

Identification and Management of Chronic Medical Problems in Juveniles

By John Bradley and Eleanor M. Kalfs

The ever-changing field of correctional health care, the critical need for population management and the chronic lack of budgetary resources has prompted the development of comprehensive correctional health care guidelines. More and more states and corrections professionals face litigation concerning the appropriate and mandated care and custody of youthful offenders. Policy and procedure manuals have become a necessary evil, as they help institutions standardize the practices of medical staff and also serve as an excellent resource and reference guide for all institutional staff.

The American Correctional Association and the National Commission on Correctional Health Care provide standards for health services for jails, prisons, juvenile training schools and juvenile detention centers. Both organizations emphasize that correctional staff must begin with the medical and clinical assessment of offenders' needs. These assessments should include information regarding family history, initial medical screening, physical appraisal and examination, mental health and substance abuse screening, educational evaluations and criminality assessments. Collectively, this battery of assessments, in concert with the necessary security requirements, creates the framework for the overall case management plan. The elements of housing, prioritization of service delivery, long-term care for chronic and recurring illnesses, behavior modification, crisis management and continuity of care all must be considered functional components of providing comprehensive, ongoing services during offenders' incarceration and upon their return to the community.

During Reception

ACA's accreditation standards establish a universally accepted structure for programming that can be applied in correctional services managed either by judicial direction or by contractual arrangements. With these standards, the concept of total quality management can be implemented to create working models that address medical screening,

evaluation, crisis management, treatment, transfer and discharge planning.

Efficient, high-quality medical care begins with a thorough intake assessment during reception, in which problem identification and tracking begin. The need for gender-specific medical accommodations cannot be overlooked. Crisis intervention and treatment, as well as suicide prevention, must also be integrated as dynamic factors in the assessment process. Intensive intervention may be necessary to maintain the safety and security of offenders and staff. Risk factors, such as domestic violence, drug use and assaultive behavior, must be considered when juveniles are adjudicated or incarcerated to protect them and reduce the risk of adverse legal judgments.

Routine childhood and adolescent developmental issues must be considered. As the designated school nurse, the immunization records must be obtained and updated in accordance with state law and maintained in a manner that facilitates sharing of these records upon release. Medical legal issues must balance the maintenance of confidentiality for juveniles while providing and obtaining adequate parental notification and consent for treatment. The length of stay must be considered in all treatment team programming, discharge planning and release preparation. For the most part, housing units for populations with special needs, such as medical, mental health and administrative segregation, will be self-contained. As such, the living units will need to incorporate additional program space, a dining area, a kitchenette and recreational space.

The provision of health care to juvenile offenders, as well as other specialized populations, within a correctional setting creates complex and unique demands. The intake assessment must provide a comprehensive picture of episodic, acute and chronic past and present health care issues. Soliciting a complete medical, mental health and substance abuse history may be challenging. By the time adolescents reach age 17 or 18, "a lot of the battle lines have already been drawn," said David Elkind, professor and chairman of the Department of Child Development at

Tufts University in Medford, Mass., and interactions “may have less to do with communication than with assertiveness and control.” Reliability of information may also be suspect due to trauma, drug withdrawal, confusion, mental illness or mistrust.

During reception, adolescent offenders’ needs are reviewed, and they are assigned placement according to the institution and program that can best address their collective needs. Youths who have debilitating, chronic medical or surgical conditions that require skilled nursing care and frequent hospital or specialty assessments, as well as those who may have significant mobility impairments, are classified as medically fragile. These complex medical conditions then become the critical element to consider in departmental placement. This may prove to be a substantial problem if medically fragile housing cannot accommodate the security level.

Continuity of Care

Following reception, the development of chronic care medical case management must begin. Within the juvenile correctional setting, this consideration must be gender-neutral, but individualized to each specific youth, even though the actual service provision may lead to gender-specific care. When necessary, programming is modified to accommodate special needs. Youths may be assigned to designated housing units for the medically fragile. This may be necessary to prioritize programming needs, address disability accommodations, provide continuity of care for chronic conditions or provide specialized medical supervision. Specialized housing or programming may also address behavior modification, crisis management and self-help treatment approaches. Table 1 highlights a cross-section of the medically fragile youths identified in the Ohio Department of Youth Services during the past eight years.

“It is estimated that 25 percent to 40 percent of inmates have significant health care conditions that will require

continuity of care services upon release,” according to the August 2001 *Corrections Today* article “Coordinating Effective Health and Mental Health Continuity of Care” by Catherine McVey. Thus, ACA’s standards recognize the importance of maintaining critical data on continuity of care from admission to discharge. Pertinent medical and mental health information must be collected to identify high-risk groups that may ultimately be a risk to the community. It is no longer just hard-core adult offenders who present health concerns such as HIV, tuberculosis, hepatitis, sexually transmitted diseases, and chronic and severe psychiatric disorders.

Once youths with special medical needs are identified, physicians can prioritize the significant health problems and major health risks while intervention strategies are planned to address these needs. Basic principles of problem identification, assessment and medical management must clearly be acknowledged in order to provide primary, secondary and tertiary care. Regardless of population size or the age and gender of offenders, all programs must implement a medical classification system that:

- Reflects recognized correctional health care standards;
- Provides policies and protocols for medical, mental health and substance abuse decision-making;
- Identifies the levels of medical, mental health and substance abuse service provision;
- Provides comprehensive health care service delivery in the management of simple to complex conditions;
- Provides crisis management;
- Provides medical and/or mental health discharge planning and linkage programs between corrections, public health or welfare of disability services; and
- Provides a methodology for the collection, analysis and interpretation of statistical data to accommodate system improvement.

