Office of Health Services Technical Assistance Bulletin

Practical Applications of Medical, Mental Health and Substance Abuse Policies and Procedures

September-October 2010
Issue 5

Charlie Crist, Governor
Frank Peterman, Secretary

Serving the Children of DJJ Providing Quality Medical, Mental Health & Substance Abuse Services

Mental Health & Substance Abuse —Trauma Informed Care

Trauma:

The experience of violence and victimization including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disasters. (NASMHPD, 2006)

Acute Trauma:

Typically involves a one-time experience (e.g., natural disaster or car accident. (NASMHPD, 2006)

Complex Trauma:

Involves prolonged or multiple traumatic events. Complex trauma can occur within a care giving relationship by neglect, physical, sexual or verbal abuse.

Individuals we serve often have experienced trauma that affects their current development and adjustment. We are resolved that in Florida, trauma will be recognized and addressed through a statement of purpose that ensures comprehensive assessment and individualized interventions designed to promote healing and foster hope and resilience and service environments that:

- ☑ Are sensitive and responsive;
- ☑ Prevent victimization, abuse, or trauma as a result of our care;
- ☑ Are driven by the voices, needs, and choices of children, youth, adults, and their families.

Trauma can occur from:

- ☑ Being in a car accident or other serious incident;
- ☑ Having a significant health concern or hospitalization;
- ☑ Sudden job loss;
- ☑ Losing a loved one;
- ☑ Being in a fire, hurricane, flood, earthquake, or other natural disaster;
- ☑ Witnessing violence; or
- ☑ Experiencing emotional, physical, or sexual abuse.

Exposure to Trauma:

It is an individual's experience of the event, not necessarily the event itself that is traumatizing.

Some Protective Factors:

- ☑ Parental resilience;
- ☑ Social connections;
- ☑ Knowledge of parenting and child development;
- ☑ Concrete support in times of need; and
- ☑ Nurturing and attachment/social and emotional competence of children.

Facts about Trauma and PTSD

- ☑ Trauma does not automatically cause PTSD (25% risk), violation/degradation/betrayal increases risk to 50-75+%;
- ☑ Trauma is Epidemic in 60% of Adults and 50% of Children;
- ☑ Trauma is almost Universal for boys (93%) and girls (87%) in the JJ System;
- ☑ Trauma increases the risk of further trauma (most survivors have at least 2 distinct trauma incidents);
- ☑ Being abused or neglected as a child increases the likelihood of arrest as a juvenile by 59% (Widom, CS, 1995); and
- ☑ 70% - 92% of incarcerated girls reported sexual, physical, or severe emotional abuse in childhood (DOC, 1998; Chesney & Shelden, 1992).

Some researchers describe a pathway in which exposure to violence and pervasive feelings of not being safe develop into a state of chronic threat requiring the youth/adult to use physical aggression in order to manage (Schwab-Stone et al, 1995).

Gender and Trauma

Females Typically Experience:

- ☑ Sexual assault/abuse;
- ☑ Domestic violence; and
- ☑ Childhood neglect;

Males Typically Experience:

- ☑ Physical assault;
- ☑ Physical abuse;
- ☑ Military violence; and
- ☑ Accidents.

Impact on Child Development

- ☑ The ability to form healthy relationships is highly dependent on learned social skills;

Continued on Page 2

Overarching Goals—The long term vision and planning for the Office of Health Services is to extensively improve the quality of medical, dental, mental health, substance abuse and developmental disability services provided to the youth in our care through increased resources, improved staffing, early troubleshooting for problem areas and improved collaborations with other state Agencies.

Mental Health & Substance Abuse —Trauma Informed Care

Impact on Child Development

- ☑ Children's social skill learning is directly related to the characteristics of their environments;
- ☑ Disordered environments =dysfunctional skills;
- ☑ Violence teaches withdrawal, anxiety, distrust, over-reaction and/or aggression as coping behaviors; and
- ☑ Extreme behaviors are rooted in dysregulated emotional states (NF Commission, 2003; SG Report, 1999; Hodas, 2004; Saxe et al, 2003).

