country of Birth	
United States	13 (38.2%)
Mexico or Central America	13 (38.2%)
Country of birth unavailable	8 (23.5%)
Household Structure	
Two-parents (at least one is not the biological parent)	8 (23.5%)
Biological mother and biological father	8 (23.5%)
Single parent	7 (20.6%)
Household structure unavailable[a]	11 (32.4%)
Language of Interview	
English	18 (52.9%)
Spanish	16 (47.1%)

[a]Some data are not available for parents whose children did not participate, as youth self-reported the demographic characteristics of their parents.

Qualitative Analysis

We conducted two-staged thematic analysis (Braun & Clarke, 2022) of youth and parent interview transcripts using Dedoose software (Version 8.3.35, 2020). First, we selected the home, school, and neighborhood microsystems as the basis of our analysis, reflecting prior research where youth undergoing reentry identified their homes, schools, and neighborhoods as the environments most impacting pathways toward re-confinement (Barnert et al., 2015; Bronfenbrenner, 1979). We defined home as the youths' primary residence, school as the school's youth attended before and after confinement, and neighborhood as all other community spaces where youth reported spending time during reentry (e.g., parks, community centers, and public spaces). Aligned with the broader values of social work and typical aims of social work intervention (Council on Social Work Education [CSWE], 2016; National Association of Social Workers [NASW], 2021.), our analysis used a broad definition of health as, "A state of complete physical, mental, and social well-being and not merely the absences of disease or infirmity" (World Health Organization [WHO], 2020). Given the dose-dependent health impacts of confinement and recidivism, we also considered risk for recidivism in our definition of health, as increased exposure to the juvenile legal system adversely impacts health trajectories. In addition, we included risk for recidivism when considering health and health-related behavior, which

aligned with how participants often framed health during reentry in the context of risk for recidivism.

Table 3. *Environmental Influences on Youths' Health During Reentry*

Microsystem	Feature	Example*	Representative Quote
Home	Relationships	(+) Supportive Adults	Well, [my parents are] supporting me in everything I'm doing right now —*15-year-old Latine male*
	Physical Space	(-) Crowded Home	I live in a small house so I get stressed a lot and I can't go anywhere to relieve my stress — *16-year-old Latine female*
	Resources	(-) Financial Instability	I did not have insurance…if you are not insured you [have to] pay. Nobody [wants] to pay $250 for a hospital bill just to be told [that they] are sick — *16-year-old Latine female*
School	Relationships	(+) Supportive Adults	I feel like I don't need to [speak with my therapist], but it's always good… Even my teacher told me, 'that's a real man.' — 18-*year-old Latine male*
	Physical Space	(-) Conducive to Risks	High school is too big, that's why he could never be in a high school setting, he always [needs] to be in a small setting — *Mother*
	Resources	(+) Attendance Incentives	They pay you to go to school — *16-year-old Latine male*
Neighborhood	Relationships	(+) Supportive Adults	[His probation officer] was able to take him to get [what] was required, like special shoes and clothing, so she is very helpful — *Mother*
	Physical Space	(-) Proximity to Drugs	Later I got involved with drinking and smoking…When I got into that, I would not come home at all — *16-year-old Latine male*
	Resources	(-) Limited Parent Support	A lot of parents don't know [what a mental health facility is] or where they're located or the services that they have to offer. — *Mother*

Note. Examples of health-promoting sub-features are signified by "+" and examples of health-detracting sub-features are signified by "-."

We first open-coded interviews to determine features within the identified microsystems that youth and parents perceived as influencing youths' health during reentry. After open-coding, we developed a preliminary codebook with three prevailing environmental features described as impacting youths' health across the identified microsystems during reentry: *relationships*, *physical space,* and *resources*. Next, we developed a final codebook through regular team meetings centered on the identified

features across the key microsystems. In our subsequent and final round of coding, we applied the final codebook to all interviews to extract sub-features specific to the identified microsystems. Youth and parent interviews across all timepoints were analyzed using the finalized codebook. Sub-features described as facilitating health and desistance during reentry were coded as health-promoting, and features reported as impeding health and desistance were coded as health-detracting. Finally, the study team met to extrapolate features and sub-features into themes regarding the effects of environmental features on the Black and Latine youths' health during reentry across the home, school, and neighborhood microsystems (Table 3).

Results

The Black and Latine youth and their parents described their home, school, and neighborhood microsystems as both health-promoting and health-detracting, with influences on health reportedly operating through three prevailing features across the identified microsystems: *relationships, physical space,* and *resources* (Table 3).

Home Microsystem

Relationships in the Home Microsystem

Participants viewed relationships within the home microsystem as generally health-promoting, chiefly through supportive parents. Participants reported parents as instrumental in facilitating health-promoting behaviors, such as helping youth maintain sobriety and meet related probation requirements. One parent stated, "I tell [my son] that he can't let [drugs] hold him back or let them take over his life." Participants also described parents as facilitating the utilization of needed health and social services; participants reported that parents scheduled appointments, provided transportation, and encouraged youth to engage with treatment and providers. Finally, some of the youth discussed parents as supporting their health more directly, such as caring for them when ill. For example, one youth explained that his mother provided food-based remedies and shared, "My mother [gave] me oil, lemon, and salt to make my stomach stop hurting." Youth and parents included other supportive family members who promoted youths' health during reentry. For example, participants discussed siblings helping youth engage in physical activity by providing encouragement, equipment, and transportation. Overall, participants perceived relationships within the home microsystem, particularly parents, as mainly health-promoting.

While youth and parents typically described parents as health-promoting, some youth explained that parental substance use in the home microsystem negatively affected their health during reentry. The Black and Latine youth reported direct health impacts, such as secondhand smoke, as well as experiencing increased temptations or decreased resistance to substance use. For example, one youth shared, "My parents smoke cigarettes or drink beer… that affects me." However, concerns over parental substance use in the home were limited to a small number of youth, and parents did not describe any health-detracting aspects of their relationships with their children. Despite some of the youth reporting

concerns about parental substance use, participants described parents as health-promoting relationships within the home microsystem.

