Ch.12 Healthcare

Author: Michelle Staples-Horne, MD, MS, MPH, CCHP

Youth and families involved in the juvenile justice system are considered one of the most at-risk populations in the community. Unmet or inconsistent mental healthcare has been identified by the juvenile courts as one of the major issues causing youth to remain in the system, usually for reoffending. Unmet medical healthcare needs also play an important role in the rehabilitation of these juveniles. Health and mental health issues impact each other, so both must be addressed simultaneously in the juvenile system. The courts have mandated a comprehensive healthcare system for incarcerated persons to address both physical and mental health needs. For some youth, the system during detention can be more stable than the circumstances in which they live on a daily basis in their community.

Juvenile offending behavior is strongly related to poor health, deteriorating family relationships, worsening school performance, lack of employment, and other social and psychological problems, including lowered school performance, poor family relationships, high rates of conduct disorders, and increased interactions with alcohol and drug abusing peers.

Often, the public perceives juvenile offenders as “well enough to get in trouble.” Ironically, it is often the behaviors that got them into the juvenile justice system that increase their risk for premature death and disease. Detained youth are more likely to have experimented with smoking, alcohol, and drugs; used weapons; and been exposed to violence and trauma compared to the non-offender population. Engagement in risky sexual behaviors such as multiple sex partners and lack of condom use increases the risk of exposure to HIV and other sexually transmitted infections. All these behaviors increase their likelihood of injury, overdose, suicide, and early disease.

The care of youth in custody is unique and requires correctional facilities—whether it is juvenile facilities or adult facilities that house youth—to accommodate their
needs. In adult facilities, housing, including medical care, must be provided separately—outside of sight and sound of adult inmates. If a separate area for medical care cannot be provided, facility staff should adjust the schedule to bring youth to the medical area at a different time.

The American Correctional Association (ACA) and the National Commission on Correctional Healthcare (NCCHC) clearly outline the requirements for healthcare in this population. Often it is the development and implementation of health policies and procedures that ensure that the standards are met; policies and procedures are the key to consistency. They should never be developed in isolation. Input should occur from medical and security staff, with representation from line staff as well as administrators. Health policies and procedures should include definitions, be simple to follow, and not be too long. They should outline a broad approach to facility operation, but also define required details in a local operating procedure (LOP). Staff must be trained and must practice implementing procedures. Health policies and procedures should not be stagnant, but should include an annual review process to determine their effectiveness and the need for any modifications or revisions. Finally, it is inadequate to have policies and procedures without a continuous quality improvement program to monitor compliance and ensure that the practices of the healthcare staff lead to improved healthcare outcomes for youth.

**Staffing and Equipment**

No organization has been able to create a standardized staffing pattern for healthcare providers in a juvenile setting. Most correctional healthcare standards use the term “adequate” when referring to staffing. How do you determine what is adequate healthcare staffing for your facility? That decision should be based on purpose, form, and function.

What is the **purpose** of the facility? Short-term detention centers need more healthcare staff, due to the high turnover of admissions and discharges compared to a long-term juvenile facility. If an adult facility houses juveniles, will there be enough staff to care for youth separately? Will the facility house females or a special population with high mental health needs that will increase the use of health services?

The next consideration is **form**. What is the layout and location of the facility? Larger facilities will require more staff, but how many also depends on whether all services are in one building or spread across a large area. Location in a rural community or even a highly competitive urban area may require some creative
staffing. It may be difficult to hire full time healthcare staff at a competitive rate, or the personnel may not be available in the area. In these cases, consider contracting for healthcare staff or partnership agreements with community providers such as public health and teaching hospitals or universities. Agreements and contracts should be as detailed and inclusive as possible.

Finally, how does the clinic function? Is there enough healthcare staff to meet the needs of the youth within the healthcare standard’s recommended time frame? This consideration will take a continuing reassessment of staffing to determine if all healthcare service needs are being met in a timely manner.

The first step in staffing is the establishment of the health authority. This person is responsible for all levels of healthcare and for providing quality, accessible health services to all youth. The position may be filled by a nurse or other health professional, particularly in a small facility, or by a health administrator, which may be more applicable in a larger facility. When this health authority is anyone other than a physician, clinical judgment rests with a single designated responsible physician licensed in that state. A dentist, psychiatrist, and pharmacist should be available for consultation by the responsible physician, if these providers are not available on site. The health authority manages the schedules of all clinicians and serves as a member of the facility administrative team. The health authority should be involved in the hiring and supervising of the healthcare staff and should serve as a consultant to the facility administration and security staff regarding all aspects of health. Clinical decisions and actions regarding healthcare services provided to youth are the sole responsibility of the healthcare staff and must never be compromised for security reasons. The health authority should cooperate with security staff to create an environment that meets the health needs of the youth, without compromising safety.

All healthcare staff should be licensed and credentialed as required by state and federal law; licensing needs ongoing monitoring to ensure up-to-date compliance. Requirements for continuing education vary by state and should be promoted. Continuing education specific to correctional health is strongly recommended.

The use of interns and students must include agreements with the schools and must entail close supervision. Exposure of healthcare students to correctional medicine is a great opportunity to encourage recruitment of future staff.

There should be an on-call healthcare system for facilities that do not operate 24/7. Minimally, a nurse should be on call when the clinic is closed. The nurse should have
access to the physician, dentist, and psychiatrist. A designated clinic cell phone allows security staff to have immediate access to healthcare staff when the clinic is closed. All staff should be trained and certified in first aid and CPR for immediate response to an emergency. Basic training and annual updates on medical emergencies should be provided to non-healthcare staff. Medical emergency drills should include all staff.