Traumatized Children May:

- ☑ Appear guarded and anxious;
- ☑ Are difficult to re-direct, reject support;
- ☑ Are highly emotionally reactive;
- ☑ Have difficulty "settling" after outbursts;
- ☑ Hold onto grievances;
- ☑ Do not take responsibility for behavior;
- ☑ Make the same mistakes over and over;
- ☑ World is threatening and bewildering;
- ☑ World is punitive, judgmental, humiliating and blaming;
- ☑ Control is external, not internal;
- ☑ People are unpredictable and untrustworthy;
- ☑ Defend themselves above all else; and
- ☑ Believe that admitting mistakes is worse than telling truth (Hondas, 2004).

By adolescence, children have sufficient skill and independence to seek relief through the following:

- ☑ Drinking alcohol;
- ☑ Smoking tobacco;
- ☑ Sexual promiscuity;
- ☑ Using psychoactive materials;
- ☑ Overeating/eating disorders; &
- ☑ Delinquent behavior.

Impact Over Lifespan

Are neurological, biological, psychological and social in nature. They include:

- ☑ Changes in brain neurobiology;
- ☑ Social, emotional & cognitive impairment;
- ☑ Adoption of health risk behaviors as coping mechanisms (eating disorders, smoking, substance abuse, self harm, sexual promiscuity, violence); and
- ☑ Severe and persistent behavioral health, health and social problems, early death. (Felitti et al, 1998; Herman, 1992)

Trauma-Informed Care (TIC)

Provides the foundation for a basic understanding of the psychological, neurological, biological, and social impact that trauma and violence have on many young Floridians.

Incorporates proven practices into current operations to deliver services that acknowledge the role that violence and victimization play in the lives of most of the children entering our system.

Trauma-Informed Care (TIC) provides a new paradigm under which the basic premise for organizing services is transformed.

Trauma Informed Systems

- ☑ Are based on current literature;
- ☑ Are informed by research and evidence of effective practice; and
- ☑ Recognize that coercive interventions cause traumatization and re-traumatization.

When a human service program takes the steps to become trauma-informed, every part of the organization, management, and services delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual receiving services.

Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization. ✪

Trauma Informed	Non-Trauma Informed
Recognition that a high number of our children have trauma histories	Lack of education on trauma prevalence & "universal" precautions
Assess for traumatic histories & symptoms	Cursory or no trauma assessment
Recognition of primary and co-occurring trauma diagnosis	Over-diagnosis of Schizophrenia & Bipolar D, Conduct D, & singular addictions
Recognition that culture and practices can re-traumatize our children	"Tradition of Toughness" valued as best care approach
Power/control minimized - constant attention to culture of universal precautions	Keys, security uniforms, staff demeanor, tone of voice, respect is demanded
Caregivers/supporters – collaboration	Rule enforcers – compliance
Address training needs of staff to improve knowledge & sensitivity to symptoms of trauma and re-traumatization	"Patient-blaming" as fallback position without training
Staff understand **function** of behavior (rage, repetition-compulsion, self-injury)	Behavior seen as intentionally provocative or a personal attack
Objective, neutral language: the child was triggered by…, he/she feels threatened when…, the child misbehaves when he/she believes no one is listening, etc…	Labeling language: manipulative, needy, "attention-seeking"
Transparent systems open to outside parties	Closed system – advocates discouraged

(Fallot & Harris, 2002; Cook et al., 2002, Ford, 2003, Cusack et al., Jennings, 1998, Prescott, 2000)

Universal Precautions: Operate as if every child in our care has been exposed to abuse, violence, neglect, or other traumatic event(s).

Medical — Episodic Care vs. Sick Call

Episodic Care vs. Sick Call

What is Episodic Care?

HSM 9-1: Episodic Care is the health care component intended to provide medical services in response to unexpected illness, accident, or conditions that require immediate attention or an immediate professional assessment to determine their severity. This term also refers to health care provided in response to unexpected injuries or accidents, which do not necessarily require transfer to a hospital or emergency room.

