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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.
NCCHC and AAHIVM Partner on Corrections Issue of HIV Specialist

The American Academy of HIV Medicine recognizes the importance of continuity of care for individuals released from incarceration to the community—both for the health of the patient and to reduce risk to the community. But while AAHIVM’s members may encounter these patients in their community practices, they are not, on the whole, familiar with the unique corrections practice setting nor the complex issues surrounding HIV in correctional populations.

To enlighten these HIV care clinicians, NCCHC developed a special section for the Academy’s HIV Specialist magazine. We recruited six authors with a wealth of experience and strong expertise in the nuances of HIV care in corrections. The introduction by Anne Spaulding, MD, MPH, CCHP-P, FIDSA, shares her personal journey into this field. The remaining articles touch on weighty topics such as HIV/HCV coinfection (by Neil Fisher, MD, CCHP), HIV and mental health (by Glenn Treisman, MD, PhD), reentry and continuity of care (by Barry Zack, MPH, and Katie Kramer, MPH, MSW) and the challenges and rewards of providing HIV care to inmates in low-income countries (John May, MD, AAHIVS, CCHP, and Spaulding).

The special section appeared in the March 2017 issue and is available for free download at https://aahivm.org/hiv-specialist-magazine.

Board of Directors Reaffirms Two Position Statements

NCCHC develops position statements to express its expert opinion on matters of concern and to assist correctional facilities in designing policies and procedures. The policy and standards committee reviews these statements at least every five years. At its April meeting the board of directors reaffirmed two statements. Find all statements online at www.ncchc.org/position-statements.

**Competency for Execution**

NCCHC’s standards require that the determination of whether an inmate is competent for execution should be made by an independent expert and not by any health care professional who works in the correctional institution holding the inmate. Correctional health personnel remain responsible to treat any mental illness of death row inmates. First adopted in 1988, this statement was reaffirmed without revision in 2017.

**Correctional Health Professionals’ Response to Inmate Abuse**

Should correctional health staff witness or become aware of an inmate being subjected to harm (as defined in the statement), it is their duty to report this to the appropriate authorities to protect patients and other inmates. The statement outlines nine principles to guide correctional health professionals in averting and reporting the mistreatment of inmates. First adopted in 2007, this statement was revised to update the references.

Calendar of events

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<tr>
<td>July 28-29</td>
<td>Correctional Health Care Leadership Institutes, Las Vegas</td>
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<td>July 29</td>
<td>CCHP exams, Las Vegas</td>
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<td>July 30-31</td>
<td>Correctional Mental Health Care Conference, Las Vegas</td>
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<td>August 26</td>
<td>CCHP exams, regional sites</td>
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<td>September 13</td>
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<td>November 4-8</td>
<td>National Conference on Correctional Health Care, Chicago</td>
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<tr>
<td>November 5</td>
<td>CCHP exams, Chicago</td>
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<tr>
<td>April 21-24</td>
<td>Spring Conference on Correctional Health Care, Minneapolis</td>
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Now Available Online!

**2016 NCCHC Annual Report – In Video!**

2016 was a year of milestones for NCCHC, including the 25th anniversary of the CCHP program and the 40th National Conference. Our first-ever video annual report celebrates these milestones, features comments from key players in correctional health care and highlights the year’s accomplishments. View the report at www.youtube.com/user/NCCHC.

**Recorded Webinar on Transgender Youth**

This free, one-hour webinar explores the concepts of gender identity, sexual orientation, gender presentation and sexual behavior, examining each concept individually and describing how they combine to define a person’s overall sexual identity. Presented by John Steever, MD, it emphasizes increasing one’s “cultural competency” with regard to the health care and mental health needs of gender nonconforming youth. It also includes a short introduction to the medication and management of gender transitioning.

The audio recording and PowerPoint are available at the NCCHC University website: www.ncchc.org/NCCHC-University. Watch your email for future webinars.
On the Value of Change

by Eileen Couture, DO, RN, CCHP-P

Spring is in the air. Each spring as the trees begin to bud and the perennials begin to protrude their green little sprouts from the hard ground, it is amazing how the season changes right before our eyes. Despite the fluctuations in temperature, nature makes its way to a full bloom.

Spring is my “restart time” to evaluate aspects that I may need to change in my personal or professional life. Change can be defined as the act of becoming different. Change is often an uncomfortable thought, but often necessary. It is all around us, and it occurs in our everyday lives. When we are asked to change, we may respond with resistance, especially if the change alters or interferes with our comfort zone.

In one of my roles as the medical director of an addiction program, many of the clients are referred from the court or local jails as an alternative to serving time. Sometimes this may be their second or third time at the center. One of my standing questions during the intake health exam is, “How were you referred?” Although my interest is to determine whether they have any outstanding medical issues from recent hospitalization, the answer frequently is, “It was a better choice to come here than to jail.”

However, a couple of questions often remain: Are they aware of the behavior change they need to make, and is there a desire to change, especially if they have no conscious intention of stopping their behavior? Although the benefits are apparent, the choice to come to the treatment center is a better option than incarceration.

Difficult but Necessary

I recently recommended sending out one of our clients because she was short of breath. Although she denied having difficulty breathing, her exam revealed findings consistent with congestive heart failure. Reluctantly, she went to the hospital for treatment. One week later she returned and her first comment to me was, “You changed my life.” She felt much better physically and offered the conscious decision that her use of alcohol had to change.

As health care providers, we understand that change is very difficult and we witness the difficulty firsthand, especially in correctional health care. Whether the change be in the system, policy or everyday practice, it is often necessary.

Correctional care has evolved significantly over the past four decades, and it has progressed because there were champions who worked to improve the practice to what it has become today. The impact we all have is so important: Whether it is a small change or a significant change, we touch many lives.

Eileen Couture, DO, RN, CCHP-P, is chair of NCCHC’s board of directors and serves as the American College of Emergency Physicians’ liaison to the board. She is the medical director at the South Suburban Council on Alcoholism and Substance Abuse, Hazel Crest, IL, as well as an attending emergency physician at several Chicago-area hospitals.

Save the Date!

Beautiful, vibrant, expansive, welcoming, historic, musical, fun, down-to-earth, Chicago is truly one of the greatest cities in the world.

Having begun as a project of the American Medical Association in Chicago in the mid-'70s, NCCHC became a separate entity in 1983. We’ve been working to improve the quality of health care in the nation’s jails, prisons and juvenile confinement facilities from our Chicago offices ever since.

We are thrilled to invite you to gather with your correctional health colleagues from around the country here in Chicago, the big city with the hometown feel.
Policies and procedures are essential to outlining a facility's mission and providing clarity when dealing with correctional health care issues. An up-to-date, accurate manual is an important reference for new and established health staff alike.

A Manual That Follows NCCHC Standards

Standard A-05 in all five of NCCHC’s Standards manuals outlines the requirements for policies and procedures and requires that a manual or compilation address each applicable standard including all compliance indicators. Whether establishing a manual for the first time or updating a current manual, the first step is to determine which policies already exist, which policies exist but need revision and which policies need to be developed. We recommend that each policy be cross-referenced with the appropriate NCCHC standard(s), although the policies don’t need to be placed in the same order as the standards.

As policies are developed, there may be one policy that addresses multiple standards or several policies that address one standard. Facilities need not develop policies for standards that are not applicable (e.g., Infirmary Care when the facility does not have an infirmary). While most correctional health-related policies are developed by the responsible health authority (RHA), it is permissible to use policies promulgated by custody staff to complete or augment the health services policy and procedure manual. It is not necessary to write duplicate policies if the custody policy includes all components of a particular standard.

However, if policies on the same topic exist in both the custody and health care manuals, it is important that they do not conflict. Let’s continue using the emergency response plan as an example. If the emergency response plan for health staff is to set up a triage area in the hall between A Pod and B Pod but the custody policy indicates that triage will be conducted in a court holding area, then the plans are in conflict. Similarly, if the custody policy on restraints indicates that health staff monitor the restrained inmate every 15 minutes but the health services policy indicates monitoring every hour for these individuals, then the policies conflict. The RHA should ensure that other policies for custody, kitchen, industries or corporate do not conflict with health care policies.

Approval Process

As policies and procedures are developed, an approval process is required. Each policy and procedure in the health care manual should be reviewed at least annually and revised as necessary under the direction of the RHA. Documentation of this review can be done by inserting a signed and dated declaration at the beginning of the manual stating that the policies and procedures have been reviewed and approved. Or each policy can be signed individually. While it is important that key staff review and approve the policies and procedures, at a minimum, the signature of the facility’s RHA and responsible physician should be present to signify approval. Policies included in the manual that are not promulgated by health services should have authorizing dates and signatures but do not need signatures from the RHA and responsible physician.

Availability of the Manual

The standard intends to ensure that policies and procedures are written and accessible to staff. Having the only manual locked away in an administrator’s office is not useful and should be avoided. Manuals should be stored in a place that is readily accessible to health staff. Facilities may have one or more binders or have the policies available electronically on a shared drive.

Finally, the RHA should ensure that actual practice matches the newly developed or revised policies and procedures. Staff training may be a component of ensuring that practice matches the written word. When properly developed, the policy and procedure manual will be a useful tool to staff as they carry out the facility’s mission.

Tracey Titus, RN, CCHP-RN, is NCCHC’s vice president of accreditation. If you have a question about the standards, write to accreditation@ncchc.org. Find the complete Spotlight series online at www.ncchc.org/standards-explained.
Today's correctional environment demands a lot of its leaders. In a complex and changing world, learning is more essential than ever. At the Leadership Institutes, correctional physicians, other clinicians and administrators will gather to learn from one another and from expert speakers. Gain fresh perspectives, explore new ideas and learn effective strategies for taking a multidimensional approach to correctional health care.