Adequate equipment and supplies are essential to the operation of the clinic. Input from clinical staff should be included during site planning and construction. Appropriate equipment should be chosen by the staff that will use them on a daily basis. Once a facility is equipped for operation, it should be a simple matter for healthcare staff to order supplies and equipment from their designated budget. It is helpful to designate the types of medical equipment and supplies required by policy. This practice will standardize the clinic and eliminate squabbles over budgets. The facility health authority should designate strategic points inside the facility to locate Automated External Defibrillators (AEDs) and first aid kits. This equipment should be readily accessible to CPR-trained staff for use in an emergency. Personal protective supplies and equipment for avoiding contamination with biohazards such as body fluids should be available to all staff. A system of storage, collection, and decontamination of biohazardous waste must be in place and controlled by the health authority. Staff should use and account for safety needles, syringes, and all medical sharps. An inventory of safety needles and syringes should be completed at the start of each shift. The superintendent should take a periodic unannounced count of needles and syringes at least quarterly. Needles should never be re-capped, bent, or broken after use. Needles and other sharps should be disposed of intact in designated, puncture-resistant containers located in a secure area.

Intake Screening and Assessment

Many facilities lack 24-hour nursing care. Correctional officers or whoever first comes in contact with the youth at intake must be trained in basic medical and mental health screening procedures. There must be a clear mechanism to determine if healthcare staff need to be contacted if they are off site or if a youth needs further assessment prior to admission. The screening should be simple enough for health-trained security staff to be able to make a determination whether to place a youth in general population or in isolation for infection control. Screening instruments should reflect the common concerns among this population and include mental health and dental status as required by the ACA and NCCHC standards. (See Ch. 9: Admission and Intake) [2]
If the facility houses adults, there should be some modification of the screening instrument to reflect the needs of youth, such as inclusion of immunization history and questions to identify sexual and physical abuse history. A mechanism to report and address any allegations of abuse must be incorporated throughout the system, beginning at intake, for all facility types. Long-term juvenile facilities that accept youth transferred from short-term detention facilities or transfers between secure facilities should still use a screening instrument at intake. Healthcare staff must complete the health assessment after health-trained security staff complete the initial intake screening. Healthcare staff should review the intake screening results and obtain additional information on past medical, dental, and psychiatric history. This assessment involves a more detailed line of questioning of the youth.

Ideally, healthcare staff would be available 24 hours a day to conduct the intake screening and the health assessment, especially in a high-volume detention center. But, due to staffing limitations, 24-hour on-site care may not be available. If it is not, it is critical to have a system in place to address medical emergencies with on-call medical staff and to access outside emergency services. Licensed clinicians should complete a thorough physical examination (PE) within the required timeframes, according to ACA and NCCHC standards. The PE should include areas specific to the adolescent population, such as scoliosis screening, developmental pubertal staging, growth charting, vision and hearing screening, and the identification of physical characteristics that may reflect conditions such as fetal alcohol syndrome (FAS). Some youth display many behavioral characteristics and intellectual impairments of FAS and may not have been previously diagnosed. If applicable, youth should receive physical examinations annually.

Sick Call and Clinic Visits

It is essential to implement an unimpeded process for access to sick call for youth. Sick call boxes, with forms available, should be easily accessible. Access to sick call boxes should be limited to healthcare staff to protect the confidentiality of the youth. Consideration should be given to literacy skills when sick call requests are written. Also, youth may sometimes request services for something other than the real problem for which they need to be seen, due to embarrassment or fear of peer criticism.

Policy and procedure should outline the sick call process and set time frames for completion. Sick call clinic hours should be flexible, and not always during school or recreational hours. Facilities that house adults need policies that exclude youth from copays or other systemic barriers to healthcare. Youth may not prioritize the need
for healthcare, given the choice between the sick call copay and a snack from the commissary.

Nursing staff can triage the initial sick call. Medical assessments should be completed by the healthcare staff trained and credentialed to do so. In most states, nurses use protocols developed by physicians to treat common ailments, such as a colds and acne, with over-the-counter medications. Depending on the location, advanced practice nurses and physician assistants can diagnose and treat with prescription medications. These types of staff greatly augment the healthcare provided in juvenile correctional facilities. Every facility needs a physician who will ultimately be responsible for the healthcare of the residents, even if only through remote supervision or limited on-site visits. This tiered approach to sick call assessments can be very efficient in a juvenile healthcare setting. Most ailments in this population are minor and can be addressed by nursing staff. However, when a youth’s condition fails to improve, staff should consult a higher-level clinical provider. Youth may make multiple complaints, which staff sometimes perceive as malingering. Chronic complaining may require further medical assessment or may be a somatic symptom of a mental health condition or situational stress. All complaints must be taken seriously and assessed thoroughly. If all medical and psychological reasons have been ruled out, it may be beneficial for some youth to have regularly scheduled appointments with healthcare staff, thus reducing the number of sick call requests.

A significant number of clinic visits in juvenile settings are for injuries—both intentional and accidental. Intentional injuries from fights and self-inflicted wounds are very common and always require a clinic visit for assessment. Be certain to involve behavioral health staff when a youth presents with a self-inflicted wound or any suicidal ideations. Accidental injuries are also quite common and result from sports, adolescent horseplay, or security control measures. X-rays can verify or rule out any potential fractures; any fracture should be treated and followed up. Access to healthcare staff who can suture wounds on site is exceedingly valuable in a juvenile healthcare setting. For more serious injuries, emergency care is required. Healthcare staff should determine when youth are to be transported outside the facility for urgent care. Some juvenile facilities maintain infirmary beds for youth who may need a higher level of care than the living unit can provide, but do not require inpatient hospitalization. Infirmary care requires 24-hour skilled nursing. It is rare that a youth will require inpatient hospitalization for an extended period or is diagnosed with a serious medical condition such as leukemia. Under these circumstances, administrators may want to approach the courts to request a release from custody or a stay in sentence.
Healthcare staff play a vital role in the special incident reporting process when youth or staff are involved in physical altercations. Healthcare staff should be allowed privacy in interviewing youth about the incident. Policy should require an examination to be completed within specific time frames. Healthcare staff reports should be used to cross reference security reports and serve as an unbiased account of the event; reports should document any injuries or allegations of abuse.