Examples of Emergency/Episodic or First Aid Care: respiratory distress, asthma symptoms, seizures, insect bite/sting (immediate if symptomatic), anaphylaxis (severe allergic reaction), abdominal pain, burns, diarrhea x4 or greater in 8 hours (witnessed), dizziness lasting greater than a few seconds, fever, foreign body in eye, fracture/dislocation, head injury, heat exhaustion, sudden onset of hypertension (elevated blood pressure), nausea & vomiting (witnessed), nose bleed, abrasions w/ active bleeding.

What is a Sick Call?

HSM 6-1: Sick Call is the component of health care that responds to a youth's complaint of illness or injury of a non-emergent nature that requires a professional nursing assessment, evaluation, and intervention or plan for care.

Examples of Sick Call: abrasions without bleeding, acne, athlete's feet, back pain, boils, calluses/corns, a cyst on the eyelid, chapped lips, musculoskeletal pain, general malaise, indigestion, cold symptoms, conjunctivitis, constipation, cough, earache, swelling, allergy/hay fever, follow up on headaches, hemorrhoids, joint pain, lice, mouth ulcers, dermatitis/rash, scabies, sinusitis, sore throat, sprain, stomach ache, sunburn, tinea versicolor (skin spots), follow up on toothache/dental pain, traumatic blisters, urinary tract infections/ bladder pain, venereal warts, wax in ears.

What do I do when I find a sick call that a youth has completed that would qualify as episodic care?

HSM 6-1: Every facility shall incorporate into their facility operating policy & practice a means by which sick call requests are triaged promptly and screened for urgency, so that emergency conditions are treated promptly & not delayed until the next regularly scheduled sick call session.

For those times of the day where licensed health car staff are not on site, the facility must have a procedure in place whereby the shift supervisors (or officer) reviews sick call requests for issues requiring immediate attention. This should occur promptly, but no longer than every (4) four hours after the request is submitted.

When the triaged complaint meets the criteria for episodic care, i.e. something that requires immediate attention and would result in a negative outcome if not treated immediately, it is episodic care and treated accordingly.

The Superintendent/Program Director and the DHA/Physician Designee shall develop Facility Operating Procedures that define the instances that require immediate attention.

What is the difference between a Non-Health Care Staff Protocol and a Health Care Staff Protocol?

Non-Health care staff protocols are steps that outline the information needed for non-licensed staff to gather information from the youth & to report that information to healthcare personnel, so they can make an informed decision of the needed care, when the health care staff is not physically on site to perform an evaluation.

These protocols also describe the intervention that non-licensed staff may follow for youth complaints such as headache without other symptoms suggestive of a more serious condition, menstrual cramps, and toothache as examples. They are limited to one time treatment and include parameters for DHA or medical staff notification and consult.

Nursing protocols are procedures that outline the subjective data (youth report or staff report), objective evaluation (what the medical staff quantifies) assessment (for RN) or nursing diagnosis (for LPN) and plan (MD orders for the specific situation) that the nurse follows when a Physician/Clinician is not on site.

Documentation Requirements:

All care provided to youth must be contained in the youth's individual Healthcare record in the Progress notes and follow the Health Services Manual 2006 and nursing documentation standards. The specific category for care is stated, e.g. Episodic care, Post Par Medical review, Sick Call, etc.

For those facilities that have the Detention Facility Management System (DFMS) the information is documented electronically and the completed hard copy is placed into he youth's Individual Healthcare Record for continuity of care while in the youth is in the Department's custody.

Episodic Care and Sick Call documentation must also be placed onto an aggregate log that identifies the youth, date care provided, complaint and disposition. DFMS Sick Call summary may substitute for the Sick Call log.

