Policy and Advocacy Work Group Purpose Statement
The purpose of the OYS Policy and Advocacy Work Group, is to codify best practices and change policies that hinder the juvenile justice system, including coordinating policy-related action items that arise in the work groups.

1. Welcome and Introductions
   a. Present: Shawne Coonfare, James Hubbard, Kim Hawekotte, Christine Henningsen, A’Jamal Byndon, Kerri Peterson, Andrea Wright, Keith Miller, Jeff Severns (by video), Janee Pannkuk, Karla Dush, Debora Faga

2. Announcements
   a. The Juvenile Justice Center lawsuit is not going to be appealed, so they’re moving ahead with the bonds

3. Activity
   a. Legislative Bill Updates
      i. YRTC’s
         1. A couple of the bills have been prioritized
         2. A few kids have been moved to the YRTC in Lincoln, a couple of girls have moved back to Geneva
         3. Legislation this year will probably center around putting more procedural guidelines/safe guards in place
         4. Nothing has been passed out of committee yet
         5. Any bill that doesn’t pass this year is dead and would have to be refiled
         6. We’ll have an opportunity to look at some of the ones we support and do some work in the off-season to see what we can do going forward
         7. HHS has put together a group again; Kim Hawekotte and Chris Rodgers are sitting on it and they are starting discussions on a regional center
      ii. Use of confinement
         1. Room confinement bill did pass and was signed by the governor, and that will go into effect this summer
         2. Data is being tracked differently, so the Ombudsman’s Office, Inspector General, is working on coming up with definitions so data can be compared apples to apples
         3. DCYC has started work on the confinement policy

Mission Statement:
Across Douglas County, our vision is a comprehensive, coordinated, and community-wide approach to juvenile services that eliminates the need for youth involvement with our justice system while maintaining public safety.

For all youth who do enter our justice system, our goals are to provide effective, compassionate and individualized support that empowers youth and their families to succeed and to build an environment of mutual trust and accountability.
b. Status of Advocacy Guidelines Memo-OYS
   i. Presented our memo to the Steering Committee and did receive some direction
   ii. Need to rehash what is in there and what our process will be
       1. Coming up with a proposed policy or plan, fleshing that out within our
          group, bringing that to the Steering Committee, which would then bring it
          to the County Board and their lobbyist could then push that legislation,
          while not losing that educational piece of how people can write their own
          letter
   iii. With the JJC, it is as simple as writing a standard introductory paragraph that clearly
        defines who they are and that they are not representing OYS; that can be cleaned
        up easily
   iv. The group could look at how to inform the community more on legislative
       information
   v. If OPS and OPD start becoming more regularly involved in the Steering Committee,
      are there other Douglas County elected bodies that could offer other mechanisms
      that we could work with to position policy; this policy would be toward state
      legislative policy, not necessarily at the county level

c. 2020 Working Plan Updates-approval
   i. The updates from the last meeting have been plugged in, some still need target
      dates
   ii. Provide updates to areas of the work plan that have responsible parties; may also
       be listed in the follow up/next steps section
   iii. Make sure that RED is addressed in the work plan; add a column that runs through
        each item
   iv. Add 3.e. Do some research on what states are doing well in this area;
       Massachusetts, Connecticut, Washington
   v. Wait until the next co-chair planning meeting to add target dates

d. Terra Luna presentation-Keith Miller and Jeff Severns
   i. Obstetric Care in Out-of-Home Placement (memo attached) prepared by the Lived
      Experience Project, which is a project that combines healing for people who have
      experienced the juvenile justice system (youth, families, etc.) and combine healing
      with research to support systems change
   ii. Not presenting as subject matter experts; work is focused in part on where young
       people experience gaps in system support and often talk in terms of help and harm.
       So we’re looking at those areas and when we find a gap we start talking about it.
   iii. Young people have shared their experiences with being pregnant and being placed
        in out-of-home placements like Geneva, DCYC, entities licensed as residential child
        care facilities
   iv. There are so few pregnant juveniles placed out-of-home each year that almost any
        element of their story can be considered identifying information; we take great
        pains to protect the identities of the young people they interview

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v. When we began looking at negative experiences that juveniles have experienced out-of-home, we decided to zoom out and started looking at the protections that are, or should be, in place to protect and support this vulnerable population.

vi. First step was to call organizations in Douglas County that might work with pregnant juveniles and ask them if they do work with this population and if they provide any special resources. Generally, the response was no, but great idea.

vii. Next step was to talk to Geneva and DCYC and make public records requests.

viii. DHHS provided 30 policy memos covering nursing and medical care at Kearney and Geneva; 8 addressed pregnancy or obstetric care.

ix. DCYC provided 13; only one mentioned pregnancy (a medical procedure note that mentions an extra mattress can be provided to a pregnant detainee upon request, if they’re in their 3rd trimester).

x. DCYC Nurse Manager did state that, although there are no written policies, pregnant juveniles are treated similar to all other youth who have special needs.

xi. Private residential child caring facilities – talked to 6 facilities and generally speaking there weren’t written policies, but there were a lot of practices similar to DCYC, they would be treated as a specialty case.

xii. Opportunities:

1. There is a knowledge gathering gap that exists; there is a need to support data collection initiatives (just to even get the number of pregnant juveniles that are in the system)

2. An effort to thoroughly document policies and procedures in order to identify areas for improvement

3. External monitoring; supporting the creation of an “early warning system”

4. Policy review – supporting policy makers at the county level, helping DCYC to document their obstetric care practices (written and unwritten) and create robust written policy based on that.

