The Looming Challenge of Dementia in Corrections

Leadership Principles for Correctional Health Managers

Correctional Nursing Practice: What You Need to Know
The National Conference features the most comprehensive and highest quality educational programming in this field, designed to help correctional health professionals navigate the road to quality of care and professional advancement. This year’s meeting offers a broad range of timely topics, engaging sessions and opportunities to connect with colleagues.

Learn more at www.ncchc.org. Or e-mail info@ncchc.org.
CorrectCare™ is published quarterly by the National Commission on Correctional Health Care, a not-for-profit organization whose mission is to improve the quality of health care in our nation’s jails, prisons and juvenile confinement facilities. NCCHC is supported by the leading national organizations representing the fields of health, law and corrections.
Extra! Extra! Get the Inside Scoop

We know our readers are savvy consumers of information who rely heavily on the Internet for news and research and subscribe to a zillion e-mail newsletters. But according to a special question on the evaluation survey for NCCHC’s recent Updates in Correctional Health Care conference, many of you are not using social media. (Yet.)

That’s a shame, because you’re missing out on some good stuff. Case in point: NCCHC Right Now podcasts on BlogTalkRadio. Our crack social media consultant, Lorry Schoenly, PhD, RN, CCHP-RN, has interviewed several thought leaders in this field on topics as diverse as metabolic syndrome, correctional settings as clinical education sites and leadership (our feature article on leadership covers the same ground in more detail). Next up: interviews with some of the experts who will be presenting at the Correctional Mental Health Seminar, with the first topic being suicide risk assessment and response.

What else? Video interviews! On our YouTube channel, you will find live, on-site interviews with “NCCHC Newsmakers” such as board member Joseph Penn, MD, CCHP, discussing the work of the Commission’s juvenile health committee to update the juvenile health standards. Lorry also shares tips on how to make the most of a professional conference.

The NCCHC Blog at WordPress.com provides a behind-the-scenes look at the work of the Commission and its various departments, committees and special projects. Facebook is another easy way to share news. With nearly half of Updates survey respondents telling us they use Facebook, it was no surprise when “fans” of our site mushroomed quickly soon after it was launched. Finally, Twitter. We are a chatty crowd here at NCCHC so it’s hard to keep our tweets to 140 characters, but we try, we try. A great application for Twitter is to share on-the-spot information at meetings, so we hope to see lots of participation at our National Conference.

Importantly, all of these social media venues are designed to be interactive, so let’s hear from you!

Who’s Doing What?

About 280 people responded to our survey question regarding use of social media. Here are the percentages who are using various outlets at least occasionally:

- Online video (e.g., YouTube) ............... 54
- Mobile internet (smart phone, PDA) ... 53
- Online audio (e.g., podcasts) .......... 49
- Facebook ........................................ 45
- Blogs ............................................. 34
- RSS feed (e.g., GoogleReader) ............ 28
- Linked In ....................................... 13
- Twitter ......................................... 7

Where to Find Us

Facebook facebook.com/ncchc
Twitter twitter.com/ncchc
Blog ncchcblog.wordpress.com/
Podcasts blogtalkradio.com/ncchc
Youtube youtube.com/ncchc

Conference-Goers: Stay in Touch!

If you will be at the National Conference in Las Vegas this fall, follow us on Twitter for up-to-the-minute information about events and activities. Find us at http://twitter.com/ncchc; for conference tweets, track on this hashtag: #NCCHC10.

Your Input Is Very Important!

Conference Evaluations: The evaluation data we collect at each conference is essential in helping the NCCHC Education Committee to improve our educational programming. We ask not only about attendees’ experiences at this meeting, but also about desired approaches and topics for future events. That we can see what works, what doesn’t and how to refine the program to be most valuable. (At Updates 2010, a whopping 81% of respondents said they plan to change their practice habits as a result of attending! That’s a good indicator that we are hitting our mark.) So the next time you attend a meeting, please complete the survey with careful consideration about how we can help you meet your educational needs.

Check Your Mail for H1N1 Survey: NCCHC and Emory University are collaborating to conduct a survey about the H1N1 pandemic and its effect on individual jails and prisons. A sample of facility-level health care administrative personnel will receive e-mails in the coming weeks inviting them to participate in the online survey. We encourage you to fill out the survey if you are among this group.
Healthy Inmates 2020: Let’s Get on Board

by Susan Tiona, MD, CCHP

It’s time to move past Estelle v. Gamble. In the decades since the Supreme Court mandated that the correctional care profession must provide for the “serious medical needs” of the inmate population, correctional health care has fallen stagnant, content to do only that which is “required.”

As we move forward into the next decade, let’s take our profession away from Estelle v. Gamble and put it back into the hands of providers—those with the training, talent and tenacity to reject the status quo that says, “It can’t be done.” We should instead pursue excellence in correctional health care with a passion for medicine and a commitment to making a difference in the health of our inmates.

One of the tools that we can use in this pursuit is to utilize the concepts promoted in the national Healthy People 2020 program. Healthy People 2020 is the latest in a series of comprehensive 10-year health promotion and disease prevention objectives aimed at improving the health of all Americans. The entire Healthy People 2020 program encompasses 38 focus areas, with each area having many objectives. A fair number of these objectives do not apply well to the correctional environment. But there are dozens that can be useful in developing a core of initiatives tailored to correctional care and that we can use to launch a Healthy Inmates 2020 program (see box).

Partnering With Public Health

This program can be part of a wider correctional health care effort toward a healthier inmate population, cost-effective health care delivery and a commitment to working with the global public health community to transition our population into the public sector. The idea behind the program will be to enable correctional practices to collect data on current trends and baselines related to Healthy Inmates 2020 objectives; share that data with other correctional practices; implement one or more program objectives; and periodically collect interim data to monitor progress.

It will be exciting to watch this new trend unfold in the practice of correctional medicine as we strive to improve our partnership with public health.

Community health care providers all over the country will be implementing the national Healthy People 2020 initiatives into their private practices throughout the coming decade. As we join in this effort, we do so at a distinct advantage. No other primary care practice has such an opportune environment in which to make a difference in the health of its patients. As correctional providers, we have a truly captive audience, reliable follow-up, ample opportunity for observation and patients who have plenty of time to get healthy and stay that way.

So reflect on your patient population and take ownership of their health and disease status. Where possible, consider adopting one or more of the Healthy Inmates 2020 objectives. And join the team of correctional health professionals who are dedicated to achieving a healthier inmate population in the coming decade.

For more ideas and tools for putting Healthy Inmates 2020 into practice, visit www.care4cons.com.

Susan Tiona, MD, CCHP, is a physician at Kit Carson Correctional Facility, Burlington, CO. To contact her, email susan.tiona@gmail.com.

Sample Healthy Inmates 2020 Focus Areas and Objectives

Diabetes
- Increase the proportion of persons with diabetes and chronic kidney disease who receive recommended medical treatment with angiotensin-converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs)
- Improve glycemic control among the population with diagnosed diabetes by increasing the proportion with A1c values below 7%
- Increase the proportion of diabetics whose blood pressure is under control

Arthritis and Chronic Back Pain
- Increase the proportion of inmates with chronic joint symptoms who have seen a health care provider for their symptoms
- Increase the proportion of inmates with diagnosed arthritis who have had effective, evidence-based arthritis education as an integral part of the management of their condition
- Reduce activity limitation due to chronic back conditions

Health Communication
- Increase the proportion of inmates who report that their health care provider ...
  ... listens carefully to them
  ... explains things so that they can understand them
  ... shows respect for what they have to say
  ... spends enough time with them

Heart Disease and Stroke
- Increase the proportion of inmates ...
  ... who have had their blood cholesterol checked within the preceding five years
  ... with hypertension who meet the recommended guidelines for body mass index, saturated fat consumption, sodium intake and physical activity

Nutrition, Physical Activity and Fitness
- Increase the proportion of correctional care providers who regularly measure the body mass index of their patients
- Reduce the proportion of inmates who engage in no leisure-time physical activity
- Increase the proportion of encounters for chronic health conditions that include counseling or education related to exercise
“More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States” is the compelling title of a new report by the National Sheriffs’ Association and the Treatment Advocacy Center. A key finding: The odds of a seriously mentally ill individual being incarcerated rather than hospitalized are 3.2 to 1, according to state data, although the ratio varies by state.

The report is based on a comparative analysis of statistics from the U.S. Department of Health and Human Services and the Bureau of Justice Statistics that were collected during 2004 and 2005, respectively.

The report cites other research that suggests at least 16% of inmates have a serious mental illness, such as schizophrenia or bipolar disorder. In comparison, the figure was 6.4% in 1983. Today it is “extremely difficult” to find an available psychiatric hospital bed, the authors state.

“With minimal exception, incarceration has replaced hospitalization for thousands of individuals in every single state,” said James Pavle, executive director of the not-for-profit Treatment Advocacy Center, which works to remove barriers to treatment of severe mental illnesses.

The report also found a very strong correlation in which states that spend less on mental health services also have more mentally ill persons behind bars.

Unfortunately, correctional facilities “are not designed for treating patients, and law enforcement officials are not trained to be mental health professionals,” said study coauthor and NSA executive director Aaron Kennard. Furthermore, it is far more costly to house mentally ill inmates for reasons that include expensive psychotropic medications, psychiatric examinations and lawsuits.

The study makes several recommendations. These include adopting laws to provide assisted outpatient treatment and mental health courts to keep people with severe mental illness out of the criminal justice system and in treatment. Studies show that assisted outpatient treatment reduces hospitalization, homelessness, arrest and incarceration, while increasing adherence to treatment and improving overall quality of life. Other proposed solutions entail changing the financial structures that currently support policies to that lead to incarceration of the mentally ill, and reform of mental health treatment laws.

Find the report online at www.sheriffs.org/about/SurveyofStates.asp.

Reader Response

I was very interested in your recent issue (Vol. 24, Issue 1) with articles about both sleep and traumatic brain injury. After training in internal, sleep and addiction medicine and while serving as a general medical doctor in a medium-security prison for the Wisconsin Department of Corrections, I became especially sensitive to inmates with a combination of physical brain impairment and chronic, unrelenting insomnia.