Physical Space of the Home Microsystem

Participants described the physical space of the home microsystem as promoting youths' health by protecting them from health-detracting features of the neighborhood microsystem. Participants discussed how their homes sheltered youth from perceived threats to health and desistance, such as neighborhood violence. For example, one youth stated, "Staying at home helped [me] stay off the streets [and] out of trouble." As such, most of the Black and Latine youth described intentionally spending more time at home to avoid features they viewed as potentially harming their health or increasing their risk for recidivism, namely exposure to negative peer influences and risky behaviors like substance use. Similarly, parents reported fewer concerns about youth engaging in substance use or health-detracting behaviors when youth were at home. Thus, youth and parents understood the physical space of their home microsystems as health-promoting by acting as a buffer between the Black and Latine youth and health-detracting features in the neighborhood microsystem.

Participants also viewed their homes as a safe and accessible place for youth to engage with needed services, particularly home-based reentry programs and behavioral health treatment. Several parents described using their homes as a space to facilitate youths' service utilization during reentry (e.g., behavioral healthcare). Many parents reported a preference for home-based services, as the convenience allowed youth to circumvent accessibility and safety barriers. For example, one parent shared, "The home-based [mental health] program makes a world of difference." Another parent explained how the option to receive services at home facilitated treatment engagement and said, "My son was more comfortable being in his own space during therapy." Youth and parents perceived their homes as health-promoting physical spaces that facilitated youths' treatment engagement and protected youth from potential risks and harm.

While many participants viewed the physical space of their homes as protective, some of the Black and Latine youth described their home microsystems as causing distress and negatively impacting their well-being during reentry. When naming challenges at home, youth discussed crowding and lack of physical space. For example, one youth explained that having to share beds with siblings diminished his quality of sleep. Another youth described the lack of physical space as negatively affecting their mental health and said, "I prefer being out in the streets [rather than] being home, having to deal with my emotions." Though a few youth described concerns about reportedly cramped spaces, most expressed excitement about returning home and a desire to increase time spent at home during reentry. Most participants saw youth spending time at home as health-promoting because they viewed the physical space of home as limiting youth from engaging in risky or health-detracting behaviors, protecting youth from exposure to health-detracting features of the neighborhood microsystem, and providing a safe and accessible space to utilize services.

Resources in the Home Microsystem

Youth and parents spoke about resources within the home microsystem as health-detracting during reentry. In general, participants described insufficient resources to meet their basic needs and reported returning to resource-scarce homes. For example, several of the Black and Latine youth described food insecurity and poor nutrition as negatively impacting their health during reentry. One youth stated, "[There is] not a lot of food to eat." In contrast, most parents highlighted their efforts to provide youth with healthy foods despite reported resource constraints, such as by cooking at home and limiting the availability of highly processed foods. In addition to food insecurity, participants discussed how lack of insurance coverage prevented and deterred youth from seeking routine healthcare or other needed services. Instead, participants reported that youth primarily relied on emergency care, which they viewed as more costly and less effective. Finally, the Black and Latine youth expressed a pressure to "start working and helping out" during the already stressful reentry period. Despite often needing to resume their education, meet probation requirements, or attend mandated treatment, youth described feeling pushed to prioritize financial stability over their health and well-being. Participants reported experiencing a range of resource-related challenges (e.g., food insecurity) and viewed resource scarcity as an overwhelmingly health-detracting feature of the home microsystem during reentry.

School Microsystem

Relationships in the School Microsystem

The Black and Latine youth perceived supportive adults, particularly teachers and counselors, within the school microsystem as promoting their health during reentry. Youth shared how school staff facilitated health-promoting behaviors, such as encouraging youth to connect and engage with behavioral healthcare. Youth also reported that school staff helped them address barriers to health and desistance by providing linkages and referrals to needed resources, such as employment opportunities to help them meet their basic needs. While youth described teachers and counselors as supporting their health and desistance during reentry, most did not discuss adult relationships in the school microsystems and instead focused on peer relationships.

The Black and Latine youth shared concerns about how negative peer influences and stigma within the school microsystem negatively affected their health, well-being, and desistance during reentry. Youth discussed feeling pressured by peers to engage in risky behaviors that could negatively impact their health and risk for recidivism, such as substance use and truancy. For example, when asked about the biggest challenge of going back to school during reentry, one youth said, "Just trying to focus on myself more and not do the things I used to do." Another youth shared concerns about perceived negative influences within the school microsystem and explained, "I would have been back in the [juvenile legal] system if I [returned to the same school I attended before confinement]." Youth also expressed how efforts to avoid negative influences led to isolation and distress, as youth reportedly minimized social interactions. In addition, other youth described

feeling stigmatized by peers due to their confinement. For example, one youth stated, "I feel weird because everybody would look at me, and they would just look at me, and I would turn to look at them like, saying like, 'Hi. What's up?' Then they would just turn away." While the Black and Latine youth perceived adults within the school microsystem as health-promoting, their discussions of school relationships centered mostly on their peers who they generally viewed as health-detracting. Notably, parents did not comment on youths' peer relationships at school and instead focus their concerns on potentially criminogenic peers within the neighborhood microsystem.

Physical Space of the School Microsystem

Youth and parents perceived the physical space of the school microsystem as generally health-promoting. Participants described schools similarly to homes such that schools provided a physical space that protected youth from health-detracting features in the neighborhood and facilitated engagement in health-promoting behaviors. While parents endorsed schools as a health-promoting space, they shared concerns about the limitations of school. For example, one parent stated, "School itself is not enough. There are no programs that [my child] is looking for [outside of school]." Parents shared worries that, without structured programming or supervision, youth might engage in risky or health-detracting behaviors in the neighborhood. Additionally, parents viewed school as a space where youth could safely engage in physical activity and avoid potential safety concerns in the neighborhood. As such, parents often spoke about wanting afterschool programing and other reason for youth to spend more time at school. Despite the youths' concerns about negative peer influence, youth and parents generally viewed schools as physical spaces that promoted health and protected youth from risks during reentry.