5. Supporting efforts to guide privately owned facilities in reviewing their obstetric care practices, creating policies

6. Through that process creating model language that people can take back

xiii. Discussion:

1. After this presentation last month to Sherwood staff, one of the action steps Sherwood took to send this memo to the Women’s Fund because of their initiative about adolescent health, postponing teen pregnancy, and STDs; the Women’s Fund is also partnering with You Turn on a grant to develop curriculums specifically around young women.

2. Written policies do not guarantee the care they outline, but having a codified practice is important because without one it’s hard to tell if improvements are being made.

3. There has been a focus on pre-natal trauma and this would be an opportunity to provide positive support to the pregnant teen.

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4. Not addressed in the memo: what is probation’s policy regarding pregnant juveniles? An important area of inquiry that TerraLuna has not delved into yet.

5. We have an opportunity to add “how are they given the nurturing they need and an understanding of what is and is not going to be happening to them.”

6. Things can be done differently at YRTC’s because they are state wards; at DCYC they are still in the custody of their parents so, unless requested, some things can’t be provided

7. There is an opportunity to draft a policy at the county level (DCYC): exit planning, warm hand-offs, parenting classes, activities, etc. Have to be realistic that RED will be an issue in a lot of this

8. Suggestion: there may be an opportunity with regard to child welfare, there’s a specific part of the Family First Prevention Service Act that diverts funding into prevention programs for pregnant and parenting youth; the State is in the works of finalizing their 5-year plan, which has some stuff in it about pregnant/parenting youth. It may be an opportunity for us to partner with them to effect system-wide policies

4. Next Steps
   a. A’Jamal will follow up on the states research for the addition of 3.e. to the work plan, and report back to us next meeting
   b. The co-chairs will add tentative dates to the work plan, as well as responsible party and resource information to have available for review at next month’s meeting

5. Feedback Survey – Handed out

Next Meeting: Monday, March 23, 2020, from 8:30am to 10am, at the Barbara Weitz Community Engagement Center, Marion Ivers Board Room, Room 128

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Obstetric Care in Out-of-Home Placement
Prepared by Lived Experience Project for the OYS Policy Work Group (February 2020)

Issue Brief
All juveniles drawn into the juvenile justice system are vulnerable, and each lives with layers of vulnerability. This memo focuses on juveniles who are pregnant while in out-of-home placements in Douglas County. This layer of vulnerability comes with countless sub-layers, some of which we have documented. It also should be made explicit that the vulnerabilities, in this case, are not just those of the individuals under the control of the juvenile justice system, but the developing life (or lives) inside that individual.

In their 2015 report, Gender Injustice: System-Level Juvenile Justice Reforms for Girls, Francine T. Sherman and Annie Balck write of pregnancy in the juvenile justice system:

"Despite their relatively low numbers in the juvenile justice population, the heightened vulnerability of pregnant and parenting [juveniles] and the consequences for the next generation make further research essential. A full understanding of these [juveniles'] needs and the ways current policies impact them is essential for jurisdictions to craft programs and policies that will help pregnant and parenting [juveniles] transition successfully back to their communities, avoid future justice-involvement, and parent their children successfully.”

In addition to understanding the unique needs of pregnant juveniles in the juvenile justice system, it is also important to know just how many juveniles are in need. To the best of our knowledge, Nebraska does not currently maintain aggregate data on pregnant juveniles in out-of-home placements, nor does any state agency or research entity focus on assessing and documenting the specific needs of these youth. To estimate the number of pregnant juveniles who are placed out-of-home in Nebraska each year, we reviewed a combination of state and federal data and estimated the number of pregnant juveniles in out-of-home placements in Nebraska to be fewer than 50 annually.

Facility policies can give clues to the needs of pregnant youth. However, the largest facility for detained Douglas County juveniles has no written policies specifically directing staff on the care of pregnant youth. Without such policies, it is difficult for families, caregivers, policymakers,

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3 "Appendix I: State and Federal Data on Pregnant Juveniles in the Juvenile Court System."
and health advocates to gauge the level of care provided by Douglas County to this profoundly vulnerable group.

Of the total number of juveniles placed out-of-home in Nebraska, **52 percent are in privately-owned facilities, the tenth-highest percentage in the country.**

Staff at a sampling of privately-owned out-of-home placements for Douglas County juveniles told us that they either do not accept pregnant youth, or see very few of them, and do not have dedicated written policies for care.

This memo intends to illuminate the needs of pregnant juveniles to initiate conversations at the facility, community, county, and state levels about levels of care and gaps in care with the hope of adding layers of support for this population.

**About the Lived Experience Project**
The Lived Experience Project is an Omaha-based research collaboration between The Sherwood Foundation and TerraLuna Collaborative. Our research design process centers the lived experience and voices of youth and families impacted by the juvenile justice system.

**How we do our research**
We partner with community-based organizations and facilitate group conversations, focused on healing, with system-impacted persons. Our Omaha-based interview and facilitation teams include system impacted persons who conduct qualitative interviews with oversight from an independent Institutional Review Board. Additionally, we collect system-generated data and documents to supplement and add context to our qualitative data.