I labeled the latter chronic organic insomnia (COI), not a common concept among sleep specialists. Even subtle brain injury, of myriad causes, can chronically impair sleep architecture. Etiology may include childhood injuries and abuse, head trauma, post-traumatic stress disorder, chronic illness, drug addiction, developmental and personality disorders, etc.

Guessing that the anxiety, suspiciousness and noise in the prison were not the cause of sleeplessness but vice versa, I considered that the insomnia might be creating the emotional and environmental distress.

Needless to say, treatment of COI was challenging, even with optimal medical care and sleep hygiene. Eventually, I found a combination of low-dosage tricyclic antidepressant and low-dose major tranquilizer (namely, doxepin 25-75 mg and thioridazine 50-150 mg, once daily) reasonably effective (and inexpensive) for brain-damaged insomniacs without escalating dosages nor true dependency, although it did need to be given permanently.

This combination seemed to me (without somnographic proof) to allow improved slow-wave sleep and some catch-up in extremely needed REM-stage sleep. Most patients experienced extended sleep time and some had benign nocturnal hallucinations early on in the therapy, suggesting the catch-up sleep and REM, but were reassured that this was not dangerous and only temporary. Discontinuation would lead to gradual return of the previous degree of insomnia over several days.

Since many organic insomniacs are prone to abuse hypnotics in general and are very, very sensitive to therapeutic doses of psychiatric medication, whether or not they are diagnosed with chronic anxiety, depression, hypomania or psychosis, this seemed to be a safe combination for the long term, with no serious side effects.

It also appears to me that the harnessing of psychedelic herbs (e.g., ibogaine, peyote, ayahuasca, salvia) may someday solve the challenge of “replacing” lost and needed REM-stage sleep, as is being researched worldwide in drug addiction and post-traumatic stress disorder.

Edward S. Friedrichs, MD (retired)
Brown Deer, Wisconsin
Treat HIV Confidently With TRUVADA

- Demonstrated efficacy and tolerability profile through 3 years in Study 934
- DHHS-preferred dual-NRTI backbone for more than 5 years
- Chosen partner with leading PIs

![Depend on TRUVADA to be your NRTI backbone](image)

Important Safety Information

- **WARNINGS:** Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogs, including VIREAD, a component of TRUVADA, in combination with other antiretrovirals
- **TRUVADA is not approved for the treatment of chronic hepatitis B virus (HBV) infection, and the safety and efficacy of TRUVADA have not been established in patients coinfected with HBV and HIV-1.** Severe acute exacerbations of hepatitis B have been reported in patients who are coinfected with HBV and HIV-1 and have discontinued TRUVADA. Hepatic function should be monitored closely with both clinical and laboratory follow-up for at least several months in patients who are coinfected with HIV-1 and HBV and discontinue TRUVADA. If appropriate, initiation of anti-hepatitis B therapy may be warranted.

Indication and Usage

TRUVADA, a combination of EMTRIVA (emtricitabine) and VIREAD (tenofovir disoproxil fumarate), is indicated in combination with other antiretroviral agents (such as nonnucleoside reverse transcriptase inhibitors or protease inhibitors) for the treatment of HIV-1 infection in adults.

The following points should be considered when initiating therapy with TRUVADA for the treatment of HIV-1 infection:

- It is not recommended that TRUVADA be used as a component of a triple nucleoside regimen.
- TRUVADA should not be coadministered with ATV/3TC (at least 600 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg), EMTRIVA, VIREAD, or lamivudine-containing products.
- In treatment-experienced patients, the use of TRUVADA should be guided by laboratory testing and treatment history.

Dosage and Administration

- Recommended dose: one tablet (containing 200 mg of emtricitabine and 300 mg of tenofovir disoproxil fumarate) once daily taken orally with or without food.
- Dose recommended in renal impairment: creatinine clearance (CrCl) 30–49 mL/min: 1 tablet every 48 hours; CrCl <30 mL/min or hemodialysis: do not use TRUVADA. The safety and effectiveness of these dose adjustment recommendations have not been clearly evaluated in patients with moderate renal impairment, clinical response to treatment and renal function should be closely monitored in these patients.
- No dose adjustment is necessary for patients with mild renal impairment (CrCl 50–80 mL/min).

Warnings and Precautions

- New onset or worsening renal impairment—Emtricitabine and tenofovir are principally eliminated by the kidney. Renal impairment can include acute renal failure and Fanconi syndrome.
- Anemia CCR3 before initiating treatment with TRUVADA. Routinely monitor CCI and serum phosphates in patients at risk for renal failure, including patients who have previously experienced renal events while receiving VIREAD (adefovir dipivoxil).
- During initial adjustment of TRUVADA and dose monitoring of renal function, measurements are recommended in all patients with CrCl 30–49 mL/min. No safety or efficacy data are available in patients with renal impairment who received TRUVADA using these dosing guidelines, so the potential benefit of TRUVADA therapy should be assessed against the potential risk of renal toxicity.
- Avoid administering TRUVADA with concomitant or recent use of nephrotoxic drugs.
- TRUVADA is a fixed-dose combination of emtricitabine and tenofovir disoproxil fumarate. TRUVADA should not be coadministered with ATIVAN (alprazolam), EMTRIVA, or VIREAD. Due to similarities between emtricitabine and lamivudine, TRUVADA should not be coadministered with other drugs containing lamivudine, including Combivir (stavudine/lamivudine), Epivir (or eniluracil HBV) (emtricitabine), and Truvada (emtricitabine/tenofovir disoproxil fumarate).
- TRUVADA should not be administered with VIREAD.
- Decreases in bone mineral density (BMD): consider monitoring BMD in patients with a history of osteoporosis or fractures who are at risk for osteoporosis. Cases of osteonecrosis (associated with proximal femoral shaft fractures) have been reported in association with the use of VIREAD.

Drug Interactions

- Dolutegravir (dolutegravir disoproxil fumarate increases dialyzed concentrations. Consider dose reductions or discontinuations of dolutegravir.
- Alafenamide (alafenamide increases SU concentrations and increases tenofovir concentrations. Use TDF with TDF only with caution, monitor for evidence of tenofovir-associated adverse reactions.

References:

The following is a brief summary of TRUVADA (emtricitabine/tenofovir disoproxil fumarate) [DPP]. For full prescribing information, refer to “Full prescribing information.”

**Warnings:**

**Lactic acidosis, severe hepatomegaly with steatosis, and the treatment acute exacerbation of hepatitis B**

Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported in patients who were receiving nucleoside analogues, including VIREAD® (emtricitabine fumarate), a component of TRUVADA, in combination with other antiretrovirals. (See Warnings and Precautions.)

TRUVADA is not approved for the treatment of chronic hepatitis B virus (CHBV) infections. CHBV and efficient CHBV treatment regimens have not been established in patients co-infected with HIV and CHBV. Severe acute exacerbations of hepatitis B have been reported in patients who were co-infected with HIV and CHBV and have discontinued TRUVADA. Hepatic function should be monitored closely with both clinical and laboratory follow-up for at least 12 months after discontinuation of co-infected patients who have experienced an acute exacerbation of hepatitis B while receiving TRUVADA and discontinuing TRUVADA. If appropriate, initiation of anti-hepatitis B therapy may be warranted. (See Warnings and Precautions.)

**Adverse Reactions**

Adverse reactions for clinical trials experience are reported by treatment-emergent adverse events (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to other antiretrovirals or the treatment-emergent adverse event (TEAE) occurring in ≥2% of patients treated with TRUVADA and are listed in Table 1. Some TEAEs are considered by the investigator to be related to...
Health staff are often asked by correctional staff to conduct tasks that might give them pause. For instance, perhaps an inmate has smuggled pills into the facility and custody asks a nurse to identify them. The primary question to ask is whether the act is medically necessary for the safety of the patient. If there is a risk that the inmate is under the influence of an unknown drug, then health staff should identify the pill to determine what actions might be needed for the benefit of the patient’s health. On the other hand, if health staff are being asked to identify pills to help in charging the inmate, they would do well to resist.

NCCHC’s standard on forensic information (I-03) requires that health services staff are prohibited from participating in the collection of forensic information. This is a topic on which we often receive questions due to the impact that such activity would have on patient–health staff relationships. NCCHC defines forensic information as physical or psychological data collected from an inmate that may be used against him or her in disciplinary or legal proceedings. Such acts are usually performed without inmate consent.

There are some exceptions to the prohibition. An example is when health staff are complying with state laws that require blood samples from inmates, as long as the inmate consents and health staff are not involved in any punitive action taken if the inmate does not participate in the collection (Compliance Indicator 1a). Another exception, noted in Compliance Indicator 1b, is the conduct of body cavity searches and blood or urine testing for alcohol or other drugs when it is done for medical purposes by a physician’s order. Other exceptions include inmate-specific, court-ordered lab tests, examinations or radiology procedures with consent of the inmate and, in the case of sexual assault, the gathering of evidence from the victim with his or her consent (Compliance Indicators 1c and 1d). Note in each exception the caveat that inmate consent or a physician order for medical purposes is required.

The Rationale
The intent of the standard is to ensure that the role of health staff is to serve their patients’ health needs. This means maintaining ethical boundaries and ensuring that the patient–health staff relationship is not jeopardized. Ethical conflicts arise when health staff take part in activities aimed at producing evidence that has negative consequences for the inmate. Think about it: A patient is not likely to want to see health staff for a health need if that person has helped to collect evidence. This can have bearing on access to care (see Standard A-01) by creating unreasonable barriers and deterring patients from seeking health services.

For similar reasons, the NCCHC standard on executions (P-I-07) prohibits health staff from participating in inmate executions. The ethical dilemma here relates to the same principle of maintaining an appropriate professional relationship with patients. The preservation of the therapeutic role is paramount in both the I-03 and I-07 standards.

Some facilities use the services of nonstaff or outside health professionals to collect forensic information, or someone on staff who is not in a therapeutic relationship with the inmate. Other options for accomplishing such tasks include using corrections staff to conduct oral and buccal swabs for DNA and urine testing for drug use, and using a dry cell as an alternative to body cavity searches.