The challenges of providing adequate services to adolescents is compounded when the population includes youths with special needs. Essentially, the broad interventions usually adopted within the correctional environment are inadequate to meet the requirements of the special needs population. The management of chronic diseases should follow national standards of care promulgated by a consensus of corrections professionals. In turn, these standards may be tailored and applied to the unique programming and needs of individual correctional settings.

Custody and treatment staff should recognize their unique roles in supporting the treatment process. Unit and custody staff must be knowledgeable, alert and proactive in their observations while still providing appropriate supervision. Special needs offenders require informed staff who are able to respond to a variety of conditions, some caused by the special needs of offenders, some by facility limitations and some as a result of simple adolescent development.

Health Care Management

Medication administration in a correctional setting is the most commonly shared custody/treatment responsibility. It is generally accepted that medication management is

Table 1. A cross-section of medically fragile youths identified in the Ohio Department of Youth Services during the past eight years.

Diagnosis	Number of Youths
Cancer (not skin)	5
Cardiomyopathy or Valvular Disorder	4
Crohn’s or Ulcerative Colitis	7
Deafness	5
Detached Retina or Artificial Eye	7
Hemophilia	9
HIV	15
Infusaports and Mediports (noncancer)	6
Nephropathy (renal failure and dialysis)	5
Neuromuscular (Multiple Sclerosis, Osteogenesis Imperfecta, Muscular Dystrophy)	17
Tuberculosis (active pulmonary)	2
Ventriculo-Peritoneal Shunts	7

correlated to the success of chronic disease care and management, while at the same time, a potentially significant security concern if inadequately monitored and controlled to prevent “palming” and “cheeking,” whereby inmates hide the pills in their hand or mouth rather than swallow them. Quality assurance monitoring tools and process evaluations can help identify problems in many elements of service delivery. Once identified, specific strategies can be developed, and the most appropriate intervention initiated. Surveillance may use primary data collection from clinical encounters or secondary data collected from available records.

When dealing with specialized or chronic care disease management, such as renal failure (requiring dialysis), HIV, hemophilia or high-risk pregnancy, the fiscal impact must be identified early. Specialty referral is often required when trying to create a comprehensive treatment plan that integrates supply and demand on limited resources and a multipronged delivery strategy to accommodate various inmate needs. Continuity must be maintained with regard to episodic procedural care such as dialysis, as well as continuation of medication. These expenditures can negatively impact a budget shortly after reception and may stretch existing resources to the breaking point. The fiscal impact of chronic management care can be staggering. As a result, medical care cost containment must constantly maintain a balance between what is fiscally sound and in accordance with departmental resources, and what is appropriate in the management of complex medical conditions. Establishing partnerships with children’s hospitals and university hospitals often results in lower medical costs and the creation of a statewide provider network and, thus, a more uniform standard of care.

Female Offender Medical Needs

Reception screening also must encompass unique needs presented by female adolescents. Individualized health histories must include the obstetric/gynecologic components of health care management. Case management must be initiated upon arrival for pregnant adolescents. Many medical conditions put youths into a higher risk category for pregnancy; therefore, some diseases, such as kidney disease, diabetes and epilepsy, compounded by mental health and substance abuse issues, may increase the risk of miscarriage and birth defects. Conversely, these pregnancies may also affect the medical and mental health management of the incarcerated adolescents.

Few adolescents realize that pregnancy is also affected by their lifestyle prior to conception. Histories of drug and alcohol abuse, poor dietary habits, domestic violence, criminal lifestyles that may involve prostitution, the absence of prenatal care, and exposure to hepatitis and HIV greatly affect the management and outcome of their pregnancy. Pre-existing conditions may develop into pregnancy-induced diabetes, hypertension and toxemia. With this in mind, it is critical to monitor placental function and fetal growth. Depending on medical and lifestyle histories and mental health status at the time of reception, it may be necessary to use considerable community resources to safeguard the health and well-being of pregnant youths, as well as their unborn babies. Resources must be available to

access gynecologists and infectious disease specialists in addition to care at high-risk pregnancy clinics. The complications of diabetes in high-risk pregnancies can be greatly reduced with consistent medical and obstetrical management. Increased diabetic blood-sugar levels cross the placenta and raise the blood sugar and insulin levels in the fetus, which may lead to very large babies and an increased risk of trauma during birth. Careful monitoring of fetal development is necessary and must include consideration of Caesarean section delivery if the mother has not matured sufficiently to safely accommodate a vaginal birth.

Conclusion

Researchers theorize that if juvenile offenders receive intensive intervention while incarcerated, during their transition to the community and while they are under community supervision, they will benefit in such areas as family and peer relations, education, job skills, substance abuse, mental health and recidivism. The goal is to implement a working model to provide youths with comprehensive, ongoing services while they are incarcerated and when they return to their communities. When considering the collective medical and mental health needs presented by today’s adolescent population, the responsibility falls on the correctional health care worker to focus on the development of individualized chronic care treatment plans that will address the myriad needs of juveniles while they are incarcerated and after their release into the community.

Community placement and discharge planning must incorporate the elements identified in reception, the services provided while incarcerated, and ultimately, a realistic discharge plan identifying ongoing needs. Aftercare should begin during the active treatment phase, and the duration and intensity should be based on the risks and needs of the offender. Transition and reintegration into the community must address linkages for medical, surgical, mental health and substance abuse follow-up.

Many components must be addressed in discharge planning. Community resources must be identified, medical supervision and continuity of care must be arranged, and a community liaison must be identified to provide links between corrections, public health, welfare, disability and other human services programs. Security and public safety must be addressed with regard to infectious or communicable diseases. These issues may involve considerable behavior modification and lifestyle changes for affected youths, and these needs must be addressed in accordance with the youths’ economic status and available family or placement resources.

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