**How we use our research**
We analyze data by looking for themes, patterns, and impactful stories. Informed by the data, we offer data-informed trainings to juvenile justice entities. These trainings focus on cultivating staff solidarity and empathic connection with youth and families; staff awareness, knowledge, and understanding of the system impacted persons; positive narratives and discourse of system impacted youth and families; restorative and transformative justice values, attitudes, and beliefs; and youth informed, restorative, and transformative justice capacities, practices, and policies.

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5 Lived Experience Project spoke with staff at six entities operating with a State of Nebraska Residential Child Caring Facility license (Boys Town, Child Saving Institute, NOVA Treatment Community, OMNI Behavioral Health, Uta Halee, and Women In Community Service). Only entities holding a State of Nebraska Residential Child-Caring Agency license were contacted.
Towards a Framework for Policy Creation

To better understand the policies and procedures governing the care of pregnant juveniles placed out of home, the Lived Experience Project team made public records requests to YRTC-Geneva, governed by the Nebraska Department of Health and Human Services (DHHS) and the Douglas County Youth Center (DCYC), governed by Douglas County.

Our request was for “all policy and procedure manuals and memorandums created by administration/staff related to nursing/medical care.”

Both DHHS and Douglas County were responsive to our request, providing us with multiple documents. DHHS provided 30 policy memos covering nursing/medical care at their Kearney and Geneva YRTC facilities. Douglas County provided 13 policy memos.

Of the YRTC-Geneva policy memos, eight of them specifically mention pregnancy/obstetric care. One of those documents is a dedicated obstetric policy.

Of the DCYC policy documents, only one mentions pregnancy/obstetric care. That is the “Medical Treatment Orders” policy, which notes that a second mattress may be provided to a pregnant detainee in their third trimester upon request. Upon noting no specific mention of pregnancy, a Lived Experience Project researcher reached out to DCYC, asking if any obstetric-specific policy documents existed. Pam Agee-Lowery, the DCYC Nurse Manager, confirmed there were no additional written policies and explained that pregnant juveniles are transported for outside obstetric care at least once per month and that pregnant juveniles are treated similar to all others and sent to specialists as needed.

What this description of care and the comprehensive Geneva-YRTC policies do not address, is care in the facility—such as nutrition and special care to physical comfort.

Using YRTC-Geneva policy memos as a starting point

The YRTC-Geneva policies, which are comprehensive, helped us to identify the areas of need for a pregnant juvenile in an out-of-home placement (and, in this case, in a secure detention environment).

By viewing the text of the YRTC-Geneva documents as answers to questions, the Lived Experience Project created a list of questions other facilities could answer through written policies, including questions regarding pregnancy tests; prenatal care; and labor and delivery:

General
  - How would you describe the level of care you provide for pregnant juveniles?

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6 See “Appendix II: YRTC-Geneva Policy Memos.”
7 See “Appendix III: DCYC Policy Memos.”
Pregnancy tests
- How are they administered? Is it part of the intake process or only administered upon request? (According to the national 2004 Juvenile Facilities Census, 15-17% of facilities test for pregnancy on admission.)

Prenatal care
- When a pregnancy is confirmed, who is notified, and how?
- What state, federal, or other policies, procedures, and/or recommendations are observed when coordinating the care of pregnant juveniles?
- Who is designated to be the primary point of contact for the juvenile regarding the pregnancy?
- What counseling is offered regarding options for pregnancy, birth, and post-birth?
- If termination of the pregnancy is an option, and it is chosen, how is that facilitated?
- How do you facilitate transport to hospitals, clinics, offices, or other relevant facilities?
- Who coordinates and accompanies the juvenile to off-site pre-natal appointments?
- Who coordinates pre-natal education?
- What happens if the need is greater than can be met by the responsible facility physician?
- How is risk-level assessed for pregnancy? (For example, at YRTC-Geneva, all pregnant juveniles are managed as high-risk pre-natal cases.)
- What if the juvenile is diagnosed with Substance Use Disorder?
- Is the use of restraints allowed during pregnancy?
  - If so, what special rules govern the use of restraints?

Labor and delivery
- Where is the juvenile taken to give birth?
- What preparations are made at the facility and at the birth site in advance of the birth?
- What lines of communication are opened once labor has begun and at the time of delivery?
- How is discharge from the hospital managed?
- What happens after the birth if juvenile is retaining custody of the child?
- What happens after birth if juvenile plans to relinquish her child?
- What special care will the juvenile receive after discharge from the hospital and return to the facility?
- Who will coordinate and monitor that care?
- Is the use of restraints allowed during labor?
- If so, what special rules govern the use of restraints?

Not covered in the YRTC policy documents
- What is not covered in the YRTC medical/nursing policies are guidelines for care of pregnant juveniles in the regular course of the day. Some examples might be: Of the
physical demands made of detainees/residents, which are pregnant juveniles exempted from?
• What physical accommodations are made for pregnant juveniles (e.g. special mattresses and seating)?
• What special protections are offered to pregnant juveniles?

Opportunities
There are numerous opportunities for action at the facility, community, county, and state levels to assess and serve the needs of pregnant youth in the juvenile justice system.

Knowledge gathering
• Support data collection initiatives focused on the number of pregnant juveniles in the system.
• Support an effort to thoroughly document policies and procedures governing the treatment of and decisions about pregnant juveniles, in order to identify areas for improvement.
• Support an effort to learn the needs of pregnant juveniles and how those needs are being met by the system.

External monitoring
• Support the creation of an early warning system, so that the appropriate service providers are made aware of pregnant juveniles entering the system and can offer supports.