**Ancillary Care**

Ancillary care (labs, X-rays) should be available as a part of the facility’s healthcare program. All efforts should be made to provide these services on site. Transporting youth off site for these services increases the demand for staffing and the risk of escape. Mobile radiology services allow studies to be completed inside the facility. Contracts should include interpretation by a Board Certified Radiologist. When emergency X-rays are needed off site, staff should coordinate with providers to reduce wait times in the emergency room or urgent care center.

Detention intake should include a standard set of admission labs. Simple Clinical Laboratory Improvement Amendment (CLIA) waived tests can be incorporated into the admissions process. A single urine sample can be used for urinalysis testing, pregnancy testing, and screening for gonorrhea and chlamydia. Medical staff are not involved in the collection of forensic evidence, such as urine drug screening, so youth should be made aware of the purpose of the specimen collection. Pregnancy testing should be performed on all females routinely as a part of the intake process, regardless of their sexual history. Pregnant girls will require specialized care, and pregnancy may prohibit some security measures, such as the use of restraints during labor and delivery. Additional laboratory services should be accessible if they are medically necessary. A laboratory contract will provide fixed prices, supplies, and pick-up schedules. Many labs offer online electronic results. Smaller facilities or those located in rural areas may not be able to contract with the larger labs for service. Such facilities may be able to contract with a local hospital for service. Another option is to partner with another agency, such as the adult department of corrections to take advantage of a larger purchasing group. In some locations, public health agencies can provide laboratory support. Administrators may contract for other ancillary services such as optometry, physical therapy, speech pathology, etc. based on volume. Again, if possible, bring the services to the facility. In some cases, education departments or school systems can provide or pay for these types of services for special needs youth while they are detained.

**Dental Care**
Dentistry is probably the most common unmet need among youth offenders. Many have never seen a dentist since they were screened for admission into elementary school. A dental clinic with adequate equipment and supplies should be a component of every juvenile health system. If the facility is too small or rural to attract a dentist, some arrangement must be made with a community provider for care.

Dental screening is a part of the admission process. If dental staff are not available, nursing staff can be trained by the dentist to conduct an initial dental screening. Nurses can inquire about dental pain, note dental decay, note the presence of braces and missing teeth and note abnormalities of the mouth. In the case of positive screenings, staff must contact with dental providers for further instruction. In some settings, dental protocols can be developed to allow nurses to accommodate dental needs on a temporary basis, such as giving acetaminophen for dental pain.

Only a licensed dentist may conduct dental examinations and treatment. The presence of a dental assistant allows the dentist to conduct treatment more efficiently. Community recommendations are for two routine dental visits a year for examination and cleaning (prophylaxis). Detention centers, especially those where youth may move in and out several times a year, should establish a tracking system for examinations. Dental education is key in this population and can be accomplished by dental staff, nurses trained by dental staff, or educational DVDs. Larger juvenile systems can benefit from hiring a dental hygienist for cleaning and instruction. Tooth brushing and flossing should be allowed only with security-approved items and should be scheduled as a routine part of the youth's hygiene practice.

In juvenile settings, dental care should go beyond only providing extractions and should focus on preventive and restorative dental care. Youth housed in adult facilities will require restorative dental services that may not routinely be available to the adult inmate population.

Adolescents commonly present with pain related to wisdom tooth (third molar) eruptions. There is also the likeliness of jaw fractures occurring from fights. An oral surgeon should be available for consultation and treatment in these two areas. Sometimes youth are admitted while under the treatment of a community orthodontist. In short-term detention facilities, continued use of braces may be acceptable. Deterioration or self-removal of braces creates a security risk. For youth with longer sentences or those confined to adult facilities, the community orthodontist may recommend temporary removal of these dental appliances.
Pharmacy and Medications

Pharmacy policy and procedure should outline how medications are handled at every point within the facility. In short-term facilities such as detention centers, detained youth may be carrying their current medications. Policy should dictate whether that medication can be accepted for administration or whether it should be held in a secure manner until the youth is released. For security and patient safety, medical staff need to confirm the medications to limit contraband. A pharmacist by employment or contract must be available to monitor pharmaceutical practices and ensure compliance with all state and federal drug laws. In a small or rural facility, the facility can arrange with the local drug store pharmacist to visit and monitor compliance. Larger systems may want to employ a full-time pharmacy director.

It is recommended that a formulary (list of preapproved medications) be generated by a physician trained in pediatrics or family medicine. A formulary can also help control pharmaceutical costs. However, a mechanism must be in place to allow for dispensing of non-formulary medications when they are clinically indicated. Many medications—even over-the-counter medications such as aspirin—are not appropriate for children and adolescents and should not be included on the formulary for juveniles. Adults are generally not treated in the adult correctional systems for certain diagnoses such as Attention Deficit Hyperactivity Disorder (ADHD). The use of stimulant medications to treat ADHD is needed for youth attending school, but has potential abuse by youth and staff. These drugs and other newer and more costly psychotropic medications should be included on medication formularies for facilities that house youth. Some medications need dosage modifications based on body weight; others are not approved for use with children.

In facilities that house youth with adults, it is often the practice to allow inmates to keep on person (KOP) medications for self-administration. It may not be developmentally appropriate for youth to self-administer medication; directly observed therapy (DOT)—where staff administer medication to youth—may be called for. Young people would be more likely than adults to mismanage their medication through noncompliance, overdosing, or sharing their medication with other youth.

Inventory of all medications is essential to all correctional facilities. A unit dose packaging system works best for management of drug inventory. Medical staff must document and account for any medication refusals. Clinical staff should be notified if youth refuse their medication. Depending on the jurisdiction and legal status of the youth, parental consent also may be required for the administration or
discontinuation of medications to juveniles. In some juvenile and adult systems, officers are allowed to administer medications. If, after intensive review, this practice is allowed, specific training and procedures for administration must be developed and enforced. Errors may occur within the routine administration of medication. A system must be in place to document and report these errors to the responsible physician, address any related adverse event, and review them as a part of a continuous quality improvement process during the committee meetings that deal with pharmacy and therapeutics.