Resources in the School Microsystem

Many parents described a lack of reentry-specific resources as health-detracting for youth. For example, several parents reported difficulties enrolling youth in school post-release, which they attributed to a lack of reentry-specific support. One parent shared, "The school is giving us a really hard time to take [my son] back. It took him approximately 3 months to get him back, and he wasn't fully enrolled yet." One mother explained that her son's school failed to receive verification of the academic credits her son completed while confined, rendering him ineligible for enrollment despite meeting the requirements. In addition to simply wanting their children to receive education, parents expressed concerns that gaps in school enrollment might lead youth to spend more time in their neighborhood microsystems and engage in risky or health-detracting behavior. Moreover, parents perceived gaps in school enrollment as preventing youth from accessing resources and health-promoting features within the school microsystem. Overall, parents described a lack of reentry-specific support and perceived gaps between systems of care as negatively affecting youths' health during reentry.

Neighborhood Microsystem

Relationships in the Neighborhood Microsystem

Youth and parents perceived adult relationships within the neighborhood microsystem as promoting youths' health during reentry. For example, participants generally described probation officers as health-promoting because probation often served as a connection to needed services and assistance, including help with school enrollment, employment, and resource referrals. Participants also viewed adult neighbors and older family members in the neighborhood as supporting youths' health during reentry, such as by providing supervision or transportation. Thus, youth and parents identified relationships in the neighborhood microsystem as health-promoting when discussing adults.

While youth and parents perceived adults in the neighborhood as health-promoting, they described youths' peers in the neighborhood microsystem as health-detracting. Like school peers, participants shared concerns about criminogenic peers in the neighborhood pressuring youth to engage in risky or health-detracting behaviors. For example, one youth stated, "My old friends smoke and ditch class, [which] was kind of the biggest distraction being out in the streets." Another youth said, "When I'm around my friends, I just want to get into trouble." As such, participants generally described neighborhood adults as health-promoting but viewed neighborhood peers as increasing youths' risk for recidivism and worse health.

Physical Space of the Neighborhood Microsystem

Youth and parents perceived the physical space of the neighborhood microsystem as containing both health-promoting and health-detracting features. Participants said the neighborhood microsystem provided space for health-promoting behaviors, such as physical activity and relaxation. For example, some of the Black and Latine youth reported playing sports and exercising in their neighborhoods. One youth shared that they enjoyed playing soccer at a community park, and several youth reported exercising at local gyms. Additionally, several of the Black and Latine youth who discussed concerns about living in a crowded or stressful home reported that they went into the neighborhood to avoid stressors at home, despite perceived risks. While participants identified some health-promoting features, they overwhelmingly discussed the neighborhood microsystem as dangerous and health-detracting.

Participants generally viewed the neighborhood microsystem as having several factors that could increase youths' risk for recidivism and worse health during reentry. For example, participants shared concerns about the presence of drugs within the neighborhood microsystem. One parent shared, "Where we live at, the population of young kids [are all] on crystal, Xanax bars, and all kinds of other drugs." Participants reported worries that the presence of drugs might push youth to resume substance use during reentry, which could result in recidivism and worse health. For example, one youth described an instance when he walked by someone smoking and felt "the urge to go over [to the person smoking] and go, 'Excuse me, do you have another [cigarette]?'" Other participants discussed safety concerns and fear of violence, which deterred youth from exercising in community spaces

or accessing community-based resources. Notably, participants' neighborhood safety concerns related to their views of the home and school microsystems as health-promoting, as they described school and home as sheltering youth from the neighborhood. While some participants identified health-promoting features of the neighborhood microsystem, they overall viewed the neighborhood as negatively affecting youths' health during reentry.

Resources in the Neighborhood Microsystem

Youth and parents cited insufficient resources to meet their needs and inaccessible services as health-detracting features of their neighborhood microsystems during reentry. Parents focused on a lack of reentry-specific resources. Many parents described feeling confused with how to help youth navigate reentry challenges, such as helping youth resume education, meet probation requirements, achieve desistance, and connect to needed services. For example, one parent shared:

> *As a parent [of a youth undergoing reentry] for the first time, it's like, you feel like you're locked up and you don't know where to turn, or who to talk to regarding whatever needs that [youth] need… so, they need to have more information for parents.*

Given that most participants viewed parent support as instrumental in promoting youths' health, well-being, and desistance during reentry, participants described inadequate support for parents as negatively impacting youth. In addition, participants explained how inaccessible services and convoluted systems of care made it difficult for youth to utilize needed support during reentry. For example, one youth stated, "Most [youth] do not know where to go [for healthcare]. Unless it is the emergency room, they do not know." Another youth discussed transportation barriers and said, "I hate waiting [for the] bus. Sometimes I get some rides, but when I can't, I'll just be like, 'Oh well.'" Overall, youth and parents described insufficient resources, particularly ones specific to reentry and health, in the neighborhood microsystem as detracting from the health of the Black and Latine youth during reentry.

Discussion

Participant perspectives suggest that the home, school, and neighborhood microsystems contain similar features (i.e., *relationships, physical space,* and *resources*) that have meaningful influences on the health of Black and Latine youth undergoing reentry. Participants perceived the identified features as health-promoting, health-detracting, or both depending on the specific microsystem. In interviews, participants explained how specific sub-features, such as insufficient resources within their microsystems, influenced health trajectories for the Black and Latine youth undergoing reentry by limiting service utilization, increasing distress, and facilitating high-risk behaviors (Abrams & Freisthler, 2010; Altschuler & Brash, 2004; Freudenberg et al., 2005; Krisberg et al., 1987). Perspectives shared in the interviews indicate various ways specific microsystems influence youths' health during reentry.