Policy review and creation
• Support policymakers at the county level in helping DCYC to review their obstetric care practices and create robust policy memos regarding obstetric care.
• Support efforts to guide privately-owned facilities in reviewing their obstetric care practices and creating robust written policies regarding obstetric care.
Appendix I: State and Federal Data on Pregnant Juveniles in the Juvenile Court System

Lived Experience Project estimates that there are fewer than 50 pregnant juveniles admitted to out-of-home placements annually in Nebraska. It is difficult to know the number with certainty. We can only follow clues, as documented below.

Data Sources

(A) 2018 data from NE Administrative Office of the Courts & Probation
According to Nebraska’s Administrative Office of the Courts & Probation, 2,094 juveniles were admitted to out-of-home placements in fiscal year 2017-2018, including 235 who were placed out-of-state. Thirty-one percent (or 649) of the juveniles placed out-of-home were female. It is important to note here that none of the data sources referenced in this section recognized non-binary gender identities.

(B) 2015 data from the federal Census of Juveniles in Residential Placement
U.S. Department of Justice data, drawn from the 2015 Census of Juveniles in Residential Placement (CJRP), showed Nebraska ranked fourth in the nation for females as percentage of total juveniles in out-of-home placement:

1. New Hampshire (39%)
2. Hawaii (35%)
3. Wyoming (32%)
4. Nebraska (30%)
5. South Dakota (26%)

(C) 2003 data from the federal Survey of Youth in Residential Placement
According to 2003 Survey of Youth in Residential Placement (SYRP), five percent of females in residential placement at the time of the survey were pregnant.

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4 Sedlak, Andrea. (2013) "Survey of Youth in Residential Placement (SYRP)." Available: [https://doi.org/10.3886/CPSR34304.v1](https://doi.org/10.3886/CPSR34304.v1)
Coming to an estimate

How many pregnant juveniles are admitted to out-of-home placements each year in Nebraska? In the absence of hard data, one option is to calculate five percent of the 649 female juveniles in fiscal year 2017-2018—which would be **32 pregnant juveniles**. This calculation is an estimate and is meant as a starting place. We recommend an exploration of options for obtaining or collecting data on pregnant juveniles in out-of-home placements.
Appendix II: YRTC-Geneva Policy Memos

Summary of Relevant Policy Memos

Note: We have only included documents with specific mentions of obstetric care. There are additional nursing and medical care policy memos that would be applied to all juveniles in the facility.

115.24.5a Obstetrical Care (p2-7): Dedicated obstetrical care document.

115.4.5 Availability of Healthcare (p8-11): Section on “Female Health Care and Pregnancy Management,” summarizing:
- “Access to obstetrical, gynecological, family planning, health education, and pregnancy management services” (p8-9)
- “Use of mechanical restraints on pregnant juveniles” (p9)
- “Physical restraint of a pregnant juvenile” (p9)
- Pregnancy tests for “victims of sexually abusive vaginal penetration” (p10)
- Revision note (p11)

115.5.5 Screening, Exams, Appraisals, Reviews (p12): Guidance re: pregnancy tests as standard screening (p12)

115.14 AR HIV Screen., Test, Management (p13-17):
- Guidance re: HIV testing of pregnant youth (p14)
- Risk note re: infection and pregnancy (p15)
- Guidance re: declining HIV testing (p17)

115.15.5 Comm. & Infectious Disease Management (18-20):
- Definition: Amniotic fluid (p19)
- Chest x-ray instructions in case of positive Tuberculin Skin Test or QFT-G result (p20)

115.24.5 Special Health Programs (p21): Defines pregnancy as a “special health need” for the purpose of medical care.
PURPOSE

To provide obstetrical services and education for pregnant youth who are committed to the Youth Rehabilitation & Treatment Center – Geneva (YRTC-G).

GENERAL

The YRTC-G will provide a full gamut of services for juveniles who are pregnant. These services include pregnancy testing, counseling regarding a pregnant juvenile’s options, routine and high risk pre-natal care and delivery, management of a pregnant juvenile diagnosed with Substance Use Disorder, educational classes about pregnancy and childcare, post-partum care, and follow-up services for the juvenile and her baby.

PROCEDURES

I. Pre-Natal Counseling and Education

A. When YRTC-G medical staff confirms a pregnancy, they will notify the assigned case manager, the Mothers & Babies Program Coordinator, and appropriate living staff of the pregnancy and the approximate delivery date. The juvenile’s parent or guardian and the Probation Officer are also notified.

B. Staff shall follow all current Department of Health & Human Services (DHHS) policies and procedures when providing counseling and services to pregnant a juvenile, including the Division of Children & Family Services Protection & Safety Procedure #9-2017.

1. The Mothers & Babies Program Coordinator will discuss options with the juvenile concerning relinquishment, retaining the baby, and terminating the pregnancy.

   a. The Mothers & Babies Program Coordinator will provide unbiased information to the juvenile regarding alternatives and appropriate agencies and resources for further assistance.

   b. The Mothers & Babies Program Coordinator will not encourage, discourage, or act to prevent or require any of these options.
2. If a juvenile elects to terminate the pregnancy, the following conditions apply:
   
a. A juvenile 18 years of age does not require parental consent to seek a termination of her pregnancy. When a juvenile who is 17 years of age or younger decides to terminate her pregnancy, the Mothers & Babies Program Coordinator will:

   1) Encourage the juvenile to discuss her decision with supportive family.

   2) Encourage the juvenile to contact her attorney to discuss legal issues regarding the Waiver of Parental Consent.