This conference has been carefully planned to give you the tools and inspiration you need to leave feeling confident, energized and ready to put great new ideas to work. You will enjoy:

- Two days of educational sessions
- Plenary session
- Educational luncheon on Friday
- Roundtable breakfast discussions on Saturday
- Educational luncheon on Saturday
- Daily networking and exhibit breaks
- Downloadable presentation materials
- Up to 15 hours of continuing education credit

**Hotel Information**

All events take place at Bally’s Las Vegas, 3645 S. Las Vegas Blvd. The hotel is ideally situated in the center of the action on the Las Vegas Strip. Bally’s captures the feel of Old Vegas, but features upgraded room amenities. To book your room, visit https://aws.passkey.com/go/SBNCC7.

**Session Topics**

- Clinical Leadership in Corrections: What’s Your Style?
- Communicating With State-Level Elected Officials
- Correctional Health Care Accreditation: The Benefits to Your Program
- Correctional Staffing: Strategies to Improve Recruitment and Retention
- Cost-Effective Medical Management
- Gender Dysphoria: Comprehensive Approach to Treatment and Policy Management
- How to Stay Out of Trouble as the Medical Director
- In-Custody Medication-Assisted Treatment: Lessons Learned
- Leadership Lessons Learned From a 25-Year Career in Correctional Health Care
- Managing Successful Vendor–Client Relationships
- One Step at a Time: Effective Guide to CQI
- Physicians as Managers: Writing Effective Policies and Procedures
- Professional Liability Insurance Primer: The 10 Things You Need to Know
- Resiliency: An Essential Element of Effective Leadership
- Segregation: Creating Policies to Ensure Quality Care
- Six Sigma Principles in Correctional Medicine
- Sticking Together: A Cohesive Correctional Health Delivery System
- Supreme MDs: What to Do When Lawyers and Judges Practice Medicine
- What Would YOU Do? Navigating Medical Ethical Dilemmas
- Working Together: Health Services and Custody Fostering Better Relationships

**Conference Educational Objectives**

- Examine the role of correctional health care leaders including administrative roles, organizing health services and applying legal and ethical practices
- Employ process improvement systems such as quality improvement, utilization review and risk management
- Identify recruitment, retention and supervision best practices for effective staff management
- Describe strategies for integrating health care services and personnel into a correctional setting

Find complete information at www.ncchc.org/leadership-institutes.
Think of our quality management program as 24-hour surveillance on risks, costs and compliance.

In this business, there's no such thing as the “end of the day.” Wexford Health can help ease your workload with a Quality Management and Contract Compliance team that constantly focuses on ways to improve health care outcomes, increase efficiencies, and lower costs. So when you go home, you can feel good that we’re still hard at work for you. To learn more, visit wexfordhealth.com.
CORRECTIONAL MENTAL HEALTH CARE CONFERENCE
JULY 30-31, 2017 | BALLY’S LAS VEGAS

The Correctional Mental Health Care Conference is a unique opportunity for correctional health professionals to convene with peers and experts in the field, exchange ideas and discuss solutions. This conference has been designed for you, to help you find solutions to chronic and emerging issues. Meet others facing comparable challenges and learn how to improve patient outcomes.

The conference features two full days of focused mental health discussions, 30 educational sessions and special networking events to help you make lifelong connections.

"This conference reminds us that, while it is our responsibility as mental health professionals to do all we can to improve the quality of care being provided to our patients, it is equally our responsibility to engage our colleagues in the medical and custody fields to partner with us for change."

—Past Attendee

Session Topics

- Altered Mental Status: Sometimes a Cigar Is Not Just a Cigar
- Beyond Restrictive Housing: Alternatives to Segregation and Strategies to Manage High-Risk Inmates
- Bringing Effective Integration of Primary Care and Behavioral Health Into Corrections
- Correlations Between PTSD and Criminogenic Behaviors in Veterans
- Counteracting the Dangers of Desensitization
- Creating a Comprehensive Reentry Bridge: Tennessee’s Approach to Case Management
- Crisis Intervention: Planning and Implementing Effective Strategies
- Diagnosing and Treating the Aging Population
- Due Process Requirements for Involuntary Medication Hearings
- Effective Mental Health Training for Correctional Staff
- Ethical Considerations in Correctional Mental Health: Dual Loyalty and Daily Dilemmas
- How Did You Sleep: Harmful Patterns and Ways to Improve Sleep Hygiene
- Increasing Medication Compliance: A Collaboration Between Psychological and Psychiatric Providers
- An Innovative Approach to Treatment Plans and Clinical Outcomes in a Mental Health Correctional Setting
- Losing Time: Dementia/Alzheimer’s Disease Behind Bars
- Making a Bicultural Marriage: How a Correctional Facility and a University Research Team Learned to Live Together
- A New Approach to Working With Inmates Who Hear Voices
- Painting Murals as a Suicide Reduction Strategy
- Performance Measures for Quality Improvement Studies
- Practical Management of Bipolar and Personality Disorders
- Psychopathy: Providing Treatment and Managing Risk
- Restoration of Competency to Stand Trial and a Model for Jail-Based Restoration Treatment
- Roots of Violent Behavior: Incorporating Mental Health Perspectives With Problematic Individuals
- Schizophrenia: Treatment, Management and Reentry
- Serious Mental Illness and Segregation: Recommendations for a System That Works
- Stories From Within: Planning and Implementing Effective Mental Health in Jails and Prisons
- Transgender Care: A Comprehensive Approach to Treatment
- Understanding the Legal Implications of Malingering

Conference Educational Objectives

- 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
- Apply the NCCHC standards for mental health services to mental health programs in correctional facilities

CCHPs, nurses, physicians, psychologists and social workers can receive 15 hours of continuing education credit.

Hotel Information

All events take place at Bally’s Las Vegas, 3645 S. Las Vegas Blvd. The hotel is ideally situated in the center of the action on the Las Vegas Strip. Bally’s captures the feel of Old Vegas, but features upgraded room amenities. To book your room, visit https://aws.passkey.com/go/SBNCC7.

Find complete information at www.ncchc.org/mental-health-conference.
Her opioid dependence got her here.

VIVITROL® (naltrexone for extended-release injectable suspension) is a non-narcotic, non-addictive, once-monthly medication indicated for¹:

- Prevention of relapse to opioid dependence, following opioid detoxification.
- Treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting prior to the initiation of treatment with VIVITROL. Patients should not be actively drinking at the time of initial VIVITROL administration.
- VIVITROL should be part of a comprehensive management program that includes psychosocial support.

For additional Important Safety Information, please see Brief Summary of Prescribing Information on adjacent pages.
Now help her get on a path to treatment.

Learn more about a non-addictive, non-divertible treatment option.

Visit TreatWithVIVITROL.com to learn more about how VIVITROL and counseling can help.

Important Safety Information

Contraindications

VIVITROL is contraindicated in patients:

- Receiving opioid analgesics
- With current physiologic opioid dependence
- In acute opioid withdrawal
- Who have failed the naloxone challenge test or have a positive urine screen for opioids
- Who have exhibited hypersensitivity to naltrexone, polylactide-co-glycolide (PLG), carboxymethylcellulose, or any other components of the diluent

Prior to the initiation of VIVITROL, patients should be opioid-free for a minimum of 7-10 days to avoid precipitation of opioid withdrawal that may be severe enough to require hospitalization.

VIVITROL® (naltrexone for extended-release injectable suspension)

INTRAMUSCULAR


INDICATIONS AND USAGE: VIVITROL is indicated for the treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting prior to initiation of treatment with VIVITROL. Patients should not be actively drinking at the time of initial VIVITROL administration. In addition, VIVITROL is indicated for the prevention of relapse to opioid dependence, following opioid detoxification. VIVITROL should be part of a comprehensive management program that includes psychosocial support.

CONTRAINDICATIONS: VIVITROL is contraindicated in: patients receiving opioid agonist analgesics, patients with current physiologic opioid dependence, patients in acute opioid withdrawal, any individual who has failed the naltrexone challenge test or has a positive urine screen for opioids, and patients who have previously exhibited hypersensitivity to naltrexone, polyactide-co-glycolide (PLG), carboxymethylcellulose, or any other components of the diluent.

WARNINGS AND PRECAUTIONS: Vulnerability to Opioid Overdose: After opioid detoxification, patients are likely to have reduced tolerance to opioids. VIVITROL blocks the effects of exogenous opioids for approximately 28 days after administration. However, as the blockade wanes and eventually dissipates completely, patients who have been treated with VIVITROL may respond to lower doses of opioids than previously used, just as they would have shortly after completing detoxification. This could result in potentially life-threatening opioid intoxication (respiratory compromise or arrest, circulatory collapse, etc.) if the patient uses previously tolerated doses of opioids. Cases of opioid overdose with fatal outcomes have been reported in patients who used opioids at the end of a dosing interval, after missing a scheduled dose, or after discontinuing treatment. Patients should be alerted that they may be more sensitive to opioids, even at lower doses, after VIVITROL treatment is discontinued, especially at the end of a dosing interval (i.e., near the end of the month that VIVITROL was administered), or after a dose of VIVITROL is missed. It is important that patients inform family members and the people closest to the patient of this increased sensitivity to opioids and the risk of overdose. There is also the possibility that a patient who is treated with VIVITROL could overcome the opioid blockade effect of VIVITROL. Although VIVITROL is a potent antagonist with a prolonged pharmacological effect, the blockade produced by VIVITROL is surmountable. The plasma concentration of exogenous opioids attained immediately following their acute administration may be sufficient to overcome the competitive receptor blockade. This poses a potential risk to individuals who attempt, on their own, to overcome the blockade by administering large amounts of exogenous opioids. Any attempt by a patient to overcome the antagonism by taking opioids is especially dangerous and may lead to life-threatening opioid intoxication or fatal overdose. Patients should be told of the serious consequences of trying to overcome the opioid blockade.