Service Utilization

The participants named specific strengths and challenges in each microsystem as influencing youth service utilization during reentry. Participants reported various barriers to service utilization and treatment engagement faced by the Black and Latine youth undergoing reentry. Participant perspectives reflect known barriers to care, such as logistical obstacles, financial constraints, structural barriers (e.g., providers' lack of cultural responsiveness), and youths' skepticism towards treatment (Abrams & Freisthler, 2010; Altschuler & Brash, 2004; Gupta et al., 2005; Udell et al., 2017). The Black and Latine youth and their parents repeatedly shared concerns about neighborhood safety and inaccessible systems of care, which they said could be remedied with the availability of home- and school-based programs. Additionally, parents highlighted a lack of reentry-specific assistance and support for parents. The parents expressed confusion related to helping their children meet probation requirements, attend needed services, and meet other reentry-related responsibilities. Given how barriers in the environment shape youth behavior during reentry and the essential role of parents in helping youth overcome reentry adversity (Bondoc et al., 2021), participant perspectives suggest an urgent need to improve connections to needed support. Social workers can aim to advocate for and implement the practices participants identified as effective or needed, including in-home service delivery, warm handoffs, and reentry-specific supports. Future efforts might also explore ways to make services more accessible to Black and Latine youth during reentry, such as providing care in additional settings or languages, utilizing lay providers, and integrating systems of care—signifying an opportunity for social work to lead innovations that redress longstanding inequity.

Participants also highlighted environmental features within the identified microsystems that facilitate service utilization during reentry. Again, participants emphasized the importance of parents in helping youth navigate challenges during reentry. Participants reported parents as promoting service utilization through transportation, encouragement, and guidance. However, participant discussions about insufficient resources in the home microsystem signaled a need to mobilize other supportive adults (i.e., non-parents) to support Black and Latine youth during reentry. Accordingly, when discussing health-promoting features of the school and neighborhood microsystems, participants identified other supportive adults as facilitating youths' service utilization during reentry, including teachers, probation officers, and extended family. Given prior studies indicating teachers and school staff have limited reentry-specific skills and knowledge, future efforts can aim to train or support school staff to help youth address reentry difficulties rather than having youth rely solely on parents and probations officers (Sinclair et al., 2016; Sullivan, 2004). Notably, the parents did not comment on adults within the school microsystems despite youth seeing school staff as potentially helpful. Still, parents emphasized concerns about continuity gaps between education and other systems of care. As such, social workers might leverage their unique multidisciplinary position to improve collaboration across microsystems to support youth during reentry. Moreover, efforts to increase the availability of needed services (e.g., mental healthcare) in schools, particularly continuation schools, might align with participant perceptions of schools as health-promoting and the reality of inaccessible services. Future work to

implement the participant perspectives into practice, such as through integrated care and collaborative service models, might improve youth service utilization, health, and desistance during reentry (Mathur & Clarke, 2014; Stroul & Friedman, 1986).

Engagement in Health-Related or Risky Behaviors

Stemming from multiple risk factors, including high rates of ACEs and systemic racism (Baglivio et al., 2014; Crawley & Hirschfield, 2018; Felitti et al., 1998; Lau et al., 2018; Laub, 2014), Black and Latine youth undergoing reentry face increased risks for engaging in health-detracting behaviors, such as substance use and risky sexual behaviors (Campbell et al., 2016; Kumpfer et al., 2003; Quinn et al., 2019). Participant perspectives echoed research indicating youth undergoing reentry face increased pressure to engage in risky behaviors as they return to criminogenic contexts post-release (Abrams, 2006; Altschuler & Brash, 2004; Sampson et al., 2002). The youth and their parents emphasized how peers in the school and neighborhood microsystems (i.e., "old friends") can act as obstacles to health and desistance during reentry. However, participant perspectives also suggest that adults across the identified microsystems can help youth overcome reentry challenges, reflecting prior work showing that prosocial relationships promote health and desistance (Kumpfer et al., 2003; Quinn et al., 2019; Todis et al., 2001). The interviews indicate supportive adults as a potential strength in all identified microsystems. Participants shared how supportive adults encouraged youth to utilize behavioral healthcare, maintain sobriety, attend school, and engage in other health-promoting behaviors. As recent studies have shown early promise in leveraging supportive adults to prevent substance use among youth undergoing reentry (Knight et al., 2021), future research might examine how supportive adults can best increase health-promoting behaviors and decrease risky behaviors among youth undergoing reentry. Efforts to connect youth with more prosocial adults and leverage existing supports during reentry might help Black and Latine youth break the vicious cycle of worsening health and repeat recidivism (Abrams, 2006; Woods et al., 2013).

Participants identified crowded physical spaces and resource scarcity across their microsystems as negatively impacting youths' health during reentry. Importantly, participant perspectives align with a large body of evidence connecting racial marginalization to health and social disparities among Black and Latine communities (CDC, 2020; Massoglia, 2008; Schwartz et al., 2022). For example, participant perspectives reflect prior work linking perceived neighborhood violence to worse health trajectories; participants explained how neighborhood safety concerns impeded youth from engaging in health-promoting behaviors during reentry, such as physical exercise and accessing needed behavioral healthcare (Meza et al., 2023). Similarly, participants repeatedly shared worries about how the presence of drugs in their neighborhoods might increase youths' likelihood of substance use despite desires or mandates to maintain sobriety, which they linked to risks for worse health and recidivism.

Finally, participants' discussions about insufficient resources across the identified microsystems align with the extant literature on poverty acting as an instrumental and negative social determinant of health, especially in Black and Latine communities (Crouch

et al., 2000; Schwartz et al., 2022). For example, participants described how poverty prevented the Black and Latine youth from engaging in health-promoting behaviors and accessing needed services that could support their health and desistance. Overall, participants highlighted specific features across the home, school, and neighborhood microsystems that social work interventions can aim to leverage (e.g., supportive adults) or address (e.g., accessibility barriers) to facilitate the health and desistance of Black and Latine youth undergoing reentry.