The Health Services Manual 2006, Chapters 5 & 9 define these services in detail. The information provided here is a guideline to follow and help with understanding the differences in these youth services. The Office of Health Services Staff is always available to provide direction for you in your continued care of youth in all DJJ Programs. ✪

Morbidity and Mortality Weekly Report (MMWR)

Prevention and Control of Influenza with Vaccines

Recommendations of the Advisory Committee on Immunization Practices (ACIP), Early Release, July 29, 2010 / 59 (Early Release);1-62
Primary Changes and Updates in the Recommendations

The 2010 recommendations include five principal changes or updates:

Routine influenza vaccination is recommended for all persons aged ≥6 months. This represents an expansion of the previous recommendations for annual vaccination of all adults aged 19---49 years and is supported by evidence that annual influenza vaccination is a safe and effective preventive health action with potential benefit in all age groups. By 2009, annual vaccination was already recommended for an estimated 85% of the U.S. population, on the basis of risk factors for influenza-related complications or having close contact with a person at higher risk for influenza-related complications. The only group remaining that was not recommended for routine vaccination was healthy nonpregnant adults aged 18--49 years who did not have an occupational risk for infection and who were not close contacts of persons at higher risk for influenza-related complications. However, some adults who have influenza-related complications have no previously identified risk factors for influenza complications. In addition, some adults who have medical conditions or age-related increases in their risk for influenza-related complications or another indication for vaccination are unaware that they should be vaccinated. Further support for expansion of annual vaccination recommendations to include all adults is based on concerns that 2009 pandemic influenza A (H1N1)-like viruses will continue to circulate during the 2010--11 influenza season and that a substantial proportion of young adults might remain susceptible to infection with this virus. Data from epidemiologic studies conducted during the 2009 pandemic indicate that the risk for influenza complications among adults aged 19--49 years is greater than is seen typically for seasonal influenza (12,23,27).

As in previous recommendations, all children aged 6 months--8 years who receive a seasonal influenza vaccine for the first time should receive 2 doses. Children who received only 1 dose of a seasonal influenza vaccine in the first influenza season that they received vaccine should receive 2 doses, rather than 1, in the following influenza season. In addition, for the 2010--11 influenza season, children aged 6 months--8 years who did not receive at least 1 dose of an influenza A (H1N1) 2009 monovalent vaccine should receive 2 doses of a 2010--11 seasonal influenza vaccine, regardless of previous influenza vaccination history. Children aged 6 months--8 years for whom the previous 2009--10 seasonal or influenza A (H1N1) 2009 monovalent vaccine history cannot be determined should receive 2 doses of a 2010--11 seasonal influenza vaccine.

The 2010--11 trivalent vaccines will contain A/California/7/2009 (H1N1)-like, A/Perth/16/2009 (H3N2)-like, and B/Brisbane/60/2008-like antigens. The influenza A (H1N1) vaccine virus is derived from a 2009 pandemic influenza A (H1N1) virus.

A newly approved inactivated trivalent vaccine containing 60 mcg of hemagglutinin antigen per influenza vaccine virus strain (Fluzone High-Dose [sanofi pasteur]) is an alternative inactivated vaccine for persons aged ≥65 years. Persons aged ≥65 years can be administered any of the standard-dose TIV preparations or Fluzone High-Dose. Persons aged <65 years who receive inactivated influenza vaccine should be administered a standard-dose TIV preparation.

Previously approved inactivated influenza vaccines that were approved for expanded age indications in 2009 include Fluarix (GlaxoSmithKline), which is now approved for use in persons aged ≥3 years, and Afluria (CSL Biotherapies), which is now approved for use in persons aged ≥6 months. A new inactivated influenza vaccine, Agriflu (Novartis), has been approved for persons aged ≥18 years.✪

Click on this link for the full report:
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr59e0729a1.htm

Visit us at http://www.djj.state.fl.us/HealthServices/index.html

Congratulations Sherrie Arnwine!

Sherrie Arwine, RN, OHS Registered Nurse Consultant, Central Region, Detention was awarded "The Outstanding Public Health Nursing Leadership Award", by the Florida Association of Public Health Nurses, during the annual conference this past weekend. The recognition was for identifying a need for improved education, and taking the initiative to develop an educational pamphlet that could be provided to Tuberculosis (TB) patients to reinforce information and counseling they received during office visits about their medication and potential side effects. The pamphlet is provided to TB patients by nurse case managers at Hillsborough County Health Department, and it was made available to other County Health Departments, as well.

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