Injection Site Reactions: VIVITROL injections may be followed by pain, tenderness, induration, swelling, erythema, bruising, or pruritus; however, in some cases injection site reactions may be very severe. In the clinical trials, one patient developed an area of induration that continued to enlarge after 4 weeks, with subsequent development of necrotic tissue that required surgical excision. In the post marketing period, additional cases of injection site reaction with features including induration, cellulitis, hematoma, abscess, sterile abscess, and necrosis, have been reported. Some cases required surgical intervention, including debridement of necrotic tissue. Some cases resulted in significant scarring. The reported cases occurred primarily in female patients. VIVITROL is administered as an intramuscular gluteal injection, and inadvertent subcutaneous injection of VIVITROL may increase the likelihood of severe injection site reactions. The needles provided in the carton are custom-sized needles. VIVITROL must not be injected using any other needle. The needle lengths (either 1 1/2 inches or 2 inches) may not be adequate in every patient because of body habitus. Body habitus should be assessed prior to each injection for each patient to assure that the appropriate needle is selected and that the needle length is adequate for intramuscular administration. Healthcare professionals should ensure that the VIVITROL injection is given correctly, and should consider alternate treatment for those patients whose body habitus precludes an intramuscular gluteal injection with one of the provided needles. Patients should be informed that any concerning injection site reactions should be brought to the attention of the healthcare professional. Patients exhibiting signs of abscess, cellulitis, necrosis, or extensive swelling should be evaluated by a physician to determine if referral to a surgeon is warranted.

Precipitation of Opioid Withdrawal: The symptoms of spontaneous opioid withdrawal (which are associated with the discontinuation of opioid in a dependent individual) are uncomfortable, but they are not generally believed to be severe or necessitate hospitalization. However, when withdrawal is precipitated abruptly by the administration of an opioid antagonist to an opioid-dependent patient, the resulting withdrawal syndrome can be severe enough to require hospitalization. Review of postmarketing cases of precipitated opioid withdrawal in association with naltrexone treatment has identified cases with symptoms of withdrawal severe enough to require hospital admission, and in some cases, management in the intensive care unit. To prevent occurrence of precipitated withdrawal in patients dependent on opioids, or exacerbation of a pre-existing subclinical withdrawal syndrome, opioid-dependent patients, including those being treated for alcohol dependence, should be opioid-free (including tramadol) before starting VIVITROL treatment. An opioid-free interval of a minimum of 7–10 days is recommended for patients previously dependent on short-acting opioids. Patients transitioning from buprenorphine or methadone may be vulnerable to precipitation of withdrawal symptoms for as long as two weeks. If a more rapid transition from agonist to antagonist therapy is deemed necessary and appropriate by the healthcare provider, monitor the patient closely in an appropriate medical setting where precipitated withdrawal can be managed. In every case, healthcare providers should always be prepared to manage withdrawal symptomatically with non-opioid medications because there is no completely reliable method for determining whether a patient has had an adequate opioid-free period. A naloxone challenge test may be helpful; however, a few case reports have indicated that patients may experience precipitated withdrawal despite having a negative urine toxicology screen or tolerating a naloxone challenge test (usually in the setting of transitioning from buprenorphine treatment). Patients should be made aware of the risks associated with precipitated withdrawal and encouraged to give an accurate account of last opioid use. Patients treated for alcohol dependence with VIVITROL should also be assessed for underlying opioid dependence and for any recent use of opioids prior to initiation of treatment with VIVITROL. Precipitated opioid withdrawal has been observed in alcohol-dependent patients in circumstances where the prescriber had been unaware of the additional use of opioids or co-dependence on opioids. Hepatotoxicity: Cases of hepatitis and clinically significant liver dysfunction were observed in association with VIVITROL exposure during the clinical development program and in the postmarketing period. Transient, asymptomatic hepatic transaminase elevations were also observed in the clinical trials and postmarketing period. Although patients with clinically significant liver disease were not systematically studied, clinical trials did include patients with asymptomatic viral hepatitis infections. When patients presented with elevated transaminases, there were often other potential causative or contributory etiologies identified, including pre-existing alcoholic liver disease, hepatitis B and/or C infection, and concomitant usage of other potentially hepatotoxic drugs. Although clinically significant liver dysfunction is not typically a manifestation of a patient airway and assisted ventilation. Irrespective of the drug chosen to reverse opioid blockade, the patient should be monitored closely by appropriately trained healthcare professionals specifically trained in the use of anesthetic drugs and the management of the surgical or diagnostic procedure. The opioid therapy must be provided by individuals closely in an appropriate medical setting where precipitated withdrawal can be managed. Opioid treatment has identified cases with symptoms of withdrawal severe enough to precipitate withdrawal symptomatically with non-opioid medications because there is no completely reliable method for determining whether a patient has had an adequate opioid-free period. A naloxone challenge test may be helpful; however, a few case reports have indicated that patients may experience precipitated withdrawal despite having a negative urine toxicology screen or tolerating a naloxone challenge test (usually in the setting of transitioning from buprenorphine treatment). Patients should be made aware of the risks associated with precipitated withdrawal and encouraged to give an accurate account of last opioid use. Patients treated for alcohol dependence with VIVITROL should also be assessed for underlying opioid dependence and for any recent use of opioids prior to initiation of treatment with VIVITROL. Precipitated opioid withdrawal has been observed in alcohol-dependent patients in circumstances where the prescriber had been unaware of the additional use of opioids or co-dependence on opioids. 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Although clinically significant liver dysfunction is not typically a manifestation of a precipitated withdrawal syndrome, opioid withdrawal that is precipitated abruptly may lead to systemic sequelae including acute liver injury. Patients should be warned of the risk of hepatic injury and advised to seek medical attention if they experience symptoms of acute hepatitis. Use of VIVITROL should be discontinued in the event of symptoms and/or signs of acute hepatitis. Depression and Suicidality: Alcohol- and opioid-dependent patients, including those taking VIVITROL should be monitored for the development of depression or suicidal thinking. Families and caregivers of patients being treated with VIVITROL should be alerted to the need to monitor patients for the emergence of symptoms of depression or suicidality, and to report such symptoms to the patient’s healthcare provider. Alcohol Dependence: In controlled clinical trials of VIVITROL administered to adults with alcohol dependence, adverse events of a suicidal nature (suicidal ideation, suicide attempts, completed suicides) were infrequent overall, but were more common in patients treated with VIVITROL than in patients treated with placebo (1% vs 0). In some cases, the suicidal thoughts or behavior occurred after study discontinuation, but were in the context of an episode of depression that began while the patient was on study drug. Two completed suicides occurred, both involving patients treated with VIVITROL. Depression-related events associated with premature discontinuation of study drug were also more common in patients treated with VIVITROL (~1%) than in placebo-treated patients (0). In the 24-week, placebo-controlled pivotal trial in 624 alcohol-dependent patients, adverse events involving depressed mood were reported by 10% of patients treated with VIVITROL 380 mg, as compared to 5% of patients treated with placebo. Opioid Dependence: In an open-label, long-term safety study conducted in the US, adverse events of a suicidal nature (depressed mood, suicidal ideation, suicide attempt) were reported by 5% of opioid-dependent patients treated...
VIVITROL® (naltrexone for extended-release injectable suspension) with VIVITROL 380 mg (n=101) and 10% of opioid-dependent patients treated with oral naltrexone (n=20). In the 24-week, placebo-controlled pivotal trial that was conducted in Russia in 250 opioid-dependent patients, adverse events involving depressed mood or suicidal thinking were not reported by any patient in either treatment group (VIVITROL 380 mg or placebo).

When Reversal of VIVITROL Blockade Is Required for Pain Management: In an emergency situation in patients receiving VIVITROL, suggestions for pain management include regional analgesia or use of non-opioid analgesics. If opioid therapy is required as part of anesthesia or analgesia, patients should be continuously monitored in an anesthesia care setting by persons not involved in the conduct of the surgical or diagnostic procedure. The opioid therapy must be provided by individuals specifically trained in the use of anesthetic drugs and the management of the respiratory effects of potent opioids, specifically the establishment and maintenance of a patent airway and assisted ventilation. Irrespective of the drug chosen to reverse VIVITROL blockade, the patient should be monitored closely by appropriately trained personnel in a setting equipped and staffed for cardiopulmonary resuscitation.

Eosinophilic Pneumonia: In clinical trials with VIVITROL, there was one diagnosed case and one suspected case of eosinophilic pneumonia. Both cases required hospitalization, and resolved after treatment with antibiotics and corticosteroids. Similar cases have been reported in postmarketing use. Should a person receiving VIVITROL develop progressive dyspnea and hypoxemia, the diagnosis of eosinophilic pneumonia should be considered. Patients should be warned of the risk of eosinophilic pneumonia, and advised to seek medical attention should they develop symptoms of pneumonia. Clinicians should consider the possibility of eosinophilic pneumonia in patients who do not respond to antibiotics.

Hypersensitivity Reactions Including Anaphylaxis: Cases of urticaria, angioedema, and anaphylaxis have been observed with use of VIVITROL in the clinical trial setting and in postmarketing use. Patients should be warned of the risk of hypersensitivity reactions, including anaphylaxis. In the event of a hypersensitivity reaction, patients should be advised to seek immediate medical attention in a healthcare setting prepared to treat anaphylaxis. The patient should not receive any further treatment with VIVITROL.

Intramuscular Injections: As with any intramuscular injection, VIVITROL should be administered with caution to patients with thrombocytopenia or any coagulation disorder (eg, hemophilia and severe hepatic failure).

Alcohol Withdrawal: Use of VIVITROL does not eliminate nor diminish alcohol withdrawal symptoms. Interference with Laboratory Tests: VIVITROL may be cross-reactive with certain immunoassay methods for the detection of drugs of abuse (specifically opioids) in urine. For further information, reference to the specific immunoassay instructions is recommended.