Strengths and Limitations

The current study offers several strengths. First, the study centers and explores the perspectives of Black and Latine youth and families directly impacted by the juvenile legal system, whose voices are underrepresented in research, policy, and treatment planning (Bondoc et al., 2023). Participant perspectives provide firsthand insight from vulnerable youth and families undergoing reentry. The study also highlights the important yet often overlooked reentry period, a critical juncture for breaking cycles of repeat confinement and escalating health needs (Woods et al., 2013). In addition, the current study's use of the SEM (Bronfenbrenner, 1979) considers the contexts youth return to during reentry rather than viewing youth as "criminals." Rather than default to an implicit deficit lens, the current study also views youth through a strengths-based framework that considers youths' assets and protective factors. Overall, participant insights provide important implications for social work intervention, programming, and policy to move away from unjust practices that punish individuals to more effective strategies that change the systems around youth.

While the study shares important insights and has several strengths, it still presents limitations. Though interviews originally focused on youths' health and well-being during reentry, the current study's secondary analysis approach means interviews were not explicitly framed around specific microsystems or their features. As such, participant responses may lack helpful details and additional nuance, such as the degree to which participants felt their schools can adequately meet youths' needs or how police presence influences youths' reentry experience. Similarly, parents may have avoided discussing the negative impacts of their behaviors due to social desirability or fear of judgment. In addition, attrition at the 3- and 6-month interviews may relate to an overrepresentation of positive perspectives, as individuals experience optimism to start reentry (Phillips & Lindsay, 2011). Despite the importance of exploring and centering the voices of those directly impacted by the juvenile legal system, framing interviews around youths' health during reentry may have caused participants to focus on micro-level challenges rather than macro-level ones. Because our sample was entirely Black and Latine, their perspectives cannot be separated from institutionalized racism, punitive policies, and other oppressive systems that drive mass confinement, racial stratification, and health inequity. Interviews and analyses did not explicitly investigate how aspects of identity (i.e., race, gender, age) affected participants' perspectives and reentry. Analyses organizing environmental features as either health-promoting or health-detracting may have overlooked more nuanced interactions between environment and health. Given that many factors impact health during reentry, future social work research might explore each feature's relative health promotion or health detraction within and across different microsystems. Finally,

while participants' releases from juvenile detention suggest most were adjudicated for less serious offenses, we do not have data on the offenses participants were adjudicated for, which carries implications for how their perspectives relate to future research and intervention. Still, the current study offers needed insights into how environments impact the health and desistance of Black and Latine youth during the important reentry period.

Conclusion

Reentry is an especially tumultuous and important time for Black and Latine youth, who disproportionately come from and return to marginalized and underserved communities, placing already vulnerable youth at risk for recidivism and poor health. Participants described their home, school, and neighborhood microsystems as promoting and detracting from youths' health across three prevailing features: relationships, physical space, and resources. Specifically, participant perspectives underscore the power of supportive adult relationships within the home, school, and neighborhood microsystems to facilitate treatment utilization and minimize risky behaviors. Moving forward, social workers can aim to leverage and support features that promote health, such as by implementing and expanding practices identified as improving service accessibility (e.g., home- and school-based programming), while advocating for policies and reform that address features that impede health and desistance (e.g., insufficient resources and safety concerns). Future research and advocacy may also focus on developing opportunities and pathways for collaboration between supportive adults within and across microsystems to help youth overcome reentry challenges. Finally, understanding how microsystems impact Black and Latine youth undergoing reentry can inform future social work intervention, programming, and policy to create environments that foster health and desistance for youth harmed and impacted by the U.S. juvenile legal system.

References

Abram, K. M., Paskar, L. D., Washburn, J. J., & Teplin, L. A. (2008). Perceived barriers to mental health services among youths in detention. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(3), 301-308.

Abrams, L. S. (2006). From corrections to community. *Journal of Offender Rehabilitation, 44*(23), 31-53.

Abrams, L. S. (2010). Sampling 'hard to reach' populations in qualitative research: The case of confined youth. *Qualitative Social Work, 9*(4), 536-550.

Abrams, L. S., & Freisthler, B. (2010). A spatial analysis of risks and resources for reentry youth in Los Angeles County. *Journal of the Society for Social Work and Research, 1*(1), 41-55.

Alaniz, M. L., Cartmill, R. S., & Parker, R. N. (1998). Immigrants and violence: The importance of neighborhood context. *Hispanic Journal of Behavioral Sciences*, *20*(2), 155-174.

Altschuler, D. M., & Brash, R. (2004). Adolescent and teenage offenders confronting the challenges and opportunities of reentry. *Youth Violence and Juvenile Justice*, *2*(1), 72-87.

Armstrong, D. (2009). Origins of the problem of health-related behaviours: A genealogical study. *Social Studies of Science*, *39*(6), 909-926.

Baglivio, M. T., Epps, N., Swartz, K., Huq, M. S., Sheer, A., & Hardt, N. S. (2014). The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. *Journal of Juvenile Justice*, *3*(2), 229-241.

Barnert, E. S., Dudovitz, R., Nelson, B., Coker, T., Biely, C., Li, N., & Chung, P. J. (2017). How does incarcerating young people affect their adult health outcomes? *Pediatrics, 139*(2), 1-9.

Barnert, E. S., Lopez, N., Pettway, B., Keshav, N., Abrams, L. S., Zima, B., & Chung, P. J. (2020). The role of parent engagement in overcoming barriers to care for youth returning home after confinement. *Journal of Community Health*, *45*(2), 329-337.