Although the Forensic Information standard is classified as “important,” meaning that it is possible to achieve accreditation without meeting this standard, its significance should not be dismissed. Health staff should be educated about ethical boundaries in correctional facilities, and communication with correctional staff on these issues can help both groups to understand the intent of this standard. Orientation and in-services are opportunities to emphasize the concepts of what a correctional health professional’s role is in providing services to patients.

Jennifer E. Kistler, MPH, is NCCHC’s director of accreditation; Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president and liaison to the policy and standards committee. Contact them at info@ncchc.org or 773-880-1460.

Developed by leaders in the field, these benchmark standards will help you:

- improve health services delivery
- increase organizational effectiveness
- enhance overall health care for inmates

To order or to see a list of all publications available, visit our Web site at www.ncchc.org.
Join Us in Boston!
Professionals from across the country will come together to explore important issues and the latest practices in correctional mental health care. Learn from leaders who have forged the way to quality along the continuum of care.
- Get the latest information from correctional mental health experts and policy makers
- Learn how mental health care is evolving and what you can do to have greater impact
- Discover exciting innovations in mental health care research, delivery and treatment
- Explore how to overcome budget constraints while maintaining quality services

Program Dates and Times
Sunday, July 11 – 8 am to 4:15 pm
Monday, July 12 – 7:45 am to 4:15 pm

Meeting Venue
Westin Copley Place, winner of the AAA Four Diamond Award, is located in the heart of trendy Back Bay. The hotel overlooks the scenic bay and Charles River, and is only a stroll away from shopping at the Copley Mall, Prudential Building and Newbury Street. It also has great room amenities for a comfortable stay. Reservations: (800) 937-8461.

Continuing Education
Up to 13.25 hours of CE credit are available for CCHPs, nurses, physicians, psychologists and social workers. Please see the Final Program for details.

Program Highlights
- 24 concurrent sessions in three educational tracks
- Sponsored breakfast and luncheon programs
- Special networking events to enable participants to learn from each other
- Continuing education credit

Quality Content
This program will address many of the major mental health care issues that challenge facilities, along with emerging concerns that can have a big impact. Speakers will share strategies for providing quality care along the continuum, including reentry assistance. Attendees will leave equipped to implement these strategies and improve mental health services delivery at their facilities. Visit the Web to see the schedule and presentation abstracts.

New! Poster Presentations
Eduational posters will be on display along with the exhibits for easy viewing. Get your first look during the session breaks on Sunday morning, when you can enjoy refreshments while chatting with the poster presenters about the topics addressed in their work. The posters will remain on display throughout the seminar.

Special Invitation!
All attendees are invited to take part in a roundtable discussion on both mornings before the educational sessions begin. With a focus on emerging trends and hot topics, these gatherings are the best time to interact with your peers, debate issues, seek advice and express your opinions. You are guaranteed to come away with a lot of great ideas.

Sponsored by the Academy of Correctional Health Professionals

Seminar Learning Objectives
At the conclusion of this seminar, participants should be able to...
- Demonstrate an increased understanding of pervasive as well as emerging mental health problems within correctional populations and related management issues
- Identify best practices in evaluation, treatment and management for incarcerated individuals with mental illness
- Enhance skills necessary to manage mental health care delivery in correctional settings
- Develop mental health programs that incorporate the NCCHC standards for mental health services

Registration Information
- Regular registration: $235
- Academy member: $160
- Guest registration: $55

2 Ways to Save Money!
- The Academy of Correctional Health Professionals is a cosponsor of the seminar and its members save $75 on seminar registration fees. If you are not a member but would like to take advantage of this discount, you may join when you register for the seminar. To learn more about the Academy and the many benefits of membership, visit the Web at www.correctionalhealth.org.
- If you are a medical director or physician leader, extend your stay in Boston and attend the Medical Director Boot Camp. Register for both events and save 50% on the Correctional Mental Health Seminar fee. Enter promotion code BOSTON on the registration form. Learn about the Boot Camp on page 10 or visit www.ncchc.org.

Presented by the National Commission on Correctional Health Care
Copresenters: Academy of Correctional Health Professionals, American Psychiatric Association, American Psychological Association

For details about the seminar or to register, visit the Education section at www.ncchc.org.
The GEO Group’s success around the world has been achieved by our highly-trained work force. Our team of over 13,000 highly skilled professionals manage approximately 55,000 offenders and residents on behalf of government agencies worldwide.

Our philosophy is to hire only the best professionals in their field. In return, we provide our employees with competitive compensation and excellent benefits, as well as an environment in which personal goals are encouraged and professional opportunities are within reach. GEO provides the work-life balance, training, education, and mentoring you need to make your vision a reality.

Discover a world of opportunities... visit our website and explore the many outstanding careers available to talented individuals like you.

Opportunities are available in many of our facilities across the country, such as:

**HEALTH SERVICES ADMINISTRATOR, RN (South Florida)**
**PHARMACISTS (South Florida)** • **REGISTERED NURSES** • **PHYSICIANS**
**DIETICIANS** • **SUBSTANCE ABUSE COUNSELOR**
**MEDICAL SERVICES DIRECTOR**

There's never been a better time to join our growing group of professionals.

Take the first step towards a “World of Opportunities” by visiting www.geogroup.com. Click on “Careers,” then “Career Search.” For more information, you may also contact:

Nichole Vinci-Adamson, Manager, National Recruitment, Toll Free: 866-301-4436, Ext 7537
Fax: 561-443-3839 • Email: nvinci@geogroup.com

www.geogroup.com

Equal Opportunity Employer • All candidates must be able to pass background investigation, drug screen and medical evaluation
Critical Skills for Correctional Physician Leaders

Correctional medicine requires specialized knowledge and expertise. Designed by experts from the Society of Correctional Physicians, this Boot Camp provides essential training you won’t find anywhere else. Whether you are relatively new to the role or a seasoned professional, you will strengthen your understanding of the core elements of directing inmate health care and discover best contemporary practices. For two days, you will be immersed in a collegial, hands-on environment, engaging in workshop exercises that stimulate interaction, sharing and growth.

Who Should Attend
- Physicians new to leadership, such as task force leaders, department heads, regional chiefs
- Physicians being groomed as leadership candidates
- Physicians viewed as opinion leaders on the medical staff
- Current physician leaders who would benefit from a refresher on the essentials

Choose Your Track!
Choose either Track 101 (for those new to the role or who want a refresher) or Track 201 (more advanced content). Below is a sampling of sessions for each. For some, such as roundtable discussions and speed mentoring, both groups will meet together.

Track 101
- Risk Management
- Ethical Obligations
- Malpractice vs. 1983
- Strategies of Health Care Services Organization
- Effective Study Design: How to Improve Quality of Service
- Providing Cost-Effective Care
- Introduction to Just Cause
- Measuring and Improving Performance
- Working With Custody
- 7 Habits of Effective Leaders
- Setting Clinical Policy
- Accreditation
- Common Mistakes to Avoid

Track 201
- Just Culture
- Common Mistakes to Avoid
- Just Cause 201
- Effective Study Design: How to Improve Quality of Service
- Peer Review: An Assessment of the Total Quality of Care
- Using Standards to Improve Performance, Eliminate Waste
- How to Testify
- Clinical Protocols: Episodic and Ongoing
- 7 Habits of Effective Leaders
- Effective Use of Technology
- ADA and Special Needs Patients

Continuing Education for Physicians
NCCHC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. 15.5 AMA PRA Category 1 Credits™ will be available. See the Boot Camp program for details.

Learning Objectives
At the conclusion of this seminar, participants should be able to:
- Examine the role of medical directors in a correctional setting, including administrative roles, setting clinical policy, applying legal and ethical practices, and interacting with outside specialists, corrections and other health staff
- Employ process improvement systems such as quality improvement and risk management to operate an effective correctional health services delivery system
- Design effective models of care that are essential to a correctional practice
- Manage correctional health care staff, including recruitment, retention and supervision

Registration Information
Regular Registration: $285
SCP Member: $260

Also attending the Correctional Mental Health Seminar? Register for both events and save 50% on the seminar fee. Enter promotion code BOSTON on the registration form. Learn about the seminar on page 8.

For details about the Boot Camp or to register, visit the Education section at www.ncchc.org.
Beyond a reasonable doubt...  
**Medi-Dose® and TampAlerT®**

The most trusted names in tamper-evident unit dose packaging

Since 1971, correctional facilities have relied on the proven Medi-Dose systems for the quickest, safest and most economical way to package solid oral medication. They’re tamper-evident, ultraviolet inhibitant and minimize errors and pilferage. **Plus Medi-Dose contains no metal or glass!**

With TampAlerT, a twist of the wrist is all you need to dispense liquids in no-leak, tamper-evident unit dose. TampAlerT vials are available from 15 ml to 120 ml, in natural or ultraviolet inhibitant polyethylene, with either regular or child-resistant screw caps. Each cap contains a tamper-evident seal. **And TampAlerT contains no metal or glass!**

Both Medi-Dose and TampAlerT can be easily identified using our MILT software ... providing complete labeling and log reporting, even bar coding!

There’s no doubt about Medi-Dose and TampAlerT, proven in correctional facilities for over 30 years.

---

**Medi-Dose, Inc.**

**EPS, Inc.**

Responding to pharmacy packaging needs around the world

Milton Building, 70 Industrial Drive
Ivyland, PA 18974
800-523-8966, Fax: 800-323-8966
215-396-8600, Fax: 215-396-6662
www.mendidose.com
E-mail: info@medidose.com
As the inmate population ages, dementia will become increasingly common in our jails and prisons. In the community, the rate of new cases of dementia is expected to double in the next four decades. Although we don't really know what the prevalence of dementia is among inmates, there is no reason to think it is less than in the community.

In fact, there is reason to think it may be two to three times more frequent in corrections than in the community: Inmates have fewer protective factors and more risk factors; increasing numbers are being incarcerated into late age or for life; and inmates may grow physiologically older faster than people in the community due to high risk lifestyles and poor health care prior to incarceration. Base rates for serious mental disorders are two to four times greater in corrections than in the community. Dementia is unlikely to be an exception.