ADVERSE REACTIONS: Serious adverse reactions that may be associated with VIVITROL therapy in clinical use include: severe injection site reactions, eosinophilic pneumonia, serious allergic reactions, unintended precipitation of opioid withdrawal, accidental opioid overdose and depression and suicidality. The adverse events seen most frequently in association with VIVITROL therapy for alcohol dependence (ie, those occurring in ≥5% and at least twice as frequently with VIVITROL than placebo) include nausea, vomiting, injection site reactions (including induration, pruritus, nodules and swelling), muscle cramps, dizziness or syncope, somnolence or sedation, anorexia, decreased appetite or other appetite disorders. The adverse events seen most frequently in association with VIVITROL therapy in opioid dependent patients (ie, those occurring in ≥2% and at least twice as frequently with VIVITROL than placebo) were hepatic enzyme abnormalities, injection site pain, nasopharyngitis, insomnia, and toothache. Clinical Studies Experience: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. In all controlled and uncontrolled trials during the premarketing development of VIVITROL, more than 1100 patients with alcohol and/or opioid dependence have been treated with VIVITROL. Approximately 700 patients have been treated for 6 months or more, and more than 400 for 1 year or longer. Adverse Events Leading to Discontinuation of Treatment: Alcohol Dependence: In controlled trials of 6 months or less in alcohol-dependent patients, 9% of alcohol-dependent patients treated with VIVITROL discontinued treatment due to an adverse event, as compared to 7% of the alcohol-dependent patients treated with placebo. Adverse events in the VIVITROL 380-mg group that led to more dropouts than in the placebo-treated group were injection site reactions (3%), nausea (2%), pregnancy (1%), headache (1%), and suicide-related events (0.3%). In the placebo group, 1% of patients withdrew due to injection site reactions, and 0% of patients withdrew due to the other adverse events. Opioid Dependence: In a controlled trial of 6 months, 2% of opioid-dependent patients treated with VIVITROL discontinued treatment due to an adverse event, as compared to 2% of the opioid-dependent patients treated with placebo.

DRUG INTERACTIONS: Patients taking VIVITROL may not benefit from opioid-containing medicines. Naltrexone antagonizes the effects of opioid-containing medicines, such as cough and cold remedies, antiarrhythmic preparations and opioid analgesics.

USE IN SPECIFIC POPULATIONS: Pregnancy: There are no adequate and well-controlled studies of either naltrexone or VIVITROL in pregnant women. VIVITROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Pregnancy Category C: Reproduction and developmental studies have not been conducted for VIVITROL. Studies with naltrexone administered via the oral route have been conducted in pregnant rats and rabbits. Teratogenic Effects: Naltrexone has been shown to increase the incidence of early fetal loss when given to rats at doses ≥30 mg/kg/day (11 times the human exposure based on an AUC(0-28d) comparison) and to rabbits at oral doses ≥60 mg/kg/day (2 times the human exposure based on an AUC(0-28d) comparison). There was no evidence of teratogenicity when naltrexone was administered orally to rats and rabbits during the period of major organogenesis at doses up to 200 mg/kg/day (175- and 14-times the human exposure based on an AUC(0-28d) comparison, respectively). Labor and Delivery: The potential effect of VIVITROL on duration of labor and delivery in humans is unknown. Nursing Mothers: Transfer of naltrexone and 6-naltrexol into human milk has been reported with oral naltrexone. Because of the potential for tumorigenicity shown for naltrexone in animal studies, and because of the potential for serious adverse reactions in nursing infants from VIVITROL, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: The safety and efficacy of VIVITROL have not been established in the pediatric population. The pharmacokinetics of VIVITROL have not been evaluated in a pediatric population.

Geriatric Use: In trials of alcohol-dependent subjects, 2.6% (n=26) of subjects were ≥65 years of age, and one patient was >75 years of age. Clinical studies of VIVITROL did not include sufficient numbers of subjects age 65 and over to determine whether they respond differently from younger subjects. No subjects over age 65 were included in studies of opioid-dependent subjects. The pharmacokinetics of VIVITROL have not been evaluated in the geriatric population.

Renal Impairment: Pharmacokinetics of VIVITROL are not altered in subjects with mild renal insufficiency (creatinine clearance of 50-80 mL/min). Dose adjustment is not required in patients with mild renal impairment. VIVITROL pharmacokinetics have not been evaluated in subjects with moderate and severe renal insufficiency. Because naltrexone and its primary metabolite are excreted primarily in the urine, caution is recommended in administering VIVITROL to patients with moderate to severe renal impairment.

Hepatic Impairment: The pharmacokinetics of VIVITROL are not altered in subjects with mild to moderate hepatic impairment (Groups A and B of the Child-Pugh classification). Dose adjustment is not required in subjects with mild or moderate hepatic impairment. VIVITROL pharmacokinetics were not evaluated in subjects with severe hepatic impairment.

OVERDOSAGE: There is limited experience with overdose of VIVITROL. Single doses up to 784 mg were administered to 5 healthy subjects. There were no serious or severe adverse events. The most common effects were injection site reactions, nausea, abdominal pain, somnolence, and dizziness. There were no significant increases in hepatic enzymes. In the event of an overdose, appropriate supportive treatment should be initiated.

This brief summary is based on VIVITROL Full Prescribing Information.
Suicide continues to be one of the leading causes of death in our nation’s jails. Although the rate of suicide has substantially declined since the 1980s, it remains a sizable public health problem. In the quest to prevent suicides, various interventions sometimes spark controversy—either because of their unconventional nature, quick-fix philosophy or concern for liability. Offered below is a sampling of several controversial approaches found in the area of inmate suicide.

Suicide Precautions Are Often Overly Restrictive and Seemingly Punitive

In many ways, the conditions for inmates placed on suicide precautions are harsher than for those on segregation status. It is not uncommon for suicidal inmates to be locked down in their cell, clothed only in a safety smock. Yet confining suicidal inmates to their cell for up to 24 hours a day only enhances isolation and is anti-therapeutic. Limiting their clothing to only a safety smock is not always necessary. Under these conditions, it is also difficult, if not impossible, to accurately gauge the source of an inmate’s suicidal ideation. Take, for example, the scenario of a clinician interviewing an inmate on suicide precautions. The inmate has been locked down for a day or two, with no access to a shower, mattress, reading materials, telephone/visiting privileges or any out-of-cell activities. The clinician approaches the inmate cellside and asks, “Are you suicidal?” Given the circumstances, the likelihood of an inmate answering affirmatively is highly questionable, since the result will be continued placement under these conditions.

Recent research suggests that suicidal inmates are often reluctant to discuss their suicidal thoughts because of the likelihood of being exposed to the harsh conditions of suicide precautions, with the vast majority (75%) of inmates reporting that they did not want to be transferred to an observation cell. According to the authors:

“Possible reasons inmates dislike observation cells are numerous. For GP patients they can suffer taunting from other inmates with the identification of being in a mental health crisis after they return from the OB (observation). Further, an inmate-patient is removed from his more familiar surroundings of a single cell with his books, writing material, and own clothes, and his normal routine of recreation and work assignment. In the OB he often can no longer wear his clothes, and books and recreation are limited. In an OB cell a patient often is dressed in a special gown and the room may only contain a special mattress. Privacy is limited, since often all four sides of the OB are available for observation whereas in his own cell only one side is open for observation. Finally, admission in an OB can create anxiety and fear for the patient as it may be an unknown environment, and because the OB is the place the psy-
Chiatrists decide if patient is to be involuntarily transferred to the distant inpatient unit.” (Way et al., 2013)

These conclusions were illustrated in a 2016 investigative report in The Boston Globe: “At times, Nick contemplated death himself. But he learned to avoid being placed on suicide watch, which meant isolation in a dark and filthy cell, without pen or paper, soap or socks, he said. Sometimes his ‘brain felt sick,’ but he kept quiet: ‘If you say you’re hurting, they’ll punish you for it,’ he said.”

Several years ago I was investigating suicide prevention precautions in a county jail. Both the sheriff and medical director separately boasted that their jail had not had a suicide in several years because they housed their suicidal inmates in small booking cages. Inmates called them “squirrel cages.” To me, the cage closely resembled a telephone booth made of sturdy chain-link fencing, measuring approximately 3 by 3 feet in diameter and 7 feet in height.

It was not uncommon for an inmate to be placed in these cages for more than 24 hours. Several inmates who had been placed in these cages on suicide precautions were interviewed. Most confided that they were still experiencing suicidal ideation, but refused to report their ideation to staff for fear of being placed back in these cages. An extreme example? Yes, but, the point remains: If we treat suicidal inmates with punitive or overly restrictive measures, we run the risk of creating barriers to mental health services.

Many correctional and mental health professionals have told me that the conditions of suicide precautions were not intentionally punitive, but driven by concern for the safety of the inmate. The commitment to safety was not being challenged here. Safety of the inmate is, of course, of utmost concern when developing a suicide prevention policy. But the number and types of restrictions (e.g., overreliance on safety smocks, denying visitation and telephone privileges) imposed in the name of safety must be reasonable and commensurate with the inmate’s level of suicide risk.

Officials have often argued that the rationale for these restrictions was that suicidal inmates were unpredictable and bad news received during a family visit or telephone call might trigger suicidal ideation and result in an increased risk for suicide. This rationale, however, ignores the obvious—what better opportunity is there to observe an inmate’s reaction to potentially negative news than when he is on suicide precautions? Interaction with the outside world also can be therapeutic and reduce isolation, which is a leading cause of suicidal behavior.

I have occasionally been told that most inmates who were mentally ill and on suicide precautions were so debilitated by their illness that “they did not care” how they were treated (i.e., the withholding of basic privileges). This assumption was not only unsupported but ignored the real possibility that these measures were contributing to an inmate’s debilitating mental illness.

Of course, it is often argued that these highly restrictive measures are effective in managing or “weeding out” those inmates suspected of being manipulative or malingering. As should be discussed during suicide prevention training workshops, although distinguishable, manipulative behavior and suicidal behavior are not mutually exclusive. Both types of behavior could occur (or overlap) in the same individual and cause serious injury and death.