   3) Provide information to the juvenile on how to submit a Petition for Waiver of Parental Consent to the court. Instructions and forms for this proceeding can be obtained from the Nebraska Supreme Court website. The Mothers and Babies Program Coordinator will ensure this is submitted to the court.

   4) Consent is not required when a physician determines a medical emergency exists. A medical emergency exists when a physician determines that the pregnancy complicates or compromises the medical condition of the pregnant juvenile and necessitates the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

b. DHHS employees may not transport a juvenile to a hospital, clinic, office, or other facility for services related to pregnancy termination. Juveniles may not be transported outside the State of Nebraska for services related to the termination of a pregnancy. State of Nebraska vehicles may never be used to transport juveniles for such purposes.
3. If the pregnant juvenile desires to investigate the relinquishment possibilities, the Mothers & Babies Program Coordinator will contact an agency of the juvenile’s choice and request services.

4. If the juvenile plans to retain custody of her child, it is the responsibility of the Mothers & Babies Program Coordinator, family, Probation Officer, appropriate divisions of DHHS, and any interested parties to assist in planning for the placement of the child until the juvenile is ready to appropriately care for her child.

C. Pre-natal care and education will be coordinated by the Mothers & Babies Program Coordinator and the medical staff.

II. Obstetrical Medical Care

A. Basic obstetrical services are provided by the contractual physician.

1. If the obstetrical need is greater than can be provided by the responsible physician, a referral is made to a specialist.

2. Due to their ages, all pregnant juveniles at the Youth Rehabilitation & Treatment Center - G will be managed as high risk pre-natal cases.

3. The YRTC-G nursing staff will coordinate all pre-natal appointments for the juvenile and will accompany the juvenile to off-campus appointments.

B. The management of a pregnant juvenile diagnosed with Substance Use Disorder will be coordinated with the medical department and the Clinical Psychologist.

1. Upon determination that a pregnant juvenile is diagnosed with Substance Use Disorder, the Nurse Supervisor and the Clinical Psychologist will develop programming that will deal with the juvenile’s addiction issues and her pregnancy.

C. The pregnant juvenile will deliver at the Fillmore County Hospital when possible, and be attended by the responsible physician.
1. The responsible physician will send a copy of the pre-natal record to the Fillmore County Hospital one month prior to the estimated delivery date.

2. Designated staff will prepare suitable clothing/items needed by the juvenile during her hospital stay. These should be in the living units two weeks prior to the expected date of delivery.

3. The nurse will be notified when the juvenile goes into labor, following the proper chain of communication if after regular office hours. The nurse, in conjunction with the physician, will determine when the juvenile is to be transported to the hospital for delivery.

   a. The nurse or designated staff will transport the juvenile to the hospital using appropriate security procedures. The responsible staff will stay with the juvenile through delivery.

   b. The Facility Administrator will be notified when the juvenile is admitted to the hospital and at the time of delivery.

D. The medical staff, Facility Administrator, and the Mothers & Babies Program Coordinator will coordinate the juvenile and her baby’s discharge from the hospital.

1. If the juvenile plans to retain custody of her child, it is the responsibility of the Mothers & Babies Program Coordinator to activate the established plan for the placement of the child until the juvenile is ready to assume physical custody.

   a. The plan needs to be coordinated with the assigned Probation officer and/or the appropriate state agency when temporary foster care is needed.

2. If a juvenile plans to relinquish her child, the Mothers & Babies Program Coordinator will coordinate the relinquishment process, including notification of the placement agency of the baby’s delivery.

E. Upon discharge from the Fillmore County Hospital and return to the facility, post-partum care for the juvenile will be provided by the YRTC-G medical staff, under the direction of the attending physician.
APPLICABLE ACA STANDARDS: None noted.

Daniel L. Scarborough

Daniel L. Scarborough, Facility Administrator

Kenneth Zoucha

YRTC-G Health Authority

Mark LaBouchardiere, Administrator
Office of Juvenile Services

Revised: April 30, 2017
Revised: February 24, 2014
Revised: April 15, 2011
Effective: August 15, 2007

Summary of Revisions

April 30, 2017
• Updated to new DHHS logo
• Changed Youth Counselor to Mothers & Babies Program Coordinator throughout OM
• Deleted references of Juvenile Services Officer throughout OM
• General: Reworded to reflect current language of a pregnant juvenile diagnosed with Substance Use Disorder
• Procedure I: B: Added reference of DCFS Protection & Safety Procedure #9-2017
• Procedure I: B2: Re-written to reflect Protection & Safety Procedures #9-2017
• Procedure I: B4: Deleted reference of Family Centered Practice.
• Procedure I: C.1: Deleted section.
• Procedure II: A3: Added reference relating to off-campus appointments.
Procedure II: B & B1: Changed Chemical Dependency Supervisor to Clinical Psychologist and reworded to reflect current language of a pregnant juvenile diagnosed with Substance Use Disorder

Procedure II: C2: Changed cottage to living unit

Changed Medical Authority to Health Authority

Changed signature line from Deputy Director Green to Administrator LaBouchardiere

February 24, 2014

- Reference to "youth" changed to "juvenile(s)" throughout the OM
- Whenever Juvenile Service Officer was mentioned throughout the OM, the addition of Probation Officer was also added
- Removed the Policy Section Administrator signature line
- Changed signature line of Administrator to Deputy Director

April 15, 2011

Section A

- Deleted section and relettered subsequent section — Information was in prior sections.
- New DHHS logo
- Signature lines changed to reflect DHHS reorganization
- Applicable ACA Standards added

August 15, 2007

This is a new OM. The information in this OM was formerly in OM 115.24.5 "Special Health Programs". A separate OM was established to make the information on obstetrical care more readily accessible.