**Specialty Care or Chronic Care**

In general, youth populations do not have the number or severity of the chronic medical conditions that exist in an adult population. Probably the most common chronic medical condition in this population is having a mental health diagnosis. Asthma is probably the next most common. As more children and adolescents have become overweight, more are being diagnosed as hypertensive, diabetic, and having high cholesterol. Medications for treating these conditions should be included on the facility formulary. With adequate medical screening and examination upon admission, staff can identify and oversee the treatment of chronic medical conditions. Community standards for treatment of chronic illnesses must be followed using appropriate clinical guidelines.

The care of a youth with a chronic medical condition may require some modifications to the correctional environment. For example, a youth with a seizure disorder should not be assigned to an upper bunk. Staff should be instructed not to place objects in the mouth of an actively seizing youth and to remove objects to prevent injury and support the youth’s airway. Youth that have asthma should not be assigned to cleaning duties or other activities where there may be environmental triggers such as cold air. Inhalers may be the only exception to the rule about KOP, depending on the severity of the symptoms. Inhalers must be readily available after clinic hours. In previous years, Type I Diabetes was the most common type of diabetes in this population. These youth require insulin injections to keep their blood sugar under control, since they cannot produce it. Now with the increasing epidemic of obesity, Type II Diabetes is more common. Youth with this type of diabetes make insulin, but the body’s cells are resistant, and the blood sugar is not reduced. Most Type II Diabetics can be managed with oral medication; however, sometimes youth may require insulin injections. Ideally, the injection of insulin and monitoring of blood sugars with finger sticks should be supervised by the healthcare staff. This is not always possible in facilities that do not operate a 24-hour clinic. Depending on the youth’s knowledge and skill level, he or she may be allowed to administer his or
her own insulin under staff supervision. All staff should have training and knowledge of the signs of very high and very low blood sugars, either of which can lead to serious injury or death. Bedtime snacks and food sugar sources approved by the healthcare staff should be available on the unit for immediate need. Staff and youth should also be educated and compliant regarding dietary restrictions and activity requirements.

Most youth with chronic medical conditions have been diagnosed in the community prior to detention. But in many instances, they have not had consistent follow-up care by their community medical providers. It is critical to get the medical history from the parent and community provider to achieve better continuity of care while the youth is detained. If possible, prescribed medications should be continued for youth in short-term detention to prevent disruption in treatment. A referral network for pediatric specialty care and hospitalization should be established for each facility, even for adult facilities that house youth. Youth with chronic medical conditions that do not have a community provider should be referred to one prior to discharge.

Medical and education staff must jointly address special medical needs of youth. Glasses, hearing aids, and other prostheses and assistive devices can create security issues in a detention center unless there is coordination. Medical staff must collaborate with educational staff to develop IEPs (Individual Educational Plans) and to provide the required devices or special services to the youth. Once a need is identified, security staff must be involved in the decisions regarding the required accommodation so that any security risk can be minimized.

Girls and young women have health needs that demand special consideration. Evidence suggests that detained young women are likely to have significant medical problems including untreated Sexually Transmitted Infections (STIs), pregnancies, chronic medical conditions, substance use, and psychiatric disorders. There are other acute and chronic medical conditions that certainly occur in this population as well. Mental health diagnoses, obesity, diabetes, hypertension, and asthma are increasingly prevalent among young women in detention.

Providing health services to young women requires an interdisciplinary approach to staffing and program development. It is important to include licensed health professionals in staffing a juvenile correctional facility, but line staff must also be well trained and educated about the medical needs of the population they serve. A young woman's history of victimization may make compliance with simple medical regimes an issue. Emotional issues may trigger somatic responses such as a Herpes outbreak or gastrointestinal upset. Sometimes this leads to the perception by staff that the
youth is being manipulative or feigning illness. All staff should be trained to take all medical complaints seriously and respond appropriately. Medical staff should be aware of the health problems more likely to affect girls of color, who are disproportionately represented in the juvenile justice system. Diabetes, for instance, appears with greater frequency among African-American girls and young women. Cultural sensitivity on the part of medical, administrative, and security staff is mandatory and should go beyond just creating cultural diversity through staff hiring. Gender equity in juvenile justice programming should be the rule and not the exception.

Greater healthcare expenses should be anticipated in the operation of a female juvenile facility compared to a male facility. Females in general use more medical care even while in the community. Staffing patterns and ratios at female facilities should reflect this increased need. The greater prevalence of chronic diseases, including mental health diagnoses, and the provision of prenatal care and delivery also tend to increase healthcare costs at female juvenile facilities.

**Sexual Behaviors and the Prison Rape Elimination Act (PREA)**

PREA was enacted by Congress and requires all confinement facilities, including those that house youth, to implement policies and procedures to eliminate sexual assault and sexual harassment. The law supports the elimination, reduction, and prevention of sexual assault and sexual harassment within confinement settings. The healthcare staff perform an important role in implementing the national PREA Standards. Each facility should develop policies and procedures to address the requirements specific to their setting. Healthcare staff should become familiar with applicable federal and state laws, as well as their professional code of ethics. The medical intake should be conducted in a confidential manner—in a private area—to determine any history of sexual abuse, the date it occurred, where, and by whom. (See Ch. 14: Behavior Management: Staffing Ratios, Turnover, and Deployment). [3]