Barnert, E. S., Perry, R., Azzi, V. F., Shetgiri, R., Ryan, G., Dudovitz, R., Zima, B., & Chung, P. J. (2015). Confined youths' perspective on protective factors and risk factors for juvenile offending: A qualitative analysis. *American Journal of Public Health*, *105*(7), 1365-1371.

Barnert, E. S., Perry, R., & Morris, R. E. (2016). Juvenile confinement and health. *Academic Pediatrics*, *16*(2), 99-109.

Bondoc, C., Aguilar, M., Aswad, Y., Lopez, N., Chung, P. J., Zima, B., Abrams, L. S., Bath, E., & Barnert, E. S. (2023). "It's not ever going to work, so why would I even try?": Black and Latino youths' perspectives on behavioral health treatment engagement during reentry after confinement. *Children and Youth Services Review*, *152*, 1-10.

Bondoc, C., Meza, J. I., Ospina, A. B., Bosco, J., Mei, E., & Barnert, E. S. (2021). "Overlapping and intersecting challenges": Parent and provider perspectives on youth adversity during community reentry after confinement. *Children and Youth Services Review*, *125*, 1-12.

Boyd, M. L., & Clampet-Lundquist, S. (2019). "It's hard to be around here": Criminalization of daily routines for youth in Baltimore. *Socius, 5,* 1-10.

Braun, V., & Clarke, V. (2022). Conceptual and design thinking for thematic analysis. *Qualitative Psychology, 9*(1), 3-26.

Braverman, P. A., Cubbin, C., Egerter, S., Williams, D. R., & Pamuk, E. (2010). Socioeconomic disparities in health in the United States: What the patterns tell us. *American Journal of Public Health, 100*(1), 186-196.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Bullis, M., Yovanoff, P., & Havel, E. (2004). The importance of getting started right: Further examination of the facility-to-community transition of formerly confined youth. *The Journal of Special Education*, *38*(2), 80-94.

Bullis, M., Yovanoff, P., Mueller, G., Havel, E. (2002). Life "on the outs" Examination of the facility to community transition of confined youth. *Exceptional Children, 69*(1), 7-22.

Burns, B. J., Schoenwald, S. K., Burchard, J. D., Faw, L., & Santos, A. B. (2000). Comprehensive community-based interventions for youth with severe emotional disorders: Multisystemic therapy and the wraparound process. *Journal of Child and Family Studies*, *9*(3), 283-314.

Campbell, J. A., Walker, R. J., & Egede, L. E. (2016). Associations between adverse childhood experiences, high-risk behaviors, and morbidity in adulthood. *American Journal of Preventive Medicine*, *50*(3), 344-352.

Centers for Disease Control and Prevention. (2020, November). *Health disparities among youth*. U.S. Department of Health and Human Services.

Cocozza, J. J., & Skowyra, K. R. (2020). Youth with mental health disorders: Issues and emerging responses. *Juvenile Justice, 7*(1), 3-13.

Corbit, K. (2005). Inadequate and inappropriate mental health treatment and minority overrepresentation in the juvenile justice system. *Hastings Race & Poverty Law Journal, 3*, 75-94.

Council on Social Work Education. (2016). *2015 education and policy accreditation standards for baccalaureate and master's social work programs*. Council for Higher Education Accreditation.

Crawley K., & Hirschfield, P. (2018). Examining the school-to-prison pipeline metaphor. *Oxford research encyclopedia of criminology*.

Crouch, J. L., Hanson, R. F., Saunders, B. E., Kilpatrick, D. G., & Resnick, H. S. (2000). Income, race/ethnicity, and exposure to violence in youth: Results from the national survey of adolescents. *Journal of Community Psychology*, *28*(6), 625-641.

De Coster, S., Heimer, K., & Wittrock, S. M. (2016). Neighborhood disadvantage, social capital, street context, and youth violence. *The Sociological Quarterly, 47*(4), 723-753.

Oembo, R., Williams, L., Schmeidler, J., Getreu, A., Berry, E., Genung, E. D., & Christensen, C. (2009). Recidivism among high-risk youths: A 2-year follow-up of a cohort of juvenile detainees. *International Journal of the Addictions, 26*(11), 1197-1221.

Eriksson, M., Ghazinour, M., & Hammarström, A. (2018). Different uses of Bronfenbrenner's ecological theory in public mental health research: What is their value for guiding public mental health policy and practice? *Social Theory & Health*, *16*, 414-433.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245-258.

Freisthler, B., Gruenewald, P. J., Ring, L., & LaScala, E. A. (2008). An ecological assessment of the population and environmental correlates of childhood accident, assault, and child abuse injuries. *Alcoholism: Clinical and Experimental Research*, *32*(11), 1969-1975.

Freudenberg, N., Daniels, J., Crum, M., Perkins, T., & Richie, B. E. (2005). Coming home from jail: The social and health consequences of community reentry for women, male adolescents, and their families and communities. *American Journal of Public Health, 95*(10), 1725-1736.

Golzari, M., & Kuo, A. (2013). Healthcare utilization and barriers for youth post-detention. *International Journal of Adolescent Medicine and Health*, *25*(1), 65-67.

Gupta, R. A., Kelleher, K. J., Pajer, K., Stevens, J., & Cuellar, A. (2005). Delinquent youth in corrections: Medicaid and reentry into the community. *Pediatrics, 115*(4), 1077-1083.

Herz, D. C., Chan, K., Lee, S. K., Nalani Ross, M., McCroskey, J., Newell, M., & Fraser, C. (2015). *The Los Angeles County juvenile probation outcomes study*. Catalyst California (formerly Advance Project California).

Kakade, M., Duarte, C. S., Liu, X., Fuller, C. J., Drucker, E., Hoven, C. W., Fan, B., & Wu, P. (2012). Adolescent substance use and other illegal behaviors and racial disparities in criminal justice system involvement: Findings from a U.S. national survey. *American Journal of Public Health, 102*(7), 1307-1310.