- Section II.C: Added paragraph to establish procedures for the treatment of chemically addicted pregnant youth
- Removed reference to abortions occurring only in the first trimester.
- All references to HHSS were changed to DHHS.
- New logo
D. Outside Medical Referrals

1. The contractual physician(s) will be responsible for the coordination of any needed medical services from off-site referrals.

2. Health care staff shall develop a list of routine and emergency resources.
   a. This listing is posted within the clinical setting and is reviewed/updated annually.

3. Juveniles needing off-campus specialty referral will be transported under appropriate security measures to the off-campus facility. (4-JCF-4C-07)
   a. The "YRTC-G Medical Transportation Instructions" shall be completed by a nurse when medically sensitive conditions and/or specific precautions need to be communicated to the transportation officer (if a nurse is not the transportation officer).

4. Nursing staff shall complete the "YRTC-G Summary of Off-Site Care Medical Consultation Report" form which contains sufficient health information to allow a complete evaluation by the specialist.

5. The consulting physician shall provide to the facility sufficient information pertinent to physical findings, diagnostic test data, clinical impression, treatment recommendations, and a plan of care, as clinically indicated.

E. Female Health Care and Pregnancy Management

(Also see Operational Memorandum 115.24.5a "Obstetrical Care" for detailed information.)

1. Juveniles are provided access to obstetrical, gynecological, family planning, health education, and pregnancy-management services, to include:
   a. Pregnancy testing
   b. Routine and high-risk prenatal care
   c. Management of chemically addicted pregnant juveniles
d. Comprehensive counseling

e. Postpartum follow-up care (4-JCF-4C-19)

2. The use of mechanical restraints on pregnant juveniles is subject to the following provisions:

a. YRTC-Geneva staff may not apply mechanical restraints to a juvenile during active labor and/or the delivery of her child or during postpartum recovery.

   1) Exceptions to this require approval by and guidance on methodology from the Health Authority and will be based on serious security risks.

b. A juvenile known to be pregnant shall not be mechanically restrained by the wrists, ankles, or around the abdomen unless deemed necessary for the safety and security of the juvenile, the staff, or the public, and only under the following conditions:

   1) The Health Authority will provide guidance on the use of restraints on pregnant youth prior to active labor and delivery.

   2) The least restrictive restraint shall be used and only for the period of time that the safety or security threat exists.

   3) If mechanical restraints are used, the juvenile shall be cuffed in front. (4-JCF-2A-18-1)

3. The physical restraint of a pregnant juvenile shall be accomplished through the Handle with Care (HWC) Behavior Management System which emphasizes the use of verbal de-escalation and the use of physical restraint only as a last resort.

a. HWC does not have specific procedures for the physical restraint of a pregnant juvenile, rather facets of the HWC model can be safely adapted for a pregnant juvenile. (4-JCF-4C-47-1)
3. Staff shall provide such victims with medical and mental health services consistent with the community level of care.

4. Juveniles who are victims of sexually abusive vaginal penetration shall be offered a pregnancy test.
   a. If the pregnancy test is positive, juveniles shall receive timely and comprehensive information about timely access to all lawful pregnancy-related medical services.

5. Juveniles who are victims of sexual abuse while at the facility shall be offered tests for sexually transmitted infections as medically appropriate.

6. Treatment services shall be provided to the juvenile who is the victim of sexual abuse without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

7. A mental health evaluation for all juvenile-on-juvenile abusers will be conducted within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. (115.383)

IV. Medical Transportation
(See also Operational Memorandum 303.3.5 “Secure Juvenile Transportation)

A. A juvenile may be transported to health services only available outside the facility in a timely manner.

1. A juvenile requiring transportation for nonemergency health purposes will be transported under appropriate security measures as determined by the health care staff/Transportation Coordinator.
   a. In emergency situations, the juvenile may be transported via a state vehicle or ambulance. (See OM 115.6.5 “Emergency Medical Care.”) (4-JCF-4C-14)
   b. The Facility Administrator/designee will make the final decision on the security procedures to be used when transporting the juvenile.
NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Division of Children & Family Services
Office of Juvenile Services
Youth Rehabilitation & Treatment Center – Geneva
OPERATIONAL MEMORANDUM

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April 1, 2014
- The word “youth” and “girl” changed to “juvenile(s)” throughout the GM
- Section II: A.1: Changed times/stays that the part-time nurse is available.
- Section III: Paragraph I relating to medical restraints was deleted.
- Section III: Added paragraph I relating to PREA standard 115.383.
- Removed the Policy Section Administrator signature line
- Changed signature line of Administrator to Deputy Director
- Added applicable PREA standard

November 1, 2011
- Section III, F.2.: Information added outlining the procedures for the use of restraints on pregnant youth.