**Child or Sexual Abuse**

A standardized child abuse reporting procedure for sexual abuse should be established by policy, keeping in mind that healthcare staff are considered mandatory reporters for suspected child abuse. Adult facilities that house youth are also obligated to report allegations of child abuse. If this initial information is obtained by security staff, they should have a procedure to immediately notify healthcare staff for further instruction regarding the need for an immediate medical assessment. Secondary reporting methods for sexual abuse can include toll free numbers and sick call or clinic visit requests to healthcare staff.
If the sexual abuse occurred within the time limitations for assessment and collection of evidence, a forensic examination is required. These examinations must be completed by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE), when possible. If SANEs orSAFEs cannot be made available, the examination can be performed by other qualified medical practitioners. A facility medical practitioner who has also successfully completed specialized training for treating sexual abuse victims can conduct forensic examinations, but an outside qualified medical practitioner is preferred to ensure objectivity. Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving youth victims to gather and preserve direct and circumstantial evidence. Examinations must be made available on site or at an outside facility without monetary cost to the youth. Facilities may choose to enter agreements with local hospitals for SANE or SAFE examinations. A facility may choose to contract directly with SANE or SAFE examiners to come to the facility. Keep in mind, with this option, proper equipment and examination resources need to be available.

PREA Standard 115.353 requires the facility to "provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies."

Medical and mental health staff should coordinate appropriate follow-up care for continued services after the assault, in collaboration with the security staff. If the sexual assault occurred prior to the time appropriate for the collection of forensic evidence—usually less than 72 hours—reporting requirements are still applicable. Healthcare staff should still screen for sexually transmitted infections, determine whether additional examinations are required, and refer youth for mental health follow up.

**Sexual History**

The discussion of sexual behaviors, including risk and protection, should be included in every preventive medical encounter. Healthcare staff should include questions about a youth’s age at first vaginal, oral, and anal intercourse; current sexual practices; number of partners within the last 3 months; and gender(s) of partners. Though sexual relations between youth residents is officially prohibited, many residents may have had same-sex sexual experiences prior to detention. When questioning all youth about sexual behaviors, it is important to use the word *partner*.
and not *boyfriend* or *girlfriend*, so as not to assume heterosexuality. Many youth may be having sex with casual partners or sex work clients whom they would not consider as a boyfriend or girlfriend. They may use these terms to refer to a regular partner with whom they may have an emotional attachment.

**Condoms**

Additionally, all clinical interviews about reproductive health should include a discussion about condoms. Though juvenile justice systems often have restrictions on displaying and dispensing condoms within the facility, medical providers and health educators can educate residents about the correct and consistent use of condoms so they will be better equipped to protect themselves after their release from confinement. Prior to release, youth should know where to purchase or get free condoms in the community.

**Sexually Transmitted Infections**

**Chlamydia**

Because chlamydia rates are so much higher in detention facilities than in the general population, chlamydia screening is recommended for *all females and, depending on local public health statistics, males as well*. Gonorrhea rates are also disproportionately high for youth residents, who should be considered for screening. Routine syphilis screening is appropriate for pregnant girls and sexually-exploited youth who may be more at risk. It should be noted that other STIs such as herpes and genital warts are also common in this population. Local epidemiological data should determine the type of STI testing. Healthcare staff must be trained in the detection and treatment of STIs. The CDC STI Treatment Guidelines should be followed.[2]

New urine-based tests can improve compliance for STI testing and may be easily incorporated into the facility’s intake process. The urine-based nucleic acid amplification tests (NAATs) are highly sensitive and specific. In many cases, the use of a urine specimen can reduce the necessity for a pelvic examination on young women (urethral swabs for males), thus extending the facility’s diagnostic capability for detecting these infections. Youth may be more compliant with STI testing if staff use these less invasive collection procedures. Also, pap smears are no longer recommended for young women under the age of 21; this also reduces the need for routine pelvic examinations.

**HIV**
The prevalence of HIV is unknown in the youth population. However, the behaviors that place them at risk for HIV infection are common, such as multiple sex partners, low condom use, drug use, and unsafe tattooing and piercing. HIV screening should be made available to youth when they request it and when it is clinically indicated. Infection rates are increasing among adolescents. If HIV testing were done routinely, unless the youth refused (Opt Out), it would increase our ability to identify youth that are HIV positive and refer them for specialty care. In all cases, facilities should educate youth about how to prevent HIV. Youth who are known to be HIV positive should not be isolated, nor should their status be disclosed for nonmedical reasons. Basic precautions—with the use of gloves, goggles, and protective gowns—to prevent exposure to body fluids should be standard for everyone.

Public health agencies must consider partnering with juvenile justice agencies to promote and facilitate STI screening and treatment of youth prior to their return to the community. Partnerships should include communication and reporting of required infections, treatment and follow up of positive cases, medication if a youth is released prior to receiving treatment, and partner notification. A Memorandum of Understanding (MOU) can allow sharing information across agencies and can define all parties’ responsibilities, whether in kind or with some fiscal responsibility.

Gender Identity

It is difficult to ascertain the true percentage of youth who are grappling with questions about their sexuality and gender identity. The majority of states do not include such questions in their Youth Risk Behavior Surveys. The limited data that we do have regarding sexual orientation indicate that between 2% and 4.5% of high school students self-identify as gay, lesbian, or bisexual. These data are definitely underestimates, as many youth have difficulty understanding the complexity of sexual attractions or they fear revealing personal information. There are virtually no data on transgenderism in the adolescent population. PREA Standard 115.341 requires that, within 72 hours of a resident’s arrival at the facility, the agency must obtain and use information about the resident’s personal history and behavior to reduce the risk of sexual abuse by or upon a resident. Sub-paragraph (c) (2) of that standard specifically requires the agency to attempt to ascertain information about any gender-nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, questioning, or intersex (LGBTQI), and whether the resident may therefore be vulnerable to sexual abuse. Transgender is an umbrella term that refers to a range of individuals whose gender identity does not match anatomic or chromosomal sex. Transgendered individuals can live as full- or part-time members of another gender and can be heterosexual, homosexual, or bisexual. Gender identity
is a person’s internal sense of being male or female, regardless of the person’s gender at birth. A person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical definitions of male or female is considered intersex. Intersex medical conditions are sometimes referred to as disorders of sex development.