Dementia is not a good thing. The gateway symptom is impairment in memory for old information and learning of new information. There also must be at least one additional cognitive impairment. This impairment may be:

- A problem in expressing or receiving language (aphasia)
- A problem in doing things, such as combing your hair or tying your shoes (apraxia)
- A problem in recognizing common, everyday objects (agnosia)
- Problems in planning, organizing, thinking abstractly and self-monitoring (impaired executive functioning)

Dementia is usually progressive. Symptoms increase and functioning declines with time, ultimately resulting in death. There are no cures, no vaccines and no treatments that are effective in halting the decline. On average, people live about six years after being diagnosed with dementia. Between diagnosis and death, approximately 90% eventually require full-time nursing care in an institution.

Dementia causes not only increasing cognitive problems, but also increasing psychiatric and behavioral problems. For the inmate, the loss of memory and other cognitive problems may be the most pressing. For our institutions and staff, the behavioral and psychiatric problems may be the most concerning. Agitation, wandering, aggression, depression, impulsivity, catastrophic emotional reactions, paranoia, delusions, hallucinations, self-neglect and incontinence commonly occur at some point in the course of dementia. Individuals with dementia have, on average, two or three additional medical conditions, further complicating their treatment and management.

Addressing the Problem
What steps can the correctional health care community take to address these challenges? We present five recommendations, along with a closing caution.
1. We need to do better at early detection
Early signs of dementia include regular forgetfulness, confusion, indecisiveness, loss of judgment, disorientation to time or place, wandering, loss of initiative, new handwriting problems, changes in mood and personality, and difficulty completing once-familiar tasks. Typically, these signs do not trigger referrals to medical or mental health services, and inmates may be unlikely to submit sick call slips for these problems.

We need to be alert to the signs. This won’t help stop dementia, but it will help manage the dementing inmate and facilitate treatment of co-occurring medical or mental health conditions. Noncompliance with treatment and treatment complications are common in dementia.

Detecting dementia early requires obtaining a good history. Because insight and memory are impaired with dementia, inmate self-report is unlikely to be the best source of information. Consulting with correctional officers, other staff and family members can be crucial. They can identify personality changes, embarrassing behaviors (e.g., self-neglect, incontinence) and impairments that represent unmistakable changes from the inmate’s previous levels of functioning. Physical examination, laboratory tests and brief cognitive tests can also be helpful in making the correct diagnosis. Many of the newest cognitive screening instruments, such as the Montreal Cognitive Test or the DemTect, are readily accessible on the Internet.

2. Once dementia is diagnosed, the inmate needs to know
Disclosing the diagnosis requires planning, multidisciplinary collaboration and sensitivity. When possible, family members should be included in the disclosure process with the inmate. While there may be a few inmates whose dementia will be identified so late that there is no meaningful way for them to appreciate the diagnosis, in most cases we need to respect the inmate’s need to know what is wrong and what is likely to happen. Disclosure and acceptance of the diagnosis will be a process, not an event, for the inmate.

Staff also need to know, because loss of functioning in most dementias is not reversible. Treatment should support and prolong functioning as long as possible. It cannot restore previous levels of functioning. Staff expectations need to be realistic and to be focused on aspects of treatment and management that have real meaning for the inmate’s experience and quality of life. As with the inmate, disclosure and acceptance of the diagnosis will likely be a process, not an event.

3. We need to structure the environment for success
Environmental features reduce the potential for confusion and agitation in an inmate with dementia. Unless we plan ahead, institutional operations and inmate management will become increasingly difficult. Environments should be well-lit and quiet; contrasting colors to delineate bathrooms should be used, mirrors should be removed; and simple signs including pictures as well as words should be posted. Handrails and wheelchair-accessible showers are also recommended. In the community, the research supports the use of locked units, the absence of rugs or carpeting with edges and consistent daily routines. In these areas, jails and prisons are ahead of the curve.

Hearing aids and eyeglasses can be critical for inmates who need them. When perceptual acuity is diminished, our brains strain to make sense of things and often come up with misinterpretations. Reducing this “brain strain” helps reduce dependency on others and proneness to agitation.

Clothing that is easy to get on and off (Velcro and elastic design) also helps support an inmate’s functioning. There are three major reasons for incontinence among individuals with dementia: not knowing where the bathroom is, not being able to get clothing off and not being able to control bodily functions. The good news is that the first two can often be addressed relatively easily through environmental interventions.

4. We need to train our staff
Research indicates that staff training has the greatest effect on dementia treatment outcomes. Much of the training is focused on communication. It is critical to treat inmates with dementia as adults, to take their perspective seriously and to avoid trying to argue them out of delusions or confusion. A nonjudgmental perspective is required: Blaming the inmate for a shrinking brain will only harden staff and alienate the inmate.

Patience, discipline and flexibility are also required; dementing inmates cannot be expected to remember or follow multistep directions. Directing their attention to the function of an item may work better than giving directions. For example, telling an inmate, “Here’s the toothbrush for your teeth” may feel less childish or threatening than “Time to brush your teeth.” Putting toothpaste on the toothbrush and placing it on the sink may be even more effective. It is critical to support the inmate’s sense of personal autonomy while keeping choices simple and manageable. This strategy

continued on page 14
helps prevent confusion, shame, anger, agitation and behavioral crises.

Due to the inmate’s memory problems, it may be necessary to reintroduce yourself each time you start a conversation. Dementia also impacts the inmate’s ability to pay attention, so it is important to make sure you have the inmate’s full attention before you begin communicating. Talking slowly, using gestures and allowing the inmate enough time to process and respond are essential. Most importantly, staff need to remember that, for an inmate with dementia, life is always like coming into the middle of a movie. They need to spend a lot of effort making sense of things as they go along. If staff can keep this perspective in mind, a great deal of the inmate’s behavior will make sense and empathic and effective communication is more likely to occur.

5. We need to develop nonpharmacological interventions to support the highest levels of functioning

Praising inmates for positive behaviors can increase the likelihood of the same positive behaviors in the future. Relaxation training, support of specific skills, physical exercise and some group and individual treatment interventions have shown positive effects. Aromatherapy, massage, music therapy, pet therapy and day programming have also demonstrated positive effects. While some of these latter interventions may be challenging to implement in corrections, they are important to consider. Inmates, like the rest of us, require holistic treatment.

Even with the best of treatments, however, most inmates with dementia are eventually going to require round-the-clock nursing care in a protected environment.

Don’t Wait! Prepare Now

Dementia among inmates is a looming crisis. The correctional system is already the largest provider of mental health services in the country. Very soon, we may also become the largest provider of skilled nursing and dementia services. We cannot afford to sit back and wait for this to happen, because we will not be able to afford the services these inmates will need if we do nothing now. We must prepare for the rising tide of dementia through institutional planning, environmental modifications and staff training.

John Wilson, PhD, is clinical operations specialist and Sharen Barboza, PhD, is senior clinical operations specialist for MHM Services, Inc., Vienna, VA. They presented a half-day seminar on this topic in April at NCCHC’s Updates in Correctional Health Care conference in Nashville. An interview with Dr. Wilson on this topic is available online at NCCHC Right Now, www.blogtalkradio.com/ncchc. To contact the authors, e-mail jwilson@mhm-services.com or sbarboza@mhm-services.com.
Does your TPA do more than just pay claims?

CHP has solutions for all of your inmate healthcare needs.

“The strong working relationship we have with CHP is unmatched in my experience with contract agencies. Their staff is highly skilled, motivated, and experienced. It is a true partnership in managing healthcare for the offender population.”

– Joan Shoemaker
Director of Clinical Services, Colorado Department of Corrections

We Deliver:
- Innovative cost reduction strategies
- Claims processing
- Prior authorization and utilization management
- Reporting and analysis
- Provider network development
- Care management and coordination
- Staffing solutions
- Pharmacy management, including formulary development
- Quality improvement

Call toll free 1.866.932.7185
or visit us at www.CHPdelivers.com
Managing and leading staff can be difficult in any setting. Corrections presents its own unique twists, made more complicated by the role division between security and health care. However, the principles of effective leadership remain the same regardless of setting. By putting these principles into practice, managers of all levels can develop skills that will make them and their operation more successful.

This article presents some of the fundamentals along with practice tips. These tips are also helpful for all staff members who wish to help create a more productive and cooperative work culture.

Leading From Possibility

Gone are the days of the notion that the leader is all-knowing boss who rules with an iron fist in a velvet glove. Businesses and staff demand more. To remain competitive, leaders can no longer accept incremental improvements. Today’s effective leader seeks breakthrough results. With all the low-hanging fruit gone, the leader and the staff must consider areas that weren’t even thought of five years ago. Today’s successful leader leads from possibility. But it’s not an easy task. And not everyone has a “possibility” mind-set. Imagine this scenario:

Two shoe sales representatives land in Africa. Upon seeing hundreds of people walking around barefoot, one rep sends a message back to the home office: “No sales here…no one wears shoes.” The other rep’s message: “Huge market, everyone needs shoes.”

In this classic story, it’s obvious that some people see the glass as half full while others see it as half empty. The goal is to get the team to see possibilities. While most would say they want their staff to think about what’s possible, that’s not how it plays out at the work site. Some managers actually discourage possibility, raising obstacles through policies that emphasize what you can’t do or dismissing creative suggestions from staff. This may simplify their management duties in the short term but it can lead to stagnation in the long run.

The biggest challenge to seeing possibilities is our own success. Through our maturation with an organization, coupled with success and recognition, we develop a success pattern. This is good. It gets us promotions, pay increases, special assignments, even employment. But this success pattern is a double-edged sword: It discourages us from trying anything new. It creates barriers such as fear, doubt and overconfidence.

So how do we break our success pattern? There are a number of methods, but two simple approaches are to turn off our auto-pilot and to change our “I already know” attitudes. An example of being on auto-pilot is when you arrive home from work, taking a route that you take every day, and you do not remember driving past streets that you know you had to have passed. It’s a safe state to be in, but it’s automatic and not attuned to what’s happening.

Leading from possibility is being present. It is recognizing that you may not know and that you are open to better alternatives.