March 16, 2011
- GM revised in total to update procedures and include 4th Edition ACA language.
- New logo
- Signature lines updated to reflect DHHS reorganization
- Reviewed/Revised dates prior to 2000 deleted
- Applicable ACA standards added
pressure, respiration, and temperature)
d. Collection of additional data to complete the medical, dental, mental health, and immunization histories.
e. Consultation with a health-care practitioner, as appropriate. (4-JCF-4C-03)

3. Nursing staff will complete the following tests/screenings on each juvenile:
   a. Hemoglobin
   b. Urinalysis (UA)
   c. Purified Protein derivative test (PPD) Tuberculosis screening, if needed;
   d. Rapid Plasma Reagin (RPR) test for syphilis;
   e. Gonorrhea and Chlamydia tests;
   f. Human Immunodeficiency Virus (HIV) testing (with youth's consent)
   g. Comprehensive Metabolic Panel (CMP);
   h. Serum Human Chorionic Gonadotropin (HCG) test for pregnancy;
   i. Therapeutic blood levels as required for certain prescribed medications (i.e. anti-seizure medications, lithium, etc.)
   j. Hepatitis Profile, as clinically indicated and in accordance with policy and procedures.

B. The contractual physician completes a health examination on all new admissions, which includes the following:

1. Review of the earlier admission screening results, appraisal data, previous medical examination(s), testing, and health problems.
2. Physical examination, including review of mental and dental status.
PURPOSE

The purpose of this policy is to provide information and outline health procedures regarding HIV infection and Acquired Immune Deficiency Syndrome (AIDS). This policy is applicable to the Youth Rehabilitation and Treatment Centers (YRTC) located at Kearney and Geneva, Nebraska. This Administrative Regulation will also serve as the Operational Memorandum (procedure) for the YRTC's.

GENERAL

It is the policy of the Department of Health and Human Services-Office of Juvenile Services to maintain a facility environment that is safe and healthy for juveniles, staff and visitors, by ensuring that all appropriate and necessary precautions are taken to prevent or control the transmission of infectious diseases within the Department.

PROCEDURES

I. MANAGEMENT OF HIV HIGH RISK JUVENILES

The admission evaluation shall provide an opportunity for nursing to assess the juvenile’s general health condition, HIV status, establish a baseline for future comparisons, identify any medical problems or conditions that might affect placement of treatment and identify any active communicable diseases.

Management of HIV high-risk juveniles includes procedures as identified in the communicable and infectious disease control program (see AR 115.15). In addition, the program for HIV management shall include procedures for the following:

A. When and where juveniles are to be HIV tested

The Department of Health and Human Services, YRTC's will offer ALL juveniles HIV Antibody testing as part of STD testing. Juveniles may be tested under the following circumstances: physician request for medical reasons, juveniles request subject to approval by the physician, juveniles involved in high risk behavior and juvenile or employee request due to incidents of parenteral exposure or mucus membrane exposure to blood or semen. In the latter case, an incident report is required.

Juveniles with a positive test result will receive counseling about the disease from appropriate medical staff. Juveniles or employees involved in incidents of parenteral
exposure or mucous membrane exposure to blood or semen will be tested after filing the required incident report. The DHHS also recommends that all pregnant juveniles who have a history of parenteral drug use, prostitution, or who have been sexually active, be tested as early in the course of pregnancy as possible.

Juveniles shall not suffer discrimination based on the fact that they have participated in testing for presence of HIV antibodies or based on the results of such tests. Juveniles in the general population may request voluntary HIV testing, subject to approval by the physicians. YRTC's shall outline in an Operational Memorandum where HIV testing is to occur.

B. Pre- and post-test counseling — Counseling shall be offered to all juveniles involved in HIV testing.

C. Employing immunization and other preventive measures, when applicable

D. Using treatment protocols

In the clinic and hospital setting, universal precautions should be taken to prevent contamination with blood and secretions (stool, urine, blood). Health care workers should refer to the Medical Department Infection Control Manual for specific procedures regarding care of HIV-infected patients. Additional information and precautionary measures for non-medical staff are included in Appendices A and B of this AR, and will be disseminated to non-medical staff by the appropriate facility or program head.

E. Ensuring confidentiality of protected health information

Juveniles have the right to privacy and individual human dignity; therefore special care must be taken to preserve the confidentiality of persons with AIDS and those infected with the virus. Communication within the YRTC should respect these rights and should not involve widespread broadcasting of the patient's diagnosis, medical condition, sexual orientation, or personal habits. Juveniles infected with HIV, like juveniles with other diseases transmitted via blood, will need to have lab tests performed and they may require other specialized treatment, such as surgery or other invasive procedures. According to 390 NAC 11-002.04D if a child tests positive for HIV, “The child’s parents, or immediate caregiver and the child’s guardian ad litem will be advised of the child’s condition and course of treatment.” Also Administrative Regulation 115.3 and the supporting Operational Memorandums for each YRTC, the Facility Administrator or designee may have access to the medical record (with a demonstrated need to know).
a. Without treatment, people who progress to AIDS typically survive about 3 years. Once you have a dangerous opportunistic illness, life-expectancy without treatment falls to about 1 year. However, if you are taking ART and maintain a low viral load, then you may enjoy a near normal life span. You will most likely never progress to AIDS.

b. AIDS is the end stage of an HIV infection. HIV attacks the body's defense mechanisms and makes it susceptible to other diseases, infectious and malignant. Treatment for those other diseases is available and, when successful, will prolong the life of the person with AIDS.

c. The prognosis for an asymptomatic patient with a positive HIV antibody test is uncertain. Current data indicates that without antiretroviral therapy most will go on to develop AIDS.

d. Anyone with AIDS or a positive HIV antibody test should be regarded as carrying the HIV virus and infectious to others. However, universal precautions should be practiced when caring for or intervening with any juvenile.