Most likely as a result of isolation caused by societal homophobia, a disproportionate number of LGBTQI youth turn to drugs or alcohol, suffer from depression, and engage in risky sexual behavior—including “survival sex,” or sex in exchange for food and shelter. These factors can increase the risk of youth confinement in this population. Though very little data exists regarding the actual number of LGBTQI youth in the system, it is estimated these youth make up between 4% and 10% of residents. These youth in confinement are at greater risk of victimization, sexual abuse, and rape. PREA requires that policies and practices prohibit discrimination on the basis of sexual orientation or gender identity and provide training for staff on how to create safe environments. (See Ch. 19: Complex Issues and Vulnerable Populations).

**Infection Control**

Correctional facilities present an increased risk for the spread of infectious diseases, due to individuals being confined in relatively close quarters. Also, in detention settings, failure to recognize infectious diseases at intake and isolate infected individuals can allow infections to spread rapidly throughout the facility. Admissions screening instruments should include questions about signs and symptoms of infection. Cough, fever, rash, or other skin lesions should prompt intake officers to notify healthcare staff and isolate a potentially infected person until a health assessment can be made. Healthcare staff should determine whether a youth should be admitted into general population if signs of infection exist.

**Tuberculosis**

Tuberculosis (TB) skin testing should be a routine part of the admission health assessment. If the TB test is positive, it should not be repeated. Healthcare staff should be trained in the placement and accurate reading of the TB skin test. The health record must document the TB skin test placement and results. Correctional, immigrant, homeless, and HIV positive populations are more at risk for TB. The Centers for Disease Control and Prevention (CDC) publishes guidelines for the prevention and treatment of TB in correctional settings. All facility staff should be TB tested annually, and the results should be documented in their human resources health record. The local health department may be able to assist the facility in its TB
monitoring program. A positive skin test in a youth most often indicates latent TB, or that the individual has been exposed to the TB germ. These youth are not contagious. Active TB, the only form that is contagious, is less common in youth. A chest X-ray can confirm the status of the TB germ. It is important to appropriately treat both latent and active TB with the proper medication.

**Influenza**

Influenza is another respiratory infection that can easily spread throughout the facility. Prevalence of the flu in the community creates an increased risk in the correctional setting. Influenza vaccines should be administered to all youth unless the vaccine is contraindicated. Staff should also be encouraged to be immunized either through public health services or their private provider; staff should stay home if they develop flu symptoms.

**Parasites**

Screening for lice and other ectoparasites is a critical part of the intake process and should be repeated when youth are transferred from one facility to another. Routine treatment with medication with no indication is unacceptable. Staff can be trained to use a Wood’s lamp (a special light) to inspect for these ectoparasite infections. Treatment should be administered on an individual basis. If infestation does occur in the facility, healthcare staff can provide direction to staff for eliminating and controlling it. To prevent facility contamination, soiled laundry should be bagged prior to being transported and should be handled as little as possible. Staff should wear personal protective equipment (gloves, cover gown, masks, face shield) when collecting or handling soiled laundry, linen, and clothing. Clean laundry should be handled, processed, and transported separately from soiled laundry.

**Containing Infectious Conditions**

Youth in correctional settings are also at risk of skin infections such as athlete’s foot and MRSA (Methicillin-resistant Staphylococcus aureus). These germs are spread by direct contact with skin and contaminated surfaces. Routine cleaning and disinfection of showers, mats, shoes, sports equipment, restraints, etc. will reduce the spread of these and other types of skin infections. Each facility should develop local procedures for containing respiratory illnesses and skin infections such as influenza and MRSA. The procedures should include, at a minimum:

- Guidelines for respiratory and contact isolation.
- Infection control inspections by a Registered Nurse.
- An allowance for limiting youth transfers.
- Notification to the designated health authority of pending youth transfers.
- Proper staffing during an outbreak of any major infection or virus.

All staff should be educated on infection control and how to protect themselves and their families. When called for, healthcare staff should recommend the use of protective equipment such as gowns, gloves, goggles, and masks. Hand washing and using hand sanitizers can help prevent the spread of many types of infections. There are some instances when units or even entire facilities should be quarantined to prevent the spread of infection. In these cases, certain staff and visitors may need to be excluded from the facility as directed by the health authority and responsible physician.

**Immunizations**

The best way to reduce the risk of certain infections in correctional settings is through a robust vaccination program and adequate levels of immunization. The federally-funded Vaccines for Children (VFC) program may be used to provide free vaccine to incarcerated youth. Juvenile justice health administrators should approach public health agencies aggressively to enroll all juvenile correctional facilities in this program and assist them in meeting program requirements. Formal agreements can also be made between the juvenile facility and the local public health department to have public health nurses administer vaccines to youth. Adult facilities that house youth are also eligible for participation to provide free vaccines for youth 18 and under. Due to the high-risk sexual behaviors in this population, routine vaccination for Hepatitis A, Hepatitis B, and (Human Papillomavirus (HPV) are highly recommended. All can be sexually transmitted. Youth should be able to give their own consent for these vaccinations; facilities should not require consent of the parent or guardian. At age 15, youth are usually due for a booster dose of the TDap (tetanus, diphtheria, and acellular pertussis or whooping cough) vaccine. All institutions should offer influenza and meningitis vaccinations and the potential for these respiratory diseases to spread quickly. Special medical conditions such as pregnancy and sickle cell anemia may require or prohibit certain vaccines.