Knight, D. K., Yang, Y., Joseph, E. D., Tinius, E., Young, S., Shelley, L. T., Cross, D. R., & Knight, K. (2021). Preventing opioid use among justice-involved youth as they transition to adulthood: Leveraging safe adults (LeSA). *BMC Public Health*, *21*(1), 1-17.

Krisberg, B., Schwartz, I., Fishman, G., Eisikovits, Z., Guttman, E., & Joe, K. (1987). The confinement of minority youth. *Crime & Delinquency, 33*(2), 173-205.

Kumpfer, K. L., Alvarado, R., & Whiteside, H. O. (2003). Family-based interventions for substance use and misuse prevention. *Substance Use & Misuse*, *38*(11-13), 1759-1787.

Lau, K. S., Rosenman, M. B., Wiehe, S. E., Tu, W., & Aalsma, M. C. (2018). Race/ethnicity, and behavioral health status: First arrest and outcomes in a large sample of juvenile offenders. *The Journal of Behavioral Health Services & Research, 45*(2), 237-251. https://doi.org/10.1007/s11414-017-9578-3

Laub, J. H. (2014). *Understanding inequality and the justice system response: Charting a new way forward*. William T. Grant Foundation.

Massoglia, M. (2008). Incarceration, health, and racial disparities in health. *Law & Society Review, 42*(2), 275-306.

Mathur, S. R., & Clark, H. G. (2014). Community engagement for reentry success of youth from juvenile justice: Challenges and opportunities. *Education and Treatment of Children, 37*(4), 713-734.

Mendel, R. A. (2011). *No place for kids: The case for reducing juvenile confinement*. Annie E. Casey Foundation.

Meza, J. I., Bondoc, C., Keshav, N., Bosco, J., & Barnert, E. (2023). Exploring the link between neighborhood violence and health among African-American and Latinx youth returning home after incarceration. *Child & Youth Care Forum, 52*(3), 533-558.

Mowen, T. J., Brent, J. J., & Boman IV, J. H. (2020). The effect of school discipline on offending across time. *Justice Quarterly*, *37*(4), 739-760.

National Association of Social Workers. (2021). *Code of ethics*. Author.

Owen, M. C., Wallace, S. B., Alderman, E. M., Chung, R., Grubb, L. K., Lee, J., Powers, M. E., Rahmandar, M. H., & Upadhya, K. K. (2020). Advocacy and collaborative health care for justice-involved youth. *Pediatrics*, *146*(1), 1-20.

Phillips, L. A., & Lindsay, M. (2011). Prison to society: A mixed methods analysis of coping with reentry. *International Journal of Offender Therapy and Comparative Criminology, 55*(1), 136-154.

Rovner, J. (2016). *Racial disparities in youth commitments and arrests* [Policy brief]. The Sentencing Project.

Rovner, J. (2021). *Racial disparities in youth incarceration persist* [Report]. The Sentencing Project.

Sampson, R. J., Morenoff, J. D., & Gannon-Rowley, T. (2002). Assessing "neighborhood effects": Social Processes and new directions in research. *Annual Review of Sociology, 28*(1), 443-478. https://doi.org/10.1146/annurev.soc.28.110601.141114

Schwartz, G. L., Wang, G., Kershaw, K. N., McGowan, C., Kim, M. H., & Hamad, R. (2022). The long shadow of residential racial segregation: Associations between childhood residential segregation trajectories and young adult health among Black US Americans. *Health & Place*, *77*, 1-11.

Sickmund, M., & Puzzanchera, C. (2014). *Juvenile offenders and victims: 2014 national report*. Office of Juvenile Justice and Delinquency Prevention.

Sickmund, M., Sladky, T. J., Puzzanchera, C., & Kang, W. (2021). *Easy access to the census of juveniles in residential placement*. National Center for Juvenile Justice.

Sinclair, J. S., Unruh, D. K., Griller Clark, H., & Waintrup, M. G. (2016). School personnel perceptions of youth with disabilities returning to high school from the juvenile justice system. *The Journal of Special Education*, *51*(2), 95-105.

Starr, S. B., & Rehavi, M. M. (2013). Mandatory sentencing and racial disparity: Assessing the role of prosecutors and the effects of Booker. *Yale Law Journal, 123*, 2-80.

Stroul, B., & Friedman, R. M. (1986). *A system of care for children and adolescents with severe emotional disturbances*. Georgetown University Center for Child Development.

Sullivan, M. L. (2004). Youth perspectives on the experience of reentry. *Youth Violence and Juvenile Justice, 2*, 56-71.

Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry*, *59*(12), 1133-1143.

Todis, B., Bullis, M., Waintrup, M., Schultz, R., & D'Ambrosio, R. (2001). Overcoming the odds: Qualitative examination of resilience among formerly confined adolescents. *Exceptional Children*, *68*(1), 119-139.

Quinn, K., Frueh, B. C., Scheidell, J., Schatz, D., Scanlon, F., & Khan, M. R. (2019). Internalizing and externalizing factors on the pathway from adverse experiences in childhood to non-medical prescription opioid use in adulthood. *Drug and Alcohol Dependence*, *197*, 212-219.

Udell, W., Mohammed, S., & Breland, D. (2017). Barriers to independently accessing care among detention youth. *Journal of Adolescent Research, 32*(4), 433-455.

Woods, L. N., Lanza, A. S., Dyson, W., & Gordon, D. M. (2013). The role of prevention in promoting continuity of health care in prisoner reentry initiatives. *American Journal of Public Health*, *103*(5), 830-838.

World Health Organization. (2020). *Preamble to the constitution of WHO as adopted by the International Health Conference*. Author.