Management and Leadership Principles

Much has been written on the principles of leadership in recent decades, but for the wisdom of a master we can look to the 16th president of the United States. In his excellent book *Lincoln on Leadership*, author Donald T. Phillips shares the following gems:

- Character: Honesty and integrity are the best policies
- Never act out of vengeance or spite
- Have the courage to handle unjust criticism
- Be a master of paradox
- Avoid major conflict in the form of quarrels
- Lead by being led

As to the basics of good management, Steven Covey nailed it with his blockbuster book *The 7 Habits of Highly Effective People*. In brief, these habits are as follows:

1. Be proactive
2. Begin with the end in mind
3. Put first things first
4. Think win/win
5. Seek first to understand
6. Synergize
7. Sharpen the saw daily

Smart advice, but good habits shouldn’t stop there. Here are some other tips for correctional health managers.

- Never forget where you came from. – Nobody started at the top; have empathy for your staff and don’t develop a superioristic attitude.
- Manage by wandering around. – There is no substitute for observation and interaction to understand your operation and staff. You will recognize minor problems before they mushroom into major ones.
- When presenting a problem, bring a solution. – Criticism serves no purpose and only breeds negativity. Instead, always propose a solution—even if it needs tweaking—and encourage your staff to do the same.
- “Every day is audit day.” – The NCCHC standards are
meant to be guidance for daily practice, not a CliffsNotes cram session to prepare for an accreditation survey.

- Accreditation standards are your fallback. – Follow the standards routinely and you will prevent many problems.
- Do the routine things well and emergencies will not be handled as a crisis. – Consistent use of quality, standards-based practices will create the professional discipline to react appropriately when emergencies occur.

Critical Leadership Competencies

No matter how brilliant or technically skillful a manager is, leadership will be lacking without strong communication and interpersonal skills. One core competency in building interpersonal relationships is having emotional intelligence. That is, you must learn to identify, understand and manage the feelings, impulses and motivations in yourself and others. Connect to your emotions, communicate nonverbally and diffuse conflicts with confidence and self-assurance. Awareness of cultural diversity is essential, as well. In conversation, be an active listener and provide feedback, both negative and positive, with empathy.

Written communication takes many forms, but in a work context, there is no place for sloppy or overly casual writing, even in e-mails. Always be clear and concise, with a smooth flow of words and ideas. Consider the reader’s comprehension level when choosing vocabulary. Don’t forget to check grammar and spelling; mistakes create the impression of unprofessionalism.

Take care with the timing, temperature and tone of e-mails. People tend to “dash off” messages, which can be a big mistake, especially during emotional stress. Take a lesson from Abraham Lincoln and set the message aside until you can rewrite it with a cool, clear head. If the stakes are high or the matter complex, don’t use e-mail at all. Instead, call or chat in person to deal with the issue together.

Management and Morale

Management style has a direct influence on staff morale, so it is important to be attentive to nuances in your own actions and interactions with others. First, you must gain people’s trust. Be honest. Be consistent in how you treat staff and don’t show favoritism. Always follow through when you say you will. Attend to staff complaints, but don’t get caught up in rumors. Never divulge confidential information.

Strengthen staff morale by serving as a coach to influence—not demand—desired behavior. Be consistent with policy implementation. In public, always be supportive. Provide positive feedback to let employees know when they do a good job. If the feedback is negative, deliver this in private. Public negativity is damaging not only for the person on the receiving end but also for staff as a whole.

Other management tips that have an impact not only on morale but also on your own performance:
- Make a good first impression
- Be hands on
- Be proactive, not reactive
- Trust but verify
- Train = retain = maintain
- Know the available resources and use them appropriately

Rewarding Performance

Employees expect work to be positive and motivating, and they tend to respond well to rewards. But here, too, a good manager will take extra care in how this is done.

Rewards should be based on demonstrated achievements, so put measurements in place. Measurement is essential in communicating direction, establishing accountability, tracking performance and allocating time and energy. People want to know how they are doing, and performance actually improves when they know how their work is being measured.

Informal rewards can include personal notes or public recognition, even celebrations and small gifts. As a rule of thumb, for every four informal rewards there should be a more formal reward, such as sending the employee to a training seminar, assigning greater responsibilities or giving a promotion.

To keep thing interesting, the reward program should encompass variety and be changed frequently. Avoid “jelly bean” motivation, giving the same reward to every member of the organization. Instead, match the reward to the person and to the specific achievement in a timely manner. A caution: You want to promote rewards, but don’t oversell them.

Common Pitfalls

Management is rife with pitfalls, but staying alert to them can help you avoid them. Here are some to watch for:
- Controlling staff. Instead engineer powerful processes.
- Choosing the wrong battles. Spend your effort where it can make a difference and get positive results.
- Providing unnecessary information. Don’t hoard vital information, but be judicious in what you share.
- Behaving like a “bull in a china shop.” Instead, get staff buy-in and roll out changes over time.
- Avoiding problems. The sooner you face and address them, the better your operation will be.
- Pretending to have all the answers. If you don’t know, say “I don’t know.” Just find the answer and report back timely.

Make the Commitment

Being a leader is a commitment. If you choose to step into that role, you owe it to your organization, your staff and yourself to live up to the charge. Actively seek to absorb and practice the principles of leadership, and remember Lincoln’s wisdom: The best leaders never stop learning.

Todd Schwartz, MPA, CCHP is senior vice president of operations and Guy Smith, MS, is vice president of people development for Correct Care Solutions, Nashville, TN. This article is based on a presentation they gave in April at the Updates in Correctional Health Care conference in Nashville. To contact Schwartz, e-mail tschwartz@correctcaresolutions.com.
Correctional Nursing Practice: What You Need to Know (Parts 1 & 2)

NCCHC’s Certified Correctional Health Professional program now offers specialty certification for RNs. The CCHP-RN certification is the formal recognition of the specialized knowledge, skills and experience deemed specific to the practice of nursing in a correctional setting. Whereas nursing licensure establishes legal authority for an individual to practice nursing, specialty certification reflects achievement of the special knowledge and skills needed for a particular practice area.

This new column, written by members of the CCHP-RN task force, will discuss various areas of correctional nursing practice covered in the CCHP-RN exam outline. This will assist nurses preparing to take the exam as well as explain the key concepts of the specialty for the novice correctional nurse. Learn more about the CCHP-RN program at www.ncchc.org/cchprn, where you can also view the entire test outline (see downloads). — Lorry Schoenly, PhD, RN, CCHP-RN.

Treatment and Interventions
Correctional nurses provide emergent, urgent, routine and preventive care and education for a group of patients who may have challenging conditions while in an environment with a primary objective other than health care. Several themes, therefore, differentiate correctional nursing practice from other nursing specialties.

Population Characteristics and Common Conditions
Correctional nurses deliver care to a diverse inmate population with some distinctive characteristics. Approximately 2.3 million individuals are now incarcerated in the United States, with a disproportionate percentage being male and black. The majority of inmates come from lower socioeconomic groups and have lower literacy rates in comparison to the general population. Many have not established good health habits or received regular medical care prior to incarceration. Levels of drug and alcohol use are relatively high. All of these factors contribute to common illness patterns and affect the application of nursing principles to delivery of care.

Nurses specializing in corrections need a solid understanding of key conditions with higher incidence in this patient population. These include infectious and sexually transmitted diseases, a number of chronic conditions and alcohol-related problems such as withdrawal and cirrhosis. Prevalence of mental illness is high. Concern for self-injury and suicide is also ever-present.

Special Needs of Women and Adolescents
Incarcerated women and adolescents have special needs that require skilled attention during care delivery. Women enter correctional facilities with greater rates of sexually transmitted diseases, substance abuse and mental illness compared to their male counterparts. They are more likely to have been sexually or physically abused, which increases their vulnerability. An estimated two-thirds of women inmates have children younger than age 18 and an increasing number are pregnant at the time of commitment, both of which create additional stresses.

Adolescents often have developmental immaturity, cognitive disorders and behavioral issues to be considered in the delivery of health care. Their special health challenges include attention to maturational stages and immunization needs.

Inmate Goals Not Related to Health Problems
Correctional nurses are aware that patients in this setting can have a variety of motivations for seeking health care other than an actual or potential health problem. Inmates may access assistance for secondary gain such as environmental comforts or work reduction. Although every health concern should be appropriately assessed and treated based on objective data, correctional nurses must guard against making assumptions or basing treatment on only subjective data.

Coping With Major Life Change and Transition
Finally, nursing care and treatment must be delivered with an understanding of the major life changes and transitions experienced by the inmate-patient upon entering the correctional system. Family and community connections have been altered. The corrections environment has a new structure and hierarchy to be adapted to. Stressors such as child custody, spouse abandonment and financial distress may be present and combined with inmate-to-inmate hostility. Correctional nurses have an understanding of the potential life changes of the patient population and how this might impact care.

Our Impact
Correctional nurses have an opportunity to improve clinical outcomes by practicing their profession with a specialized understanding of the corrections environment and the patient population.

Margaret Collatt, BSN, RN, CCHP-A/RN

Promotion of a Safe and Secure Health Care Environment
Correctional nurses have an active role in creating and maintaining a safe and secure environment for health care delivery in a correctional facility. Nurses play a vital role through use of infection control principles, control of sharps and hazardous materials, and involvement in emergency procedures.

Environmental Safety and Public Health
An important safety issue is that of infection control. Correctional nurses consistently adhere to the principles of standard precautions and are alert to the use of these principles by others in the facility. Effective and frequent hand washing is a primary way to reduce the spread of infection. 

Margaret Collatt, BSN, RN, CCHP-A/RN
in this vulnerable environment. Nurses are alert at all times for ways to encourage this practice among health care and custody staff.

Correctional nurses are also knowledgeable about the use of isolation to prevent infection entry and spread within a facility. For example, suspected TB would be a key concern, as would MRSA in an open wound.

Correctional nurses are instrumental in providing infection control information to others in the facility. Accurate information could make the difference between understanding an infection control concern and the hysteria that might come from lack of knowledge.

Other nursing responsibilities include public health reporting for certain classes of infectious disease. Correctional nurses are aware of reporting requirements of the Centers for Disease Control and Prevention and state and local health department regarding the various infectious diseases that may emerge.

**Sharps and Hazardous Materials**

Sharps are of particular concern in a corrections environment. The secure maintenance of needles, blades and instruments requires the use of declining inventories and key control. New medical and dental staff members must be informed about the contraband system. Correctional nurses continually guard against complacency in the control of these materials.

In addition, biohazard waste must be treated as infectious material requiring proper tracking of disposal and destruction.