Many states have implemented systems to electronically track immunizations. These systems allow for immunization data to be both retrieved and entered by all registered health providers. Public health agencies have taken the lead in this effort, working with community healthcare providers. Juvenile justice agencies should gain access to these databases, review immunization status on intake to facilities, and assure that patients are fully immunized prior to release. Healthcare providers should
enter data into these immunization databases without indicating linkage to the juvenile justice system, as that information could then be revealed to the public. Where full immunization is not possible because of a short detention stay, public health agencies can follow up after the youth’s release on any remaining required doses. If immunization information is not available through the public health department, the most recent school that the youth attended may be contacted for records. Keep in mind that these records may not be up to date and may require catch-up immunizations.

**Nutrition**

Juvenile detention facilities and adult facilities that house school-age youth may qualify for the federal school nutrition program; these are most often administered by the state department of education.[3] To receive reimbursements from this program, diets must meet USDA requirements for fat, sodium, and calorie counts. Reimbursable meals include breakfast, lunch, and an afterschool snack. Dinner and a bedtime snack should be made available, but are not reimbursed. A registered dietician should develop menus that will be appropriate for youth, both in nutritional content and food preference. In adult facilities that house youth, menus will need modification to at least provide milk at meals rather than tea or coffee. A registered dietician should be consulted, if not employed, to provide special diets ordered by healthcare staff. Youth should receive nutrition education and other wellness related topics at every available opportunity.

Detained youth often are not likely eating a healthy diet prior to admission. Diet-related disorders include obesity, iron deficiency anemia, and other problems. Low blood count or low hemoglobin is usually discovered at admission and is often due to poor diet. In the case of anemia, dietary improvements often resolve their problem before youth are discharged. Many obese youth will also lose weight during detention due to dietary improvements. This is especially important for youth with weight-related diabetes, hypertension, and increased cholesterol.

**Allergies**

Many youth report food allergies upon admission. It may be difficult to distinguish between true allergies and food preferences. Some will claim allergies to avoid certain foods associated with gang affiliations. Staff should obtain a thorough history and contact the parent or guardian, if possible. The most objective way to verify or rule out food allergies is to have medical staff conduct blood testing for the specific food item.
Hunger Strike

Hunger strikes are a rare event among youth in custody. If a youth is acknowledging a hunger strike, it is important that the actual food and fluid intake be monitored and verified. Sometimes youth will claim to be on a hunger strike, but are getting snacks from other detainees. Initially, maintaining adequate hydration is more critical than food intake. Medical staff and security staff must work together closely to monitor such a situation. Intervention by medical staff may be required if it is clinically indicated. Court involvement is required if medical staff recommend forced feeding or hydration.

Eating Disorders

Eating disorders also tend to be rarely identified in detained youth. Bulimia and anorexia are more prevalent among girls than boys. Inquiry into eating habits should be made at intake. Special management plans that include medical, behavioral health, and security staff are required if a youth is identified as having an eating disorder.

Food Safety

Food safety is a health concern in all correctional settings. Foods should be stored, cooked, and served at proper temperatures to reduce the risk of food poisoning. Food service operations should be monitored internally and by local authorities and should include staff that have been certified in the ServSafe Program.

Physical Activity

Adolescents today are not as physically active as they were a generation ago. There are many reasons for this, such as more time spent with technology, unsafe neighborhoods, reduced physical education in schools, and costs of extracurricular sports activities. Youth who enter facilities today are not accustomed to physical activity. Standards require one hour of daily physical activity. Medical screening and examination should occur before initial participation in rigorous physical activities. Care should be taken to gradually increase activity levels. Warm ups and adequate stretches will reduce the number of sports-related injuries. Youth may appear in the clinic with chest pain, not from cardiac causes, but from chest muscles unaccustomed to pushups. A full assessment is still required. Overweight youth should be encouraged to participate at reasonable levels. Activity modifications may be needed for youth with asthma or other medical conditions. An alert system should be in place to notify all staff of any activity restrictions imposed on the youth.
A significant number of injuries occur in relationship to sports activities. Administrative, security and medical staff should review the types of sports activities allowed and determine if too many injuries are related to a particular sport. Environmental modifications such as padding goal posts or gym floors may help reduce injuries and pay for themselves in cost savings realized by reducing emergency room visits.

Sunscreen application and access to drinking water are essential for outdoor activities, especially when the weather is hot. The health authority should intervene and coordinate with administration to prohibit outdoor activities when temperatures are too high or too low.

**Mental Health and Substance Abuse Medical Implications**

Research demonstrates that between two-thirds and three-quarters of detained juveniles have one or more psychiatric disorders. Nearly one-third of teens report episodes of sadness, depression, or hopelessness. Every juvenile health program must address mental health needs as well as physical health needs to promote better outcome for youth. Mental health diagnoses, such as clinical depression, can change behavior, physical health and appearance, academic performance, social activity, and the ability to handle everyday decisions and pressures. These feelings may prevent troubled youth from seeking preventive healthcare and complying with health regimens. Some mental health medications require medical interventions such as labs and other diagnostic testing. Youth with mental health disorders that also have concomitant substance use disorders may also require modification of medications.

Due to the high prevalence of drug use in this population, intake personnel must be trained to recognize signs and symptoms of drug intoxication. Healthcare staff should be available to provide immediate direction as to whether the youth should be accepted into the facility. Alcohol withdrawal is not as common, but should be monitored as well. Medical emergency care may be required for acute drug intoxication or withdrawal. Facility healthcare staff should not perform drug testing of youth routinely. This collection of forensic evidence by healthcare staff interferes with the patient–provider relationship and should be left to outside agencies or security staff. The use of “designer drugs” should also be a consideration for assessment of intoxication.

A range of mental health and substance abuse treatment services are needed in juvenile justice settings, as the problem of substance use is more pronounced. The following behavioral health services should be provided at a minimum: screening;
assessment; direct services, including individual, group, and family counseling; and referral to mental health, substance abuse, and other community-based services upon release.