Author note: Christopher Bondoc; David Geffen School of Medicine at UCLA; 10833 Le Conte Ave, Los Angeles, CA 90095, cbondoc@mednet.ucla.edu

Acknowledgements: The authors have no known conflicts of interest to disclose. This work was supported by the National Institutes on Drug Abuse [K23 DA045747-01], California Community Foundation [BAPP-19-154836], and UCLA Clinical and Translational Science Institute [NIH KL2U000124]. We thank our study participants and community partners. We also thank Nathalie Lopez, Bria Pettway, and Marisela Aguilar for their intellectual contributions.

Appendix. **Youth Interview Guide: Baseline Interviews**

We are conducting a research study. There are 4 fundamental domains (overall wellness, health status and beliefs, accessing care during reentry, and recommendations). These are exemplar questions we will ask during the semi-structured interviews to probe the topics covered below. We will use the same interview script for parents; however, instead of saying "you" in each instance, we will substitute this to ask about "your child." For the parent interviews, all questions will reflect back to the experiences of their child. For example: "How are things at school for your child." Similarly, the questions about health appointments will refer to health appointments of the child and recommendations will ask about how to improve care access for the child.

Script for youth: I would like to hear from you about your experiences with health and health care. I will ask you about your health and how easy or hard it has been for you to get to the doctor. By health, I mean when your body, mind, emotions, and your relationships feel strong. Health also means not have diseases or conditions like infections that make your body or mind feel bad or weak. I would specifically like to understand how things have been for you since you have been home from camp. I'd like to remind you that participation is completely voluntary. If you feel uncomfortable at any point we can skip questions or stop completely. Your participation and the answers to your questions in no way affect your standing with the court or with probation. There are no right or wrong answers. Simply tell me what is true for you. Your responses are confidential and I will not share your responses with your parents or probation officer. In order to protect your privacy, please do not give me additional information beyond what I ask for. Everything you say is confidential, meaning that we will not link your name or identity to anything you say and we will not tell others that you participated in this study. However, it is important that you are aware that there are two limits to this confidentiality. First, if you give me information that a child or elderly person is being abused or may be being abused, I may report it to the authorities. Second, if you tell me that you plan to harm yourself or others, I may report it to the authorities or a health staff member. Ultimately, the purpose of this project is so that doctors and other adults can learn how to do a better job of helping kids feel healthy after they go home from camp. We appreciate your participation. Do you have any questions before we begin? [Answer any questions. When no more questions and participants demonstrate understanding of the preamble, then begin]. Let's get started.

I. Reentry Experience/ Overall Wellness

To start off, I want to get a sense of where you're at. I'd like to understand how you have been doing since you have been home from camp.

1. How are things going for you since you left camp?
    a. __ Well?
    b. __ Poorly?
2. How are things at:
    a. Home?
        i. __ Relationships?
        ii. __ Conflicts?
    b. School?
3. How is your health? [[Get diagnosis here.]]
    a. __ Physical
    b. __ Reproductive health
    c. __ Mental/emotional
    d. __ Addictions

e. __ Social/relationships

II. Health Status & Health Beliefs

In this next set of questions, I'd like to understand a little bit more about your health and how you think about it.

Camp:

1. Besides a pediatrician, what health professionals did you see while you were at juvenile hall or camp? (e.g., psychiatrist, counselor)
2. Were you on medications while you were at camp? If so, which ones and what were they for?
3. Did the doctors or mental health providers give you any diagnoses or names of specific conditions that you have, such as asthma or depression? If so, what conditions?
    a. What do you understand about these conditions?
4. What did the health professionals at camp recommend you do to take care of your health once you got home?

Now let's switch to talking about how you've been since you got back home from camp.

Home:

1. How do you think your health conditions are affecting other things in your life, such as going to school)?
    a. __ Home
    b. __ School
2. Which recommendations were you able to follow through with and why?
    a. __ Physical health
    b. __ Reproductive health
    c. __ Substance abuse treatment
    d. __ Mental health
    e. __ Medications

III. Accessing Health Care during Reentry

I know there's a lot to adjust to when you come home from camp. The purpose of this next set of questions is to understand what is hard and what is easy about accessing care in the period after you left camp. I'd first like to understand what it's like to get to a health appointment.

Went

1. What was your last health appointment (when, with home, for what)?
2. Can you walk me through the process of getting and going to your last health appointment (outside of camp or juvenile hall).
    a. __ knowing where to go /call
    b. __ scheduling the appointment
    c. __ getting to the appointment
    d. __ insurance and payment
    e. __ other stuff you needed to happen to get you to a health appointment?
3. What role did you and others play the appointment?
    a. __ You
    b. __ Parents
    c. __ Your probation officer
4. What was the experience of the appointment like?
    a. __ Good
    b. __ Bad

Didn't go

1. What happened?
    a. __ Previous bad experience or priors
    b. __ Scheduling
    c. __ Getting there
    d. __ Insurance and cost
    e. __ Other
2. Who could have helped and how?
    a. __ You
    b. __ Parents
    c. __ Your probation officer
    d. __ Other person

IV. Recommendations

In the last few questions, I'd like to understand what you think kids need during reentry to get to health care. You've known a lot of kids and you probably know some kids that would go to all the appointments that doctors recommend and some that don't go to any.

1. What types of kids are likely to get to their appointments and which ones are not? Where do you fall in that?
2. For kids who are not likely to get to appointments:
    a. What do you think they need in order to get to health care?
    b. What about:
        i. __ text messaging
        ii. __ coach
        iii. __ probation officer more involved
        iv. __ other
3. For kids who are likely to get to appointments? What could help them get to health care after they get home from camp? Why are they able to get to their appointments?
4. What messages would you like me to tell people that would help kids coming home from camp be healthy?
    __ Court and probation
    __ Parents
    __ Teachers
    __ Health providers
    __ Other

Those were my last questions for the interview. Do you have anything else you'd like to add?

****Future Contact Info*

1. Is the number that we reached you at today still the best phone number to reach you at?
2. Are there other phone numbers for you that we can keep on file in case the number we used today changes? _____