**Safety and Security Policies and Procedures**

Security is the No. 1 priority in a correctional facility. Correctional officers not only prevent inmates from escaping but also protect all within the facility from harm. Correctional nurses must be fully aware of safety and security procedures. Common policies address items deemed contraband, metal detectors, proper identification on each person and response to security breaches.

Correctional nurses also must be aware of the surroundings at all times. This includes the facility layout and the individuals in close proximity. Any unsafe areas or events should be resolved immediately. One example might be during diabetic call and administration of insulin, if the nurse is left alone with numerous inmates and syringes are in use. Another is a “man-down” call in which other inmates are not removed from the area before medical staff begin treating the injured. These examples suggest opportunities for health care staff to work with custody to reach a mutually agreeable solution for a safe environment.

Every facility should have an emergency response plan. The correctional nurse should be familiar with this plan and know what part to play. Nurses may have responsibilities to triage and care for sick and wounded in internal or external disasters, riot/hostage situations and cell extractions.

Susan Laffan, RN, CCHP-A/RN

All three authors are members of the CCHP-RN task force. To contact any of them, write to editor@ncchc.org.

Lorry Schoenly, PhD, RN, CCHP-RN, coordinates and edits this special feature. She is an independent consultant specializing in correctional health care and social media and is based in Pennsylvania.

Margaret Collatt, BSN, RN, CCHP-A/RN, is training and development specialist for the Oregon Department of Corrections.

Susan Laffan, RN, CCHP-A/RN, is co-owner of Specialized Medical Consultants, based in New Jersey, and also works in the emergency department of a hospital in that state.
Who Is Getting Injured in Prison ... and Can We Prevent It?

Injury is the leading cause of death and disability in young adults nationwide, and in the community it is viewed primarily as a public health problem. Not so in prisons, where more than 50% of inmates are younger than 35 and injury is still “largely perceived as a managerial and disciplinary issue related to unavoidable accidents and violent behaviors,” writes Hung-En Sung, PhD, in the latest issue of the Journal of Correctional Health Care.

Sung, however, argues that injury can be proactively and effectively prevented. His research examines the prevalence, nature and risk factors of violence- and accident-related injuries among state prisoners.

Using data from the 2004 Survey of Inmates in State Correctional Facilities, conducted by the U.S. Census Bureau, Sung estimated the national prevalence of and risk factors associated with nonfatal injuries among 14,499 prison inmates.

Overall, 31.0% of the entire sample had been injured in a violent incident or unintentional accident, or both, in their current prison stay. By general category, 21.5% were injured in an accident, such as slipping or falling while at work, playing sports and so forth, and 14.7% were intentionally injured through violence, such as in a fight, assault or other incident in which someone tried to harm them. Comparing these rates to age-adjusted estimates for community residents, violence-related injuries were more than 14 times higher among the inmates and accident-related injuries were 2.3 times higher. The article also provides data by gender.

**Risk Factors**

Sung tested 39 variables as potential risk factors associated with traumatic injuries among prisoners. These variables were drawn from public health research that identified some of the key social and behavioral domains correlated with violence-related and/or accident-related injuries.

Fifteen of the variable were found to predict both categories of injuries. Among the many notable findings, a history of physical abuse, past weapon victimization and/or violent offenses made an inmate much more vulnerable to both kinds of injuries in prison. Others at higher risk include those with a recent history of mental health treatment, those prone to losing their temper and vengeful thinking and those with certain disabilities. Participation in educational programs was also a risk factor.

Among the protective factors found were female gender, drug offenses, chronic offending, increasing age at first arrest, increasing number of prior arrests and maintaining telephone contacts with friends and family.

Several factors were protective for one category of injury but risky for the other.

**Reducing the Risk**

An objective of this study was to illuminate the extent and severity of the problem of injury in prison so that correctional administrators could better prioritize and allocate health care resources. After all, the prevalence of injury far exceeds common medical conditions, and unlike the two greatest health problems—mental disorders and substance use disorders—injuries are not preexisting conditions but rather preventable harms.

The article presents a few suggestions for injury prevention in prison. For example, services could be improved to identify those who are vulnerable, and to provide interventions such as conflict resolution training for those prone to violence and accident prevention for those who participate in work or recreational programs.

Sung contends that a proactive approach is warranted because injuries sustained during incarceration have adverse physical, emotional and social effects consequences that will also present challenges when the inmate returns to the community.
Chronic Medical Conditions in Texas Prisons

How prevalent is chronic noninfectious disease in the Texas prison population? In a study by researchers from the University of Texas Medical Branch and Texas Department of Criminal Justice, nearly 25% of the inmates had at least one of six major diseases, and of these many had more than one. Using a systemwide electronic medical records system, the researchers examined data for all 234,031 inmates incarcerated from September 2006 through August 2007.

Crude prevalence estimates were as follows: hypertension, 18.8%; asthma, 5.4%; diabetes, 4.2%; ischemic heart disease, 1.7%; chronic obstructive pulmonary disease, 0.96%; and cerebrovascular disease, 0.23%. Except for asthma, prevalence increased consistently with age. Of inmates 55 or older, 64.6% had at least one condition. Although these rates do “not appear to exceed age-standardized estimates from the U.S. general population,” the authors note, these health conditions are likely to present a burden on correctional and community health care systems as prison populations increase and age. The study appeared in the May issue of the Journal of Urban Health.


Resources
• Prevention and Control of Tuberculosis in Correctional and Detention Facilities—Slide Set — This resource was developed to accompany the guidelines by the same name already issued by the Centers for Disease Control and Prevention. A self-study module is also available. www.cdc.gov/tb
• Substance Abuse Treatment: Addressing the Specific Needs of Women — Part of the Substance Abuse and Mental Health Services Administration’s Treatment Improvement Protocol series, TIP 51 is based on women’s experiences, best or promising practices and research-based approaches. It presents effective treatment approaches that consider social and economic environments; relationships with family members, significant others and support systems; and the impact of gender and culture on treatment. http://kap.samhsa.gov/products/manuals/tips

Jail Population Declines!

Here’s a first: The U.S. jail population has fallen for the first time since the Bureau of Justice Statistics began its annual survey of jails in 1982. During the 12-month period ending June 30, 2009, the local jail population fell by 2.3% (17,936 inmates). Large jails accounted for most of the declines: Of the 171 jail jurisdictions with 1,000 or more inmates on an average day, two-thirds reported a decline. In seven jurisdictions, the decrease exceeded 500 inmates (accounting for 29% of the total decline). At the same time, the total rated capacity for all jails reached 849,544 beds at midyear 2009, up 2.6% from 828,413 the previous year. The percent of capacity occupied (90.4%) was the lowest since 2001. http://bjs.ojp.usdoj.gov/content/pub/pdf/jim09st.pdf

Public Health Takes a Hit

Just when we need them most ... Recent studies indicate that about 15% of the local public health work force has disappeared in the last two years. The National Association of County and City Health Officials reports that budget cuts led local health departments to cut 7,000 jobs in 2008 and 16,000 in 2009. At the state level, nearly $392 million has been cut from public health programs, according to a report from Trust for America’s Health and the Robert Wood Johnson Foundation. Furthermore, federal spending for public health has been flat for nearly five years. http://healthyamericans.org/newsroom/news/?newsid=2045
NCCHC Accreditation

Recognition From the Most Respected Name in Correctional Health Care

For 30 years, NCCHC has worked with administrators across the country to ensure that health care provided in their facilities is effective, efficient, and meets constitutional requirements. Our success — and the success of facilities accredited by NCCHC — is unsurpassed.

Leading the Way in Every Way

- NCCHC’s standards are widely recognized by the medical profession and the courts
- NCCHC’s standards are the benchmark for measuring a facility’s health services system
- NCCHC is unmatched in our correctional health care expertise
- NCCHC’s independence assures an unbiased evaluation of your compliance with standards
- NCCHC accreditation gives greater public confidence and professional satisfaction in the work you do

No other accreditation comes close to receiving the professional acceptance and recognition that goes with NCCHC health services accreditation. Isn’t it time you became NCCHC accredited?

For more information on NCCHC accreditation, contact us at:
(773) 880-1460 • accreditation@ncchc.org • www.ncchc.org
Residential facilities for youth in custody offer an array of services. But are they the right services? And do they meet the needs of the youth who wind up in those facilities? To determine that, it is necessary to first know what the needs are. The Office of Juvenile Justice and Delinquency Prevention conducted a survey to (a) identify youth needs and (b) assess whether those needs are being met. The first of its kind, the national Survey of Youth in Residential Placement used anonymous self-reports from 7,073 youth to gather information on their needs and the services they receive, with a focus on mental health, substance abuse, health care and education. The OJJDP report builds on the survey data to examine the issues and identify areas where services can be improved. The aim is to help juvenile residential facilities to strengthen policies and practices.

This column touches on key services that were found to be inadequate, according to the OJJDP report.

**Mental Health Services**

Substantial percentages of the youths surveyed reported mental and emotional problems as well as traumatic experiences. On the high end were reports of trauma (experiencing “something very bad or terrifying,” 70%; seeing someone severely injured or killed, 67%), as well as anger (being easily upset, 68%; losing their temper easily and feeling angry a lot, 61% each). Roughly half often felt lonely (52%), experienced anxiety (51%) and had trouble paying attention (45%). Each of five suicide-related concerns was noted among about one in five youth, and 22% said they had attempted suicide.

So the need for mental health services is high. On a positive note, nearly all (97%) of the survey respondents live in a facility that offers some services. Still, these services fall short in important areas. Only 47% said their facility provides mental health evaluations or appraisals for all residents. Screening for suicide risk is often lacking; many facilities fail to screen all youth within 24 hours of intake (45% of respondents), and some fail to screen any within that time period (26%).

**Substance Abuse**

Study respondents were found to use drugs and alcohol at higher rates than their counterparts in the community. In fact, 85% reported illegal drug use and 74% had used alcohol. Furthermore, 59% were drunk or high several times a week in the months before being taken into custody, and 68% reported problems related to this use.

Despite these high rates, some facilities do not screen any youth for substance use problems (19% of respondents), and others screen some but not all (36%). The types of substance abuse screening, treatment and counseling varied widely and frequently did not meet the standards deemed appropriate by OJJDP.