Self-harm is often a complex, multifaceted behavior, rather than simply manipulative behavior motivated by secondary gain. At a minimum, any inmate who would go to the extreme of threatening suicide or engaging in self-harming behavior is suffering from at least an emotional imbalance that requires special attention. He may also be seriously mentally ill. Simply stated, inmates labeled as manipulative still commit suicide.

**Contracting for Safety**

Invariably I come upon a correctional facility that has a “no-harm” contract embedded into its intake screening form. The contract might read, “I promise not to harm myself while confined at the Smith County Detention Center. If I should have any tendency to harm myself, I will immediately alert the staff.”

There are several problems associated with contracting for safety. First, most correctional systems do not have any written policies and procedures authorizing its use. In fact, the issue is not even addressed in NCCHC and national correctional standards. Most systems do not use no-harm contracts because they have been found to be ineffective in the management of suicidal individuals. While there may be some positive therapeutic aspects to contracting for safety, most clinicians agree that once a patient becomes suicidal, her written or verbal assurances are no longer sufficient to counter suicidal impulses.

In addition, most legal experts opine that a no-harm contract is simply a self-serving sheet of paper that does not provide an agency or mental health clinician with any legal protection. As succinctly stated by several clinicians:

“The contract for safety is an aspect of suicide risk management that has been given too much weight over the past several decades. What appears to have been created primarily as an assessment tool has become a sort of checkbox, detracting from the clinician’s own judgment and formulation of risk. It has been taken out of its original context and is now used in virtually any setting, with any type of patient population despite the lack of clinical evidence to prove it is useful and an abundance of literature warning that it is not.” (Garvey et al., 2009)

**Pulse Oximetry and Other Anti-Suicide Technology**

The correctional field has long been obsessed with trying to thwart suicide attempts and manage suicidal inmates with technology and short-sighted responses. Back in 1986, I received correspondence from a police officer who fancied himself as the inventor of a system of placing a series of sensory strips on the floor and bed of the jail cell. The system operated on the principle of “weight off,” in which an inmate confined to his cell, but not laying on his bunk or standing on the floor, would presumably be hanging from a ligature off the floor. With the weight off the floor,

continued on page 14
the sensory strips would trigger an alarm in the jail’s main control station. Although this inventor obtained a patent, his discovery literally never got off the ground, presumably because many inmates were found to commit suicide by hanging in the standing or sitting position on the floor.

More recently, I received correspondence from a research professor seeking to patent a device that an inmate on suicide precautions would wear as an earpiece to monitor pulse and oxygen level. If the vital signs were detected as being outside the normal range, an alarm would presumably go off and an emergency response would be called. Of course, if the inmate simply removed the earpiece, an alarm would presumably go off and an emergency response would be called. This pulse oximetry technology has been used in a psychiatric setting for restrained patients.

Similar to the argument that use of closed-circuit television monitoring or inmate companions can alleviate correctional staff responsibilities for suicide precautions, a research arm (National Institute of Justice) of the U.S. Department of Justice funded an evaluation of equipment that can measure an inmate’s heart rate, breathing rate and body motions. A wall-mounted range-controlled radar system, originally designed for home security motion detectors, measures subtle motions on the body’s surface caused by heart and lung activity. Alarms are activated when the system detects suspicious changes that are typically found when an inmate is engaging in a suicide attempt. In a 2012 program bulletin, the NIJ acknowledged a declining inmate suicide rate, but complained that “it remains a troubling problem and traditional suicide watch requires dedicated staffing, taking officers away from other duties,” suggesting that there are other more important duties than keeping inmates safe from themselves.

What range-controlled radar systems, pulse oximetry and other anti-suicide technology all have in common is the further separation of correctional, medical and mental health personnel from the inmate who has been placed on suicide precautions. And because very few inmates commit suicide while on suicide precautions, and these gadgets would normally be deployed only after an inmate has been placed on suicide precautions, their use would have no effect on suicide prevention. These quick-fix responses also have little to do with the most important aspects of suicide prevention: how we identify the suicidal inmate who is not easily identifiable.

Rating Scales

Some facilities use a numerical scale to rate signs and symptoms of potential suicidal behavior. The sum of points corresponds with a risk level (e.g., “low”, “medium” or “high”); “caution or warning”) and an inmate is either placed on suicide precautions or not based on this rating. One scale even equates “manipulative behavior” with “low” suicide risk.

Most experts are suspicious of this approach, stressing that no rating scale is skillful enough to precisely determine levels of potential lethality. This approach also violates the principle that all threats of suicide and self-injurious behavior, expression of ideation and so forth, must be taken seriously. Does one rate the ninth “crying wolf” the same as the first? Lawsuits are brought because an individual’s so-called “manipulation” was not taken seriously. Finally, while many of these rating scale forms are popular, and even validated, for community use, they lack the sensitivity to identify risk factors specific to the correctional environment (e.g., sex offense, safety concerns, disciplinary sanctions). It is generally recommended that correctional facilities allow their staff wide discretion in referring all potentially suicidal inmates (and not just those meeting rating scale criteria) to a qualified mental health professional for a comprehensive suicide risk assessment.

Conclusion

While some may argue that overly restrictive suicide precaution measures, contracting for safety, anti-suicide technology and rating scales are nothing more than typical controversial issues in suicide prevention, they are arguably also examples of interventions that further separate staff (correctional, mental health and medical) from suicidal inmates.

Lindsay M. Hayes, MA, is a project director with the National Center on Institutions and Alternatives and a nationally recognized expert in suicide prevention in correctional facilities. His Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities is available at www.ncchc.org/reference-works. Hayes can be reached at lhayesta@msn.com.
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- Chief Medical Executives
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EOE
Critical Thinking for Correctional Nurses: Best Practices for Best Results

Frances Tompkins, MS, RN, CCHP-RN

Perspective … a word with layers of meaning. Every day we make decisions and behave according to our individual perspective. Where we were raised, whom we hang out with, where we attended school, the patients we cared for as students and our own experiences as nurses—our perspective impacts who we are: individuals influenced by a variety of personal, professional and environmental factors. Perspective also influences how nurses care for their patients. The words nurses use and the context in which they use them can impact healing or cause great damage.

Understanding Error and Decision Failures

Nurses typically make more errors than other health care providers. This statistic is understandable given their frequent and active involvement with patients. Correctional nurses, as the entry point of care for nearly all health care encounters, see the most patient care action, make patient care decisions and are involved in the riskiest, most labor-intensive and complex events. The correctional environment and patient population can influence the nurse to think less than critically precisely when focused care and deliberate actions are needed. With every decision, nurses are called upon to know the right thing to do (think critically) and to do it right (with competence).

Multiple factors affect decision-making. Context, team members, patients, resource limitations, physical plant design, ergonomics, affective state, general fatigue, interruptions and distractions, sleep deprivation, personality, intelligence, rationality, gender and other variables—all of these and more affect thinking and decrease the probability that our thinking pattern will lead us to the right decision.

Both conscious and unconscious decisions can derail a nurse's efforts to critically appraise a clinical situation. For example, a middle-aged patient complains of chest pain for the third time in two weeks. The previous times he had a complete workup that showed no cardiac disease. The housing officer says he sees no signs of distress and the nurse thinks he is "faking again"… and there is a long line of patients waiting for sick call. What to do?

Critical Thinking Competencies

Definitions for critical thinking are usually wordy and descriptive. Defining the concept does not help implement the process; yet, critical thinking remains a core competency of safe nursing practice. Below we discuss five competencies that must be a part of critical thinking, at a minimum.

Knowledge
Applying research-based knowledge from nursing and other evidence-based literature

Lack of knowledge is an easy fix. Verify information to protect your practice. Pulling out textbooks and asking experts turns nurses into active knowledge seekers.

Recognizing when to use analytical processes improves with practice. The best practices listed here influence nurses to recognize the need for and practice analytical thinking.

Remember those care plans with rationales from nursing school? The plan was to turn you into a critical thinker.

Ethics

Demonstrating an ethical basis for decisions

Correctional nurses are challenged by the environment, the public and even other nurses in their practice area. They work in a negative environment surrounded by inmate-patients who have been accused, if not convicted, of a crime. Society in general frowns upon incarcerated individuals. Although access to care, the right to a professional medical opinion and the right to the care that is ordered are guaranteed by the Eighth Amendment, public scrutiny about inmate-patients remains active.

Correctional nurses must champion patient care while maintaining strong, transparent professional boundaries. Being a patient advocate for patients identified as manipulators can create conflict between nurses and correctional officers. Nurses must build relationships with correctional staff to allow a firm stance on clinical decisions that impact the environment. An example is the patient who needs to be transported to the emergency department for care when the same patient is seen as manipulative by officers, and the transport will cause staffing issues for the facility.

Metacognition

Ongoing process of reevaluating the input to your decisions

Metacognition means taking an “observer” view of our thinking. This “executive override” helps maintain awareness of rules and procedures (how to draw the lab specimen) and the need to overcome bias (“this patient has trashed his veins”), and create an environment where mindful practice decisions occur.

Evidence-based protocols and pathways provide checklists for maintaining clinical focus and objectivity in times of uncertainty. Protocols help prevent “thinking shortcuts” (biases) and improve clinical communication with others who can contribute professional insight.

Reflection

Retrospective review of thinking and decision-making to improve competency

Reflection happens when we look back on decisions and examine personal thoughts and actions that influenced them. Reflection happens individually, in a group or with a preceptor/mentor. Reflection allows nurses to learn from others, accept feedback, explore options and create solutions for similar future situations. Quality improvement activities provide opportunities for documented reflective learning using root-cause analyses of events and improvement plans.
Intuitive vs. Analytical Decision-Making

Decisions are commonly made in two modes: intuitive or analytical. Intuitive modes are usually involuntary and occur even when not purposefully initiated. They are fast and usually effective. Analytical decision-making, in contrast, is voluntarily initiated, is slower, requires focus and leads to conscious decision-making.

Intuitive Decision-Making

Intuitive decisions are based on "what usually happens." Our brain draws on stored information to create thinking shortcuts. For example, we drive our cars automatically without thinking about involved tasks: inserting the key in the ignition, turning the engine on and so forth. Driving becomes second nature to experienced drivers. However, intuitive decisions are more likely to fail. Because they are usually unconscious, they seldom reach a level of awareness necessary for correction before failure occurs.

Nurses use "automatic drive" every day when they recognize common patterns of patient behaviors and symptoms. Cognitive shortcuts can help quickly solve the puzzle to perhaps rule out appendicitis or recognize signs of alcohol withdrawal. Unfortunately, we can just as easily take mental shortcuts that short circuit good clinical judgment. How nurses think about their patients can get the nurse (and the patient!) into trouble, much like deciding the patient with chest pain is feigning illness based only on past encounters and the officer’s evaluation.

Relying on biased thinking can save time but may lead to consistent and serious errors in judgment. For example, every morning you back out of your driveway without looking because you live on a quiet street with little traffic. But then one day you back into another car. Because you “got away” with the shortcut for a while, you became comfortable with it—until it didn’t work anymore. The following examples of bias focus on correctional settings; perhaps you can identify similar events in your practice.

Confirmation bias: Selectively accepting data that support a desired hypothesis while ignoring data that do not. The nurse looks for evidence to support a preconceived opinion. An example occurs when a nurse accepts that "all inmates are liars" and does not objectively assess the patient due to that belief.

Labeling: Shortcuts to present a commonly shared picture of the patient ("whiner," "faker," "momma’s boy"), which can and do lead to treatment errors. Labels attached to patients carry through into later health care events. If the correctional officer thinks the patient is feigning a medical issue and the nurse sees supporting data, the nurse may also accept the label without sufficient skepticism. What if the “whiner” who came to sick call three days in a row for a headache now has neurological deficits?

Framing effect: The way the problem is presented creates an emotional response that affects the decision. Nurses learn by experience how to “frame” a patient report to get what they need from a provider. Be wary of not advocating appropriately for an unstable patient by providing an inappropriate “frame” that the patient is stable.

Premature closure bias: Quick diagnosis based on pattern recognition results in the failure to recognize another possible explanation. Data collection stops when the nurse jumps to a conclusion. For example: A patient reports to sick call with complaints of headache three days in a row. The nurse intervenes by policy and scope of practice with an over-the-counter medication. The patient has a cerebrovascular accident on Day 4.

Triage cueing: Triage leads to the patient’s disposition. For example, the triage nurse codes the patient’s sick call as nonurgent, and other nurses trust that cue, missing the possibility that the patient’s complaint is urgent or emergent. Even the patient’s self-triage can play a role in this bias.

Analytical Decision-Making

Analytical decisions are made consciously and slowly and require resources, but they are more reliable. If our phlebotomist consulted one list for supplies, another for the steps to take when drawing blood, a checklist for patient identification and so on, lab draws would take significant time. Patients would line up to wait, and correctional officers would complain about time management. Eventually complaints reach the supervisor, and our very slow, albeit careful, phlebotomist would need to find a solution to the time problem to remain employed.

• Think of yourself as a decision maker who impacts patient outcomes
• Accept the role of uncertainty in clinical decision-making
• Use checklists to avoid confusion when appropriate
• Know about biases and their causes, and detect the need for debiasing
• Know the rules, procedures and strategies: they support consistent practice with minimal errors
• Build in time to regroup and thoughtfully consider next steps
• Call a “time-out” for executive overriding of intuitive decisions
• Practice competencies to be as prepared as possible
• Bounce theories off fellow staff members. Ask “What do you think about this patient?” or “What have I missed?” to encourage deeper thinking
• Encourage each other to read, write, listen and speak critically
• Use journaling to objectively and constructively self-criticize your own thinking
• Avoid labeling patients by their diagnosis (the diabetic in 211) or perceived adaptive behaviors (“a whiner”)
• Practice and encourage reflective thinking
• Debrief challenging situations; talk about event-associated thoughts and feelings
• Discuss current cases and decisions at staff meetings and during new staff orientation
• Learn to uncouple from bias
• Practice objectivity

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Avoiding Errors in Decision-Making
Most people spend about 95% of their time in intuitive mode and 5% in analytical mode. We value shortcuts, speedy solutions and easy approaches. Optimal diagnostic reasoning would appear to be a blend of both in appropriate doses.

Preventing errors can be precipitated by a vivid emotional experience. A nurse may attach emotional significance to his or her practice inadequacies and search for a new approach to the problem. How many nurses have said, “I’ll never do that again”? Emotional learning can also be vicarious. Correctional systems in place for vicarious learning include sharing man-down drills and mass disaster drill critiques at staff meetings. Incorporating new approaches and alternative strategies into cognitive decision-making are the next steps in “error-proofing.”

Debiasing
Debiasing is used to troubleshoot faulty decisions. During debiasing the nurse develops awareness, learns alternative strategies and incorporates new approaches into the thinking process. Debiasing occurs most often when the pain or anxiety of a bad decision is greater than the cost of prevention. For example, if you are easily lost when driving in strange places and feel anxiety about being lost due to a previous experience, you will arrange ways to prevent that anxiety. Perhaps you will purchase a GPS, or download maps, or both.

Environmental Control
Have you ever experienced a near-miss accident while driving? Pulling over, deep breathing and refocusing is necessary when the environment changes faster than you can process. Fatigue increases the likelihood of defaulting to intuitive reasoning; a few moments of quiet can improve clarity. Environmental control is crucial to regrouping and thoughtful next steps. Environmental management includes reducing interruptions, frequently changing activities and being prepared for tasks. Medication administration, for example, is a complex, error-prone activity easily impacted by distractions. The incidence of medication errors can be reduced with environmental control.

Critical Thinking: Essential to Competent Care
Nursing is never a meaningless activity. Practicing situational awareness and vigilance are crucial to quality health care delivery. Critical thinking is arguably the most difficult to teach and/or learn, yet we are all aware of our innate ability to adapt to and shape the world around us. Critical thinking processes advocate for patients and protect them from unsafe nursing practices by supporting nurse competency and positively impacting patient care.

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New Guidelines Aid in Reentry of Those With Mental / Substance Use Disorders

by Kevin Fiscella, MD, MPH

The Substance Abuse and Mental Health Services Administration, an agency of the U.S. Department of Health and Human Services, recently released an important resource titled Guidelines for Successful Transition of People With Mental or Substance Use Disorders From Jail and Prison: Implementation Guide.

The report offers useful guidance to correctional facilities in managing transitions of care for individuals with mental and substance use disorders, on admission and release. Compared to the general correctional population, people with these disorders experience longer lengths of incarceration. They also spend more time in restrictive housing and are more often victimized. Following correctional release, they are at higher risk for recidivism, avoidable hospitalizations and premature death. Improved admission and prerelease planning and care coordination can potentially improve outcomes for this population.

The 10 guidelines (summarized below) are based on four principles: assessment, planning, identifying and coordinating. The guidelines emphasize universal screening upon entry followed by comprehensive assessments and individualized treatment for those with positive screens. Upon release, warm handoffs and coordinated plans for transition to appropriate community-based services and treatment facilities can help to prevent gaps in care.

The SAMHSA report includes real-world examples from jails and prisons nationally that have operationalized these guidelines. The report is available for free download at http://store.samhsa.gov/shin/content/SMA16-4998/SMA16-4998.pdf.

Kevin Fiscella, MD, MPH, is dean’s professor, Family Medicine, professor, Public Health Sciences, and professor, Community Health at the University of Rochester (NY) Medical Center. He serves on NCCHC’s board of directors as liaison of the American Society of Addiction Medicine.

SAMHSA Guidelines for Transition of People With Mental or Substance Use Disorders

**Guideline 1.** Conduct universal screening as early in the booking/intake process as feasible and throughout the criminal justice continuum to detect substance use disorders, mental disorders, co-occurring substance use and mental disorders, and criminogenic risk. Valid and reliable screening instruments for the target population should be used.

**Guideline 2.** For individuals with positive screens, follow up with comprehensive assessments to guide appropriate program placement and service delivery. The assessment process should involve obtaining information on:

- Basic demographics and pathways to criminal involvement
- Clinical needs (e.g., identification of probable or identified diagnoses, severity of associated impairments and motivation for change)
- Strengths and protective factors (e.g., family and community support)
- Social and community support needs (e.g., housing, education, employment and transportation)
- Public safety risks and needs, including changeable (dynamic) and unchangeable (static) risk factors, or behaviors and attitudes that research indicates are related to criminal behavior

**Guideline 3.** Develop individualized treatment and service plans using information obtained from the risk and needs screening and assessment process.

- Determine the appropriate level of treatment and intensity of supervision, when applicable, for individuals with behavioral health needs.
  - Identify and target individuals’ multiple criminogenic needs in order to have the most impact on recidivism.
  - Address the aspects of individuals’ disorders that affect function to promote effectiveness of interventions.
  - Develop strategies for integrating appropriate recovery support services into service delivery models.
  - Acknowledge dosage of treatment as an important factor in recidivism reduction, requiring the proper planning and identification of what, where and how intensive services provided to individuals will be.

**Guideline 4.** Develop collaborative responses between behavioral health and criminal justice that match individuals’ levels of risk and behavioral health need with the appropriate levels of supervision and treatment.

**Guideline 5.** Anticipate that the periods following release (the first hours, days and weeks) are critical and identify appropriate interventions as part of transition planning practices for individuals with co-occurring mental and substance use disorders leaving correctional settings.

**Guideline 6.** Develop policies and practices that facilitate continuity of care through the implementation of strategies that promote direct linkages (i.e., warm handoffs) for postrelease treatment and supervision agencies.

continued on page 21
Family Physicians Weigh in on Correctional Health Care

American Academy of Family Physicians
AAFP has released a position paper titled Incarceration and Health: A Family Medicine Perspective that focuses on the health impact incarceration has on inmates and their families. It offers a succinct explanation of health issues during and after incarceration, and highlights actions family physicians can take to help with health issues related to incarceration, including a call to learn about the unique needs of incarcerated or formerly incarcerated individuals through resources such as NCCHC.

“Family physicians are more likely than other clinicians to care for vulnerable populations, and patients who are or have been incarcerated have higher rates of chronic health conditions, mental illness and substance abuse than the general population,” said Kenneth Lin, MD, MPH, who led the AAFP workgroup that developed the position paper.

The paper stresses that family physicians can promote individuals’ health during the important transition from incarceration to the community by supporting (1) reentry processes that begin prior to release, (2) collaborations between prison and community health services, (3) integrated models of care and (4) linkages to housing, employment and mental health support.

• www.aafp.org/about/policies/all/incarcerationandhealth.html

SAMHSA Guidelines

Guideline 7. Support adherence to treatment plans and supervision conditions through coordinated strategies.
- Provide a system of incentives and graduated sanctions to promote participation in treatment; maintain a “firm but fair” relationship style; and employ problem-solving strategies to encourage compliance, promote public safety and improve treatment outcomes.
- Establish clear protocols and understanding across systems on handling behaviors that constitute technical violations of community supervision conditions.

Guideline 8. Develop mechanisms to share information from assessments and treatment programs across different points in the criminal justice system to advance cross-system goals.

Guideline 9. Encourage and support cross-training to facilitate collaboration between workforces and agencies working with people with co-occurring mental and substance use disorders who are involved in the criminal justice system.


College of Family Physicians of Canada
The CFPC has issued two position statements on the treatment and health care of inmates in Canadian correctional facilities. The CFPC and its Prison Health Program Committee advocate for the best health outcomes and equitable health care services for these prisoners and state that the nation’s prisons should establish health care standards equivalent to those for all Canadians.

One position statement supports abolishing solitary confinement in Canadian correctional institutions. This includes ending the practice for prisoners who suffer from medical conditions or mental illness and for disciplinary reasons. It also calls for medical staff to assess the health of persons in solitary on a daily basis, and for the use of mitigation strategies to ensure that health needs are met comprehensively until the practice of solitary confinement is eliminated.

A second position advocates that responsibility for health care delivery in provincial/territorial correctional institutions be transferred from the ministries of justice to the ministries of health. It also recommends that responsibility for delivery of health care services in federal facilities be completely separated from the federal ministry of public safety.

• www.cfpc.ca/cfpc_position_treatment_health-care_incarcerated_populations/

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Equal Employment Opportunity
Antipsychotic medications can save lives, yet they also can cause serious side effects. One such side effect, metabolic syndrome, increases the risk for diabetes, coronary artery disease, stroke and death. In an effort to reduce risk for patients on second-generation antipsychotics in the New Jersey Department of Corrections, the prison system’s medical and mental health care provider (University Correctional Health Care, a branch of Rutgers University) in late 2006 implemented a metabolic monitoring program across the state’s 12 prisons.

As described by Reeves, Tamburello and DeBilio in the April Journal of Correctional Health Care, the monitoring protocol entails tracking of the following data: personal and family history of obesity, diabetes, dyslipidemia, hypertension or cardiovascular disease; weight, height and body mass index; waist circumference; blood pressure; fasting blood glucose; and fasting lipid profile.

The article reports on a study to gauge the success of this effort. NJDOC’s electronic health records were used to identify all adults prescribed antipsychotic medication for at least six consecutive months between 2005 and 2013. For each year of the study, patients’ age, gender, weight, height, BMI, race/ethnicity, psychiatric diagnoses and hypertensive, diabetic and hyperlipidemia medications were recorded.

The average prevalence of metabolic syndrome in 2005 and 2006 (before monitoring) was compared with the average prevalence in 2007-2013. Metabolic syndrome was defined as meeting at least three of four criteria: BMI ≥ 25 kg/m2 and prescription for a lipid modifying agent, an antihypertensive medication or taking insulin and taking medication for reduced HDL cholesterol.

What Is Metabolic Syndrome?

According to the Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (2001), metabolic syndrome is defined by the presence of three or more of the following criteria:

- Abdominal obesity: men ≥ 40" and women ≥ 35"
- Triglycerides: ≥ 150 mg/dl or taking medication for high triglycerides
- High-density lipoprotein: men < 40 mg/dl and women < 50 mg/dl, or taking medication for reduced HDL
- Blood pressure: ≥ 130/85 or taking antihypertensive medications
- Fasting glucose: ≥ 100 mg/dl, taking hypoglycemic medication or taking insulin

However, the rates varied widely over the nine years (range: 10.8% to 20.5%), and prevalence increased in the last two years of the study. In addition, more patients converted from no metabolic syndrome to metabolic syndrome than did the reverse. Although no clear link was found between use of the monitoring protocol and rates of metabolic syndrome, the authors made an important unexpected finding: a linear 44% decrease in the number of patients prescribed an antipsychotic.

JCHC Vol. 23, Issue 2: April 2017

- Primary Care Program in Prison: A Review of the Literature — Carmen La Cerra, MSN, RN, Milena Sorrentino, MSN, RN, Ilaria Franconi, MSN, RN, Ippolito Notarnicola, MSN, RN, Cristina Petrucci, PhD, MSN, RN, Loreto Lancia, MSN, RN
- Inmate Health Care Provided in an Emergency Department — Lindsey Koester, MD, Jay M. Brenner, MD, Aimee Goulette, MPH, Susan M. Wojcik, PhD, William Grant, EdD
- Medical Parole and Aging Prisoners: A Qualitative Study — George Pro, MPH, Miesha Marzell, PhD, MSW
- Nurses’ Perceptions of Weight Gain and Obesity in the Prison Environment — Khurshid Choudhry, MSc, David Armstrong, PhD, Alexandru Dregan, PhD
- Truth Be Told: Evaluation of a Narrative and Skills Intervention in Two Women’s Prisons — Michael W. Ross, MD, PhD, MPH
- Sleep Disorders and Therapeutic Management: A Survey in a French Population of Prisoners — Anaïs Goudard, PharmD, Laure Lalande, PharmD, PhD, Camille Bertin, PharmD, Marie Sautereau, MD, Marc Le Borgne, PhD, Delphine Cabelguenne, PharmD, PhD
- Metabolic Syndrome Prevalence and Reduction in Inmates Prescribed Antipsychotic Medications — Rusty Reeves, MD, Anthony Tamburello, MD, Lisa DeBilio, PhD
- Developing a Typology for Peer Education and Peer Support Delivered by Prisoners — Jane South, PhD, Anne-Marie Bagnall, PhD, James Woodall, PhD
- Exploring HIV Risk and Ex-Offender Status Among African American Church Populations: Considerations for Faith-Based Settings — Marcie Berman, PhD, Jannette Berkley-Patton, PhD, Alexandria Booker, BA, Carole Bowe-Thompson, BS, Andrea Bradley-Ewing, MPA, MA

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John May, MD, CCHP, Honored
John May, MD, CCHP, was named the 2017 recipient of the Dr. Thomas A. Dooley Award, which is conferred by the University of Notre Dame’s Alumni Association to recognize an alumnus who has exhibited outstanding service to humankind. May was honored for his dedication to providing medical care to prisoners around the world.

In 2001, May traveled to Haiti after watching a 60 Minutes program covering the country’s desperate prison conditions and soon began making monthly volunteer trips. By 2005, his work expanded to other countries and he cofounded Health through Walls, a nonprofit organization that provides health care services in the prisons of low-income countries.

Health through Walls is one of the few nongovernmental organizations in the world dedicated to this mission. Over the years, it has aided tens of thousands of prisoners in Haiti, the Dominican Republic, Jamaica, Ghana, Kenya, the Democratic Republic of Congo, Malawi, Tanzania, Rwanda, South Africa and Romania.

May is chief medical officer for Armor Correctional Health Services, Miami.

New Books on Correctional Health

Humane Health Care for Prisoners: Ethical and Legal Challenges
One of the pioneers of correctional health care, Ken Faiver, MPH, CCHP, brings his 42 years of experience in this field to a book that discusses the many important ethical and legal issues that arise in the delivery of health care in correctional facilities. It references national standards of professional practice as well as the advice of recognized experts. Topics include privacy, confidentiality, informed consent, extended isolation and solitary confinement, use of mace, strip searches and body cavity searches, and medical experimentation on prisoners as human subjects. It also considers participation by health care professionals in capital punishment, coerced substance abuse treatment, how much health care to provide, organizational structure and hierarchy, cooperation between correctional and health care staff, and recognizing mental illness as a chronic condition.

Faiver directed the Michigan Department of Corrections’ health care program for 16 years and was chief medical coordinator for the Puerto Rico correctional health care system for three years. The author of Health Care Management Issues in Corrections (1998), he has written a number of journal articles and made many conference presentations.

Faiver is working on two companion books: one will examine the delivery of correctional health care, and the other will focus on management topics. The titles are slated to be published over the next two years.

• http://publisher.abc-clio.com/9781440855511

Correctional Health Care: Practice, Administration, and Law
Edited by nationally recognized correctional health law expert Fred Cohen, LLM, this volume provides practical guidance on the clinical, administrative and legal issues involved in providing quality health care to correctional populations.

Chapters are contributed by some of the leading authorities in this field and address topics such as how the law applies to inmate health care and how to avoid liability risks; policy trends arising from federal regulation and widespread use of electronic health records; strategies to limit the risk of disease transmission; recommendations for managing medical, mental health, dental and pharmacy services; concerns and solutions related to aging inmates; quality assurance; strategies to contain cost while improving the quality; and more.

A prolific writer and editor, Cohen is a founder of the Civic Research Institute publishing company, where he is editor of several periodicals on correctional health, mental health and the law. He also is the author or editor of several books. In 2011, Cohen was the recipient of NCCHC’s B. Jaye Anno Award of Excellence in Communication.

• www.civicresearchinstitute.com/chcpal.html

Jailcare: Finding the Safety Net for Women Behind Bars
The plight of pregnant women incarcerated in our nation’s jails is the focus of this book by Carolyn Sufrin, MD, PhD. The book examines the experiences of incarcerated pregnant women and the practices of the jail guards and health providers who care for them. Sufrin uses her ethnographic fieldwork and clinical work as an obstetrician/gynecologist in a women’s jail to describe how jail has, paradoxically, become a place where women can find care.

Sufrin is a medical anthropologist and ob-gyn at Johns Hopkins School of Medicine. From 2007 to 2013 she worked as a physician at the San Francisco County jail, where she started a women’s health specialty clinic. Her work is dedicated to research, advocacy and care for incarcerated women, especially at the intersection of health care and criminal justice system reform. She earned an MD from Johns Hopkins, a PhD in medical anthropology from University of California at San Francisco and an MA in cultural anthropology from Harvard.

She serves on the NCCHC board of directors as liaison of the American College of Obstetricians and Gynecologists.

• www.jailcare.org
For CDR Deborah Bishop, MPH, PA-C, CCHP, working in corrections was not easy at first. “It was a big shock, because I didn’t think I’d get used to the correctional environment,” she says. Bishop had already been a medical assistant for several years but admits she “sort of tripped” into the field of correctional health care.

After hearing a presentation from a U.S. Public Health Service recruiter during her second year of graduate school, Bishop decided to apply for a USPHS scholarship. She got the scholarship and was working full time as a clinical services officer for the Federal Bureau of Prisons within one week of graduation.

Despite the initial shock, Bishop has no regrets about her career choice. “What many people don’t realize is that this is a very rewarding population to care for,” she says. “Every job has challenges, but after 17 years in correctional health care, I can’t imagine doing anything else.”

In 2003, Bishop joined the Immigration and Customs Enforcement Health Services Corps (then known as the Division of Immigration Health Services), which provides direct patient care to detainees at all 21 ICE detention facilities across the country. IHSC also manages the provision of off-site medical care for detainees in about 240 Intergovernmental Service Agreement facilities.

Though assigned a permanent duty station, Bishop has worked at many of these facilities providing support and training. She says that, in many ways, the population she serves is not unlike that of any other detention setting. IHSC staff regularly treat a wide range of acute and chronic medical and mental health conditions, including drug and alcohol addiction, and many detainees arrive at these facilities having had limited access to health care and preventive services.

Supporting High Quality Care

According to Bishop, IHSC facilities take pride in their strict adherence to NCCHC standards, and IHSC leadership views CCHP as a highly regarded credential. A few years after Bishop joined IHSC, a supervisor encouraged her to take the CCHP exam. For her, becoming a CCHP was a crucial step toward gaining the knowledge needed to provide her patients with the highest quality health care. “I am a better health care provider because I understand and wholeheartedly believe in these standards. People in correctional systems need high quality care and the CCHP shows others that I support this high quality care.”

In 2015, Bishop transitioned from direct patient care into an oversight role as chief midlevel provider. In this leadership position, she refers to the standards almost every day as she writes and reviews policies and processes. Yet she says that the CCHP credential is essential for anyone, not just administrators, planning to make their career in correctional health care.

“Being a CCHP is recognition of a level of expertise in correctional health knowledge,” she says. “If you have CCHP after your name, that tells me you really care about providing excellent health care services to some of the most vulnerable patients in the nation.”

Last year, Bishop was elected to the CCHP board of trustees. This increased involvement with correctional health care on a national level fit naturally with her IHSC leadership role, she explains. As a trustee, she intends to work for “all CCHPs out there who ‘trust’ the trustees to maintain the integrity, professionalism and quality of the CCHP credential.” She also wants to use her platform to be a resource and mentor for those interested in earning certification.

Katie Przychodzen, MA, is NCCHC’s marketing assistant. If you work in correctional health care and are interested in pursuing CCHP certification to advance your career, visit www.ncchc.org/cchp for information.

New Trustee Finds Rewards in Caring for Immigration Detainees

CCHP Exam Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 29</td>
<td>Las Vegas, NV</td>
</tr>
<tr>
<td>August 26</td>
<td>Regional sites</td>
</tr>
<tr>
<td>September 13</td>
<td>San Jose, CA</td>
</tr>
<tr>
<td>November 5</td>
<td>Chicago, IL</td>
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We are seeking sites for regional exams and CCHPs to proctor the exams. To participate, contact the certification specialist at 773-880-1460 or cchp@ncchc.org. See the complete calendar at www.ncchc.org/cchp.

Ober, Porsa Also Join Board

Two other new members joined the CCHP board of trustees last October, both of them in appointed positions serving three-year terms:

- Peter Ober, PA-C, JD, CCHP, is managing partner at Rappahannock Creative Health Care and serves as liaison of the American Academy of PAs on NCCHC’s board of directors.
- Esmaeil Porsa, MD, MPH, CCHP-P, CCHP-A, is executive vice president and chief strategy and integration officer for the Dallas County (TX) Jail.
### Who Attended in 2016?

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse/nurse practitioner</td>
<td>43%</td>
</tr>
<tr>
<td>Physician/physician assistant</td>
<td>23%</td>
</tr>
<tr>
<td>Administrator</td>
<td>10%</td>
</tr>
<tr>
<td>Psychiatrist/psychologist</td>
<td>9%</td>
</tr>
<tr>
<td>Social worker, therapist, counselor</td>
<td>6%</td>
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</tbody>
</table>

### Decision Makers With Authority

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>State/facility medical director or director of nursing</td>
<td>19%</td>
</tr>
<tr>
<td>Health services administrator</td>
<td>8%</td>
</tr>
<tr>
<td>Department manager/supervisor</td>
<td>12%</td>
</tr>
<tr>
<td>Health services, dental or mental health staff</td>
<td>26%</td>
</tr>
</tbody>
</table>

### Who Do Attendees Represent?

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jail facility</td>
<td>45%</td>
</tr>
<tr>
<td>Prison facility</td>
<td>21%</td>
</tr>
<tr>
<td>State DOC/agency</td>
<td>10%</td>
</tr>
<tr>
<td>Private corporation</td>
<td>10%</td>
</tr>
<tr>
<td>Juvenile detention or confinement facility</td>
<td>4%</td>
</tr>
<tr>
<td>Federal agency</td>
<td>2%</td>
</tr>
</tbody>
</table>

### Categories Attendees Recommend or Buy

- Dental care and supplies
- Disaster planning
- Electronic health records
- Health care staffing
- Information technology
- Medical devices, equipment
- Mental health services
- Pharmaceuticals
- Safety equipment
- Suicide prevention
- Dialysis services
- Education and training
- Health care management
- Infection control products
- Laboratory services
- Medical supplies
- Optometry services
- Pharmacy services
- Substance abuse services

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- Product Theater events
- CCHP lounge host
- Conference padfolios
- Hotel key card
- Exhibitor lounge
- Phone chargers
- Keynote speaker
- Premier educational programming
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- Meeting message board
- Conference bags
- Show bag insert
- Exhibit hall aisle sign
- Lanyards

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WellStar Health System

WellStar Medical Group is seeking BC/BE Internal or Family Medicine physician to practice in our County Correctional Center. The center is a mixed population facility with both male and female inmates. The center is located approximately 25 miles northwest of Atlanta, GA. This is a full-time position, Monday - Friday, 8:00 AM - 5:00 PM, no call duty. The infirmary has an average 40 to 50 patients, the clinic sees 18 to 20 patients per day.

Very competitive salary. Comprehensive benefits package to include malpractice coverage, medical/dental/vision insurance, disability/life insurance, 403b plus defined retirement pension plan, and vacation/sick/CME allowance.

- Sign-On Bonus: $20,000
- Relocation Assistance: Up to $10,000

To apply for this position, go to: www.wellstarcareers.org

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.

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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, email editor@ncchc.org or call 773-880-1460. We also invite letters or correction of facts, which will be printed as space allows.

Advertising: Contact Carmela Barhany, sales manager, at sales@ncchc.org or 773-880-1460, ext. 298.

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WellStar Health System

WellStar Medical Group is seeking BC/BE Internal or Family Medicine physician to practice in our County Correctional Center. The center is a mixed population facility with both male and female inmates. The center is located approximately 25 miles northwest of Atlanta, GA. This is a full-time position, Monday - Friday, 8:00 AM - 5:00 PM, no call duty. The infirmary has an average 40 to 50 patients, the clinic sees 18 to 20 patients per day.

Very competitive salary. Comprehensive benefits package to include malpractice coverage, medical/dental/vision insurance, disability/life insurance, 403b plus defined retirement pension plan, and vacation/sick/CME allowance.

- Sign-On Bonus: $20,000
- Relocation Assistance: Up to $10,000

To apply for this position, go to: www.wellstarcareers.org
Expert Advice on NCCHC Standards

by Tracey Titus, RN, CCHP-RN

Can a Paramedic Do the Physical Exam?

Q Is it within the scope of a paramedic to perform the physical examinations/hands-on portion of the health assessments?

A Standard E-04 Initial Health Assessment requires that inmates receive an initial health assessment as soon as possible and provides two options for completing this task: the full population assessment and individual assessment when clinically indicated.

The initial health assessment requires many components, some of which involve having a qualified health care professional collect additional data to complete the medical, dental and mental health histories including any follow-up from positive findings obtained during receiving screening and subsequent encounters as well as recording vital signs. A qualified health care professional is defined as anyone who by virtue of education, credentials and experience is permitted by law to evaluate and care for patients.

Your question relates to the physical examination component of the initial health assessment. The standard specifies who is permitted to complete this portion on both options. For the full population assessment, the physical exam may be completed by a physician, a midlevel provider or an RN who has completed the appropriate training. For the individual assessment when clinically indicated, the exam may be performed only by a physician or midlevel provider. The standard does not permit a physical exam