**Health Records, Confidentiality, and Consent**

Youth require a confidential area for medical intake screening and assessment. They may not easily disclose medical facts unless they trust that the information will remain confidential. Confidentiality is a concern of detained youth, particularly when they are asked to share information with adult staff. Staff should be trained about how to respect confidentiality of health information in conjunction with HIPAA (Health Insurance Portability and Accountability Act) requirements. Youth are also more likely to share personal health information with their peers. Staff still should be mindful of confidentiality requirements and encourage youth to do the same. *(See Ch. 9: Admission and Intake)*

HIPAA privacy rules may apply to youth even though adult inmates in correctional settings are excluded. Legal counsel should be involved to determine the level of confidentiality of health information required. There is a general HIPAA exclusion for correctional facilities; however, if any part of a juvenile justice system is billing electronically for medical services such as Medicaid, the juvenile justice agency should be HIPAA compliant. It is also advisable that public health and juvenile justice facilities both be HIPAA compliant, so that medical information can pass freely between agencies. Information sharing improves continuity of care and facilitates appropriate consents from youth and parents or guardians. MOUs between agencies can address any concerns about sharing of confidential medical information.

Laws differ by state as to what health information can be shared and under what circumstances. Usually, substance abuse treatment, pregnancy related services, sexually transmitted diseases including HIV, and certain psychological notes require specific releases from the youth, even if the recipient is a parent or guardian.

Concerns about confidentiality keep many youth from disclosing crucial health information and from seeking care. In the juvenile justice system, parents or guardians may not be present, but concerns about confidentiality still exist, and youth should be assured that their disclosures will be kept confidential. However, there are times when the provider may need to contact a parent and times when the law allows such contact, but the bias should be toward confidentiality. If a youth
appears to be a danger to himself or herself or to another person, state laws mandate that a provider inform parents or authorities.

Laws governing minors’ access and confidentiality to services also differ by state, and many healthcare providers are unaware of a youth's ability to consent to certain confidential health services. Title X dictates that family planning services must be confidential. In many states, confidentiality is decided by the provider, but because Title X is federal, it preempts state statutes. Medicaid provides for confidential services to minors along with Title X. Federal Medical Privacy Regulations also apply. Juvenile settings must determine if they will also comply with this community Title X healthcare standard with regards to providing confidential family planning services, when applicable.

The advent of the electronic health record (EHR) has challenged the confidentiality of the health record. More controls must be in place to protect health information transmitted electronically to be HIPAA compliant. Most hospitals and private practices already have implemented the use of EHRs to improve efficiency and portability of patient health information. The Affordable Care Act requires practitioners in the community to do so as well. Correctional facilities, however, are not required to do so and have hesitated to embrace these technological ideologies and practices. This reluctance is understandable, considering the many challenges involved in the use of EHRs in the correctional environment. Computer equipment in the medical unit needed for the EHR can be used as a weapon or can become a target for theft and vandalism if it falls into the hands of a youth. Computers may allow youth access to the outside world to acquire contraband or to make illegal contacts. Earlier software systems were often expensive and not suitable for corrections, because they did not consider complex requirements for administering medication or sick call procedures. Although there has been improvement in correctional applicability and some reduction in cost, it is still challenging to determine which software system is most advantageous. The advantage to implementing an EHR system is the ability to have complete, easily accessible, and transferable medical, mental health, and dental records. This automation allows real-time tracking of the youth's health information, which is especially important when operating short-term secure facilities with high turnover and readmission rates. The EHR also allows for remote and on-site quality-assurance monitoring of all health records. The EHR system prevents unnecessary duplication of health services, saving both a provider's time and the cost of repeating labs and other assessments. The implementation of EHR systems in correctional settings should ultimately reduce costs related to duplication of services and staff time. In addition, correctional EHRs
will provide greater continuity of care for youth as they transition from one correctional facility to the next and into the community.

**Healthcare and Reentry**

Many barriers remain for youth and their families in getting appropriate healthcare and support services upon reentry into the community. Youth are often disenfranchised from their families and are not aware of how to navigate support systems on their own. Many parents and caregivers are also unaware of healthcare services that may be available for their family members and may not seek out these services without direction from a government agency. Juvenile justice facilities, in collaboration with community health providers, should emphasize the development of a comprehensive healthcare reentry system to overcome these barriers. Because there is such a high incidence of substance abuse, acute illnesses, sexually transmitted diseases, unplanned pregnancies, and psychiatric disorders among detained youth, it becomes more critical that the treatment of these conditions continue in the community after release.

Given the potential for recidivism, continuity of services that enhance family support and address unmet physical and mental health needs is imperative. Appropriate systems can help facilities to effectively assess, address, and manage these issues. This will help youth transition successfully back into the community, which benefits and stabilizes the youth themselves, their families, and the community. Families are often not fully engaged in the rehabilitation process while their youth are incarcerated or engaged in any subsequent aftercare or community services. Family problems can worsen or contribute to the youth’s problems. The inclusion of family members into the treatment process is critical to the success of the youth during reentry and is essential to reducing recidivism. Youth should be reconnected with healthcare insurance including Medicaid and other plans created through the Affordable Care Act upon their release from the facility. Immediate access to medical care, medication, mental health services and substance abuse counseling is essential. A lack of continuity puts this already vulnerable group at high risk for relapse or reoffending. (See Ch. 18: Transition Planning and Reentry)

**Conclusion**

Providing adequate healthcare during detention or correctional confinement is not only a constitutional mandate, but an incredible opportunity to impact the health status of youth. A youth’s encounter with healthcare while in custody may save his or her life by diagnosing an unknown medical condition, by improving management of
a chronic medical problem, or even avoiding future ailments through immunization and other preventive health services. The healthcare provided contributes to the overall wellness of each youth served, as well as protecting the institution or agency from the legal liability of inadequate healthcare.

Endnotes


Source URL: https://info.nicic.gov/dtg/node/15

Links:
[1] https://info.nicic.gov/dtg/node/48#michelleh
[2] https://info.nicic.gov/dtg/node/1
[3] https://info.nicic.gov/dtg/node/21#prea07