**Find the Details**

The OJJDP report delves into each of these areas, as well as gender differences, experiences of abuse, educational needs and services, study methodology and more. It is available online at www.ncjrs.gov/pdffiles1/ojjdp/227728.pdf.

We welcome your comments on this column or other juvenile correctional health topics. Please write to us at editor@ncchc.org or CorrectCare, c/o NCCHC, 1145 W. Diversey Pkwy, Chicago, IL 60614.

---

**Health Care**

Needs for some type of health care were common, reported by 69% of the youth. These ranged from dental, vision or hearing care (37%) to care for illness (28%), for injury (25%) and for other needs (29%).

The study report concludes that the unmet health care needs of youth in custody are “significant,” with unaddressed needs related to dental health, vision and hearing being most common, reported by 32% of those with these needs.

---

*www.ncchc.org*  
*Spring 2010 • CorrectCare*
Committee and board meetings, agendas, reports and exams—what really goes on behind those closed doors at the CCHP board of trustee meetings that are held twice a year? Well, I’m here to summarize those long, four-hour meetings for you (hopefully keep you awake) and update you on the status of your CCHP program and board activities.

Let’s start with why we do this. Certification recognizes excellence and high standards. It elevates the professional level of accomplishments in a way that speaks to pride, commitment and personal satisfaction in our chosen field of corrections. Do you still find startled looks on people’s faces when you tell them you work in a jail or a prison, or at least curiosity? The field of correctional health care is still relatively new in shaping its professional image and persona. The CCHP program adds a foundation and structure to our emerging image and values.

The program’s success can be measured in part by its continuous growth. Despite the economic downturn, interest remains high and membership now exceeds 2,300. In 2009, the number of exams administered increased 50% vs. the previous year. That tells us that being CCHP certified is meaningful. Agencies and corporations are encouraging certification for their staff with tangible incentives such as bonuses, pay increases and exam remuneration.

Specialty Certification and More

The program is growing in other ways, as well. The CCHP and CCHP-Advanced certification are now joined by specialty certification for registered nurses. The CCHP-RN was launched late last year and the first group of candidates—15 nurses—took the exam at the Updates conference in April. We look forward to the official announcement of our first group of CCHP-RNs.

Establishing the CCHP-RN was a tremendous effort, involving a task force of correctional nurse experts who generously donated hours of expertise and hard work to produce this exclusive and comprehensive product. We also were fortunate to receive sponsorship that enabled us to contract for formal analysis and validation.

Now, a specialty exam for physicians is being developed by a correctional physician task force, and certification will follow in 2011. The physician task force is well on its way to finalizing and piloting the exam. The process is similar to that for the CCHP-RN exam and thus we are now seeking sponsorship to contract technical assistance.

Outreach and collaboration are important to the CCHP program. The board of trustees also coordinates with universities and professional organizations to further professional development. It supports corrections in becoming a part of mainstream education.

Volunteers Make It Happen!

One of the major components of the semiannual meetings is to set aside a block of time to review exam questions and comments. Prior to the meetings, board members review content outlines and any problematic issues, and they develop and revise exam questions. The broad, comprehensive testing tools that result are borne of an efficient process that constantly reviews and evaluates, strengthened by engaging discussions to ensure the best decisions.

All of these accomplishments are made possible by the highly skilled members of the CCHP board of trustees. The board and its various subcommittees and task forces work untringly behind the scenes and their commitment and leadership are not readily visible. I applaud all of them for this service. Did you know that our past chair, Dr. Edwin Megargee, by invitation still attends all CCHP board meetings? We are grateful to him for his valuable contributions and input to ensure that exam questions are reliable and valid.

(Much credit and acknowledgment also goes to Paula Hancock and Matissa Sammons, NCCHC staff members who work throughout the year to coordinate the program’s goals and initiatives.)

In closing, the CCHP board enthusiastically continues its efforts to respond to your needs and ideas in shaping and enhancing our correctional health profession. If you think you’d like to be part of this team, I encourage you to consider serving on the board. Find information, as well as a list of board members and program news, at the CCHP website and future issues of CorrectCare.

Sincerely,
Jayne R. Russell, MEd, CCHP-A
Chair, CCHP Board of Trustees
This department features news and information from NCCHC’s supporting organizations and other partners that share our goal of promoting quality health care in correctional institutions. If your organization has news to share, please contact editor@ncchc.org, 773-880-1460.

National Institute on Drug Abuse
A new treatment program for young adults addicted to opioid drugs was unveiled at the NIDA Blending Conference in April. Called “buprenorphine treatment for young adults,” the program is based on research by NIDA’s Clinical Trials Network and the Substance Abuse and Mental Health Services Administration. Findings showed that young adults given longer-term treatment with buprenorphine were less likely to use drugs and more likely to stay in treatment as compared to those who received short-term detoxification without follow-up medication. Buprenorphine helps relieve drug cravings. This meeting was the eighth in a series that brings together researchers and clinicians so that research findings can be immediately applied in clinical practice. NIDA is a component of the National Institutes of Health. Find more information online at www.nida.nih.gov/newsroom/2010/NR4-22.html.

Centers for Disease Control and Prevention
The CDC continues to make progress on its “program collaboration and service integration” initiative. PCSI is a major effort of the CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention that aims to improve collaboration between programs to enhance integrated service delivery at the point of service. The goal is to provide prevention services that are holistic, evidence-based, comprehensive and high quality to appropriate populations, including corrections, at every interaction with the health care system. This “syndemic” approach uses an integrated response to combat overlapping epidemics among at-risk populations. On May 10, the agency hosted a live webcast with presentations from HIV/AIDS, viral hepatitis, STD and TB leaders at the national, state and local levels. The presentations and more information are available at www.cdc.gov/nchhstp/programintegration.

Bureau of Justice Statistics
The BJS website has been always been a valuable resource, and the newly redesigned site is better than ever. It now features enhanced search capabilities, prominent placement of new products and announcements on the homepage, RSS feeds and more. Check it out at http://bjs.ojp.usdoj.gov.

National Association of Social Workers
At its Social Work Congress in April, NASW convened a meeting of 400 social work leaders to explore challenges facing their profession. Ultimately, the participants, who ranged in age from 22 to 85, adopted 10 imperatives to shape the future of the 112-year-old profession. Key themes are leadership development, management skills and educational support. Their recommendations will be published in a report this summer. Learn more: www.socialworkers.org/pressroom/2010/050510Congress.asp.

In addition, NASW is marking the 50th anniversary of the Academy of Certified Social Workers. According to NASW, this anniversary is noteworthy because it recognizes past and present social workers who have made significant contributions to humanity. Learn more: www.socialworkers.org/credentials/acsw50.
Looking to turbocharge your business? Then point your GPS to Las Vegas. As the premier educational event in this field, NCCHC’s National Conference attracts nearly 2,000 correctional health professionals who are ready to rev up their performance. The exhibit hall is a hot spot for your company to connect with these highly motivated individuals. Over three days of exhibit hall activities, these decision makers and influencers will come to map out new ideas and proven solutions for managing the complex operational and clinical demands of health care delivery to inmates. Your company’s presence will make an impact, both on site and in this market as a whole.

**Exhibitor Opportunity**

**National Conference on Correctional Health Care**

**Rio Hotel Las Vegas • October 9-13, 2010**

**Big Numbers, Big Opportunity**

With 2.3 million individuals incarcerated in the United States, serving their wide-ranging health care needs has become a big business. In fact, the nation’s correctional facilities spend roughly $7 billion each year to provide this government-mandated care. Just as in the community, services span the spectrum, from acute care to chronic disease management to routine care, including dental and mental health, along with substance abuse treatment, prevention and health education. That’s a big challenge—and a big opportunity for companies that serve this market.

**Build Relationships With the Industry’s Best**

Our multidisciplinary audience is a microcosm of the health care field at large. They are the leaders—and emerging leaders—in this field. Connecting with these influential professionals extends your reach to the departments, facilities and staff they work with every day.

**Did You Know?**

- Exhibitions are the #1 source for attendees who make purchasing decisions.
- Exhibition leads cost 56% less to close than field sales calls.
- Exhibitions allow you to reach an average of 88% of unknown prospects.

*Source: The Center for Exhibition Industry Research (CEIR)*

**Exhibitor Benefits**

- 2 full conference registrations per 10’ x 10’ booth
- Discounted full registration for up to 5 additional personnel
- 75-word listing in the Final Program (deadline applies)
- Electronic attendee lists for pre- and post-show marketing
- Free basic listing in NCCHC’s online Buyers Guide
- Discounted advertising in meeting programs & CorrectCare
- Lead retrieval technology available for rental on site
- Opportunity to participate in raffle drawings
- Priority booth selection for the 2011 Updates conference

**Sponsorship Opportunities**

Enhance your presence and maximize marketing dollars through these outstanding opportunities.

- Premier programming: Educational sessions and breakfast/luncheon programs give attendees a fresh experience while giving your company exclusive exposure.
- Final proceedings: With your company’s name on the cover, the CD-ROM enables attendees to continue their learning with these PowerPoint presentations.
- Exhibit Hall reception/luncheon/breaks: Attendees will appreciate your contribution as they gather in this high-energy center to mingle and network throughout the day.
- Smaller opportunities with big impact: Promote your company name while enhancing the attendee experience by sponsoring the conference bags, lanyards, water bottles, badges, banners and more.
- Customize your contribution. NCCHC will work with you to develop a personalized package tailored to your needs and your budget.

**Registration Information**

The National Conference is the premier event where you can meet with important contacts and raise your profile in this specialty field, so reserve your space now. Standard booth sizes are 10’ x 10’; double-size and premium spaces are available. For details and a reservation form, please see the Exhibitor Prospectus, available online at www.ncchc.org, or contact Kim Simoni, exhibits and sales manager, at conference@ncchc.org or 773-880-1460.
**EMPLOYMENT**

Come Join Our Winning Correctional Health Team at CFG Health Systems

CFG Health Systems, LLC (sister corp. of Center for Family Guidance, PC) is a physician-owned and operated healthcare organization providing comprehensive mental health and medical services to thousands of inmates across the region. With its comprehensive experience in psychiatry, medicine, nursing, psychology and dentistry, CFG is a full service provider of care dedicated to meeting the needs of its patients. We offer many diverse career opportunities with excellent benefits and are currently looking to place professionals within several correctional facilities in the Mid-Atlantic Region:
- Medical Directors/Physicians
- Psychiatric Nurse Practitioners
- Dentists (General Dentistry)
- Medical Nurse Practitioners
- DONs/RNs/LPNs
- Administrators

Please contact: Frank Zura, MA, Ed
Phone: 856 797-4760, fzura@cfgpc.com
www.cfghealthsystems.com
Nancy Delapo, Director
Phone 856 797-4761, ndelapo@cfgpc.com
www.in-sight.net

**MARKETPLACE**

To order publications, or to obtain an NCCHC catalog, please visit www.ncchc.org or call 773-880-1460.

**Standards Reference Sets**

Our best-selling publications at substantial savings! Besides NCCHC Standards, these packages contain Correctional Health Care: Guidelines for the Management of an Adequate Delivery System, an essential reference for every facility.

- NCCHC Reference Set—Save 25%
  This package contains Standards for Health Services manuals for jails, prisons and juvenile detention and confinement facilities, plus the Standards for Mental Health Services in Correctional Facilities and the Correctional Health Care Guidelines. A $314.75 value, the discounted set is only $236.10.

- CCHP Study Package—Save 30%
  This package contains Standards for Health Services manuals for jails OR prisons (choose one) and for juvenile detention and confinement facilities, plus the Correctional Health Care Guidelines. A $174.85 value, the discounted set is only $122.40.

**Special Savings**

10% discounts are offered for Academy members (single copies) and bulk purchases of a single title. (Excludes already-discounted items.)

**Handbook of Correctional Mental Health**

This expanded second edition is the most practical, up-to-date and comprehensive resource, an essential tool given changing patient demographics and evolving treatment modalities. In 20 chapters, national experts address the most pressing issues facing clinicians, presenting the current standard of care through all phases of the criminal justice system. Topics include unique populations; legal requirements and minimizing risk; malingering; administrative aspects such as documentation, quality assurance and consent decrees; and five new chapters on clinical assessment and treatment. Useful tables and summary points appear throughout. Edited by Charles Scott, MD. American Psychiatric Association (2010). Soft cover, 646 pages, $77

**New! Manual of Forms and Guidelines for Correctional Mental Health**

This compendium of forms, guidelines and procedures focuses on practical applications and useful tools. Topics include principles of record keeping and informed consent, checklists for suicide prevention, screening tools for mental illness, cross-discipline communication, treatment planning, medication management, quality improvement, advances such as touch-screen computing, plus modifiable tools. Sample forms are written "incorrectly" and "correctly" to illustrate concepts. A CD-ROM has interactive versions of the forms. Edited by Amanda Ruiz, MD, CCHP, Joel Dvoskin, PhD, Charles Scott, MD, and Jeffrey Metzner, MD. CCHP-A. American Psychiatric Association (2010). Softcover, 256 pages, $115

**New! Handbook of Violence Risk Assessment and Treatment: New Approaches for Mental Health Professionals**

Practitioners will gain the knowledge and insight needed to assess, treat and manage offenders’ violence risk. This authoritative guide shows how to apply clinical and research data in practice, including thorough reports, oral testimony and treatment. The author uses numerous clinical case studies to present a well-formulated, comprehensive risk management plan, explaining the process and tools for implementation and how to translate information into an assessment and guide for management of both adult and youth violence. By Joel Andrade, MSW, LICSW. Springer Publishing Co. (2009). Hardcover, 680 pages, $85

**About CorrectCare™**

CorrectCare is the quarterly magazine of the National Commission on Correctional Health Care. Its mission is to publish news, articles and commentary of relevance to professionals in the field of correctional health care.

**Subscriptions**: CorrectCare is mailed free of charge to members of the Academy of Correctional Health Professionals, key personnel at accredited facilities and other recipients at our discretion. To see if you qualify for a subscription, submit a request online at www.ncchc.org or by e-mail to info@ncchc.org. The magazine is also posted at www.ncchc.org.

**Change of Address**: Send notification four weeks in advance, including both old and new addresses and, if possible, the mailing label from the most recent issue. See page 1 for contact information.

**Editorial Submissions**: Submitted articles may be published at our discretion. Manuscripts must be original and unpublished elsewhere. For guidelines, contact Jaime Shimkus at editor@ncchc.org or 773-880-1460. We also invite letters or correction of facts, which will be printed as space allows.

**ADVERTISER INDEX**

- CCHP-RN Certification ......................................................... 19
- Correctional Health Partners .................................................. 15
- Dentrust Dental ................................................................. 21
- GEO Group ............................................................................. 9
- Gilead Sciences – Truvada ....................................................... 5-6
- Hibiclens ................................................................................. 14
- InFocus Marketing ............................................................... 26
- Medi-Dose .............................................................................. 11
- MHM Services ................................................................. BC
- National Conference on Correctional Health Care .IFC
- NCCHC Accreditation ......................................................... 22
- Prison Health Services (PHS) .................................................. 23
- Spectra Diagnostics ............................................................ IBC
- Standards for Health Services ............................................... 7
- Wexford Health Sources ....................................................... 25
Expert Advice on NCCHC Standards

by Jennifer E. Kistler, MPH, and Scott Chavez, PhD, MPA, CCHP-A

Infirmary Care Rounds

Q I would like some interpretation and clarification for the standard on infirmary care, and specifically how often the physician must actually see the patients in the jail infirmary. The standard states that the frequency of physician rounds is based on the categories of care provided, but are there some guidelines we could draw from? For instance, should each patient be seen by the physician daily, a minimum of three times per week, etc.?

A We do leave it to the responsible physician to determine the frequency of rounding. It depends on the acuity of the cases that are admitted. It doesn’t make sense to require daily rounding by the physician when the patient with a postsurgical gunshot wound is in the infirmary for dressing changes. Nor would it make sense to require daily rounds when the physician provides only 20 hours a week in the jail. So the answer is that the “frequency of physician rounds is specified based on the categories of care provided.” Some facilities use midlevel providers, such as a nurse practitioner or physician assistant, to conduct daily rounds, with the physician rounding three times a week or even once a week. This approach would be fine.

Transgender Health Care

Q Our facility occasionally receives an inmate who is at some stage of gender reassignment. We would like to develop policies and procedures for managing their medical needs related to this process. Do the NCCHC standards offer any guidance?

A Implicit guidance is found in three standards: Medical Autonomy (J-A-03, P-A-03), Patients With Special Health Needs (J-G-02, P-G-02) and Continuity of Care During Incarceration (J-E-12, P-E-12). However, you may find it helpful to consult NCCHC’s recent position statement on Transgender Health Care in Correctional Settings. Below are relevant excerpts from two recommendations in the Health Management section.

• The management of medical (e.g., medically necessary hormone treatment) and surgical (e.g., genital reconstruction) transgender issues should follow accepted standards developed by professionals with expertise in transgender health. Determination of treatment necessary for transgender patients should be on a case-by-case basis. Ideally, correctional health staff should be trained in transgender health care issues. Alternatively, they should have access to other professionals with expertise in transgender health care to help determine appropriate management and provide training in transgender issues.
• Diagnosed transgender patients who received hormone therapy prior to incarceration should have that therapy continued without interruption pending evaluation by a specialist, absent urgent medical reasons to the contrary. Transgender inmates who have not received hormone therapy prior to incarceration should be evaluated by a health care provider qualified in the area of transgender health to determine their treatment needs. When determined to be medically necessary…hormone therapy should be initiated and sex reassignment surgery considered on a case-by-case basis. Regular laboratory monitoring should be conducted according to community medical standards.

For the complete statement, see the Resources section at www.ncchc.org.

Accreditation After Provider Change

Q Our jail is accredited by NCCHC. We have been using a contract management company, but now services will be provided by our local health department. Will this affect our accreditation?

A Remember that health services accreditation is granted to the facility, not to the provider, regardless of the delivery model. However, such changes can have an impact on care, so NCCHC requires that the correctional authority notify us in writing of any substantive change in management of the health care program within 30 days.

The next steps depend on the particulars of your situation (such as date of the last survey, any anticipated problems). The accreditation committee may request a written report on the transition, provide consultation or require a new survey. It also may postpone the next scheduled survey by up to six months to give the new provider time to make the transition.

The current health services provider is accountable for what is happening under its authority. When the survey does occur, we will focus primarily on information dating from the time of the transition. However, if corrective action to comply with the standards was required under the previous provider, we will look for confirmation that action has been taken and has rectified the problem. As to other issues that might arise, we deal with them on a case-by-case basis.

Jennifer E. Kistler, MPH, is NCCHC’s director of accreditation. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president and liaison to the policy and standards committee. If you have a question about the NCCHC standards, please write to info@ncchc.org or call 773-880-1460.

For an archive of past Standards Q&A columns, visit the Resources section at www.ncchc.org.
At Spectra Diagnostics, we realize you deserve more than just test results from your clinical laboratory partner. That's why we provide the focused, personalized support and flexibility you need to get the job done.

Count on Spectra Diagnostics for:
• Customer Liaison assigned to each facility for personalized, single-source support
• Reliable results and rapid turnaround times
• STAT testing services
• Extensive courier network
• Customized requisitions
• Access to results and reports via custom interfaces
• Comprehensive training tools

For more information, email us at spectra.diagnostics@fmc-na.com or call 888-726-9105
LAST YEAR, I HELPED OUR CLIENTS SAVE $15+ MILLION IN DRUG COSTS.

“My team and I monitor medication usage trends and track best practices to give our clinicians better medication choices. We not only find ways to lower costs, we give savings back to you.”

Gregg Puffenberger, PharmD, MBA
MHM Director of Pharmacy Management

MHM is the leading national provider of correctional mental health. We provide value-added pharmacy management services to all of our clients to contain costs and improve outcomes.

Delivering correctional healthcare the right way costs less. Find out how by contacting Dr. Puffenberger at 800.416.3649 or gpuffenberger@mhm-services.com

MHM Correctional Services, Inc
The Public-Private Partner for Healthcare

www.mhm-services.com