e. The risk of patients with a positive HIV antibody test acquiring AIDS may be increased by repeated exposure to the HIV virus. Therefore, appropriate precautions are still indicated.

f. There is a risk of patients with AIDS or a positive HIV antibody test infecting others by intimate sexual contact (receptive anal intercourse poses a special risk) or sharing of needles. There is no evidence of casual contact transmission of HIV.

g. Women with AIDS or a positive HIV antibody test, or women whose sexual partner is seropositive, if they become pregnant, are at risk of having an infected child.

h. When seeking medical or dental care, juveniles with AIDS or a positive HIV antibody test must give this information to those providing the care so that appropriate precautions can be taken.

i. Regular medical follow-up will be recommended to all of these patients. It is important that they keep their appointments, as well as seek medical attention for any persistent symptoms.
When a juvenile is found to have a positive HIV antibody test, the appropriate medical staff person will notify a Disease Investigation Specialist with the Department of Health and Human Services to discuss partner notification.

2. A member of the mental health staff should provide psychological counseling. This counseling should address the following:

   a. The juvenile's fears anxieties and guilt feelings concerning his/her health status.

   b. Problems relating to family acceptance/rejection.

   c. Social/interpersonal problems within the YRTC.

   d. Assessment of the possible need for protective

   e. Any other emotional needs uncovered in the course of the counseling sessions.

   f. Follow-up counseling sessions should be scheduled at the discretion of the therapist, as well as the request of the juvenile.

   g. Mental Health staff may consider group therapy sessions with a number of patients, however, this must be done on a consensual basis.

**APPENDIX G**

**HIV ANTIBODY TESTING**

A. Testing

1. At the time of entry into the YRTC, ALL juveniles will be offered HIV Antibody testing as part of STD testing offered by the YRTCs. Juveniles may also be tested under the following circumstances: physician request for medical reasons, juvenile request subject to approval by the physician, and juvenile request due to incidents of parenteral exposure or mucous membrane exposure to blood or semen. Juveniles should be counseled as to high-risk behavior and counseling and testing recommended accordingly.

2. The Medical Department will not provide antibody testing for employees of the YRTCs. Employees will be referred to local county health departments for free testing, or to the personal physician for follow-up and referral.
3. All positive HIV (ELISA) test results shall be confirmed by a repeat ELISA test. If a second test is positive, a Western Blot test will be done. If this test is positive, the juvenile shall be considered confirmed HIV antibody positive.

4. When a juvenile requests voluntary HIV testing, a physician or physician assistant may order the testing on the observed input from facility staff and the physician's evaluation of the current health status and risk group of the juvenile.

5. When an employee experiences a parenteral (e.g., needle stick, cut, or skin abrasion) or mucous membrane (e.g., splash to eye or mouth) exposure to blood or other body fluids of a juvenile, the juvenile must be tested and assessed clinically to determine the likelihood of HIV infection. The incident report system must be initiated in all such cases. See Appendix H (parenteral and mucous membrane exposure). Staff and juveniles must be counseled if test results are positive.

5. All pregnant juveniles, especially those who have a history of parenteral drug use, a history of prostitution, or a history of sexual partners who are members of a high risk group (parenteral drug user, bisexual, or known to be antibody positive) should be urged to have the test as early in the course of pregnancy as possible. Those who decline the test should have a note made in their chart that an HIV antibody test was recommended but refused.

B. Medical Records

1. Juveniles with a confirmed diagnosis of AIDS:
   a. The medical practitioner shall enter "AIDS" on the juvenile's problem list.
   b. Blood and other specimens should be labeled prominently "Blood/Body Fluid Precautions."

2. Juveniles with a confirmed diagnosis of Acute HIV Infection:
   a. The medical practitioner shall enter "Acute HIV Infection" on the juvenile's problem list.
   b. Blood and other specimens should be labeled prominently "Blood/Body Fluid Precautions."

3. Juveniles confirmed positive test for HIV antibodies:
PURPOSE

To provide the Youth Rehabilitation & Treatment Center - Geneva (YRTC-G) with procedures that will assist healthcare providers in maintaining an environment that reduces unnecessary exposure to infectious and communicable diseases for juveniles, staff, and visitors.

GENERAL

The incidence of communicable and infectious diseases is minimized by providing programming that focuses on:

1. Prevention to include immunizations, when applicable
2. Surveillance (identification and monitoring)
3. Juvenile education and staff training
4. Treatment to include medical isolation, when indicated
5. Follow-up care
6. Reporting requirements to applicable local, state, and federal agencies
7. Confidentiality of protected health information and,
8. Appropriate safeguards for juveniles and staff, including post-exposure protocols.
   (4-JCF-4C-22)

In developing this programming, the YRTC-G has access to resources through the Centers for Disease Control and Prevention, Association of Practitioners in Infection Control, Occupational Safety and Health Administration, Nebraska Department of Health and Human Services (DHHS), and the Nebraska Department of Health.

DEFINITIONS

*Communicable Disease* – an infectious disease that can be transmitted from one individual to another either directly or indirectly.

*Direct Contact* – transmission via person-to-person contact with an infected host.

*Ectoparasite* – a parasite that lives on the outer surface of the body, such as fleas, ticks and lice.

*High risk exposure for blood and body fluids* – when body fluids contact non-intact skin or mucus membranes.

*Incubation Period* – is the phase in the development of a disease between the infection and first appearance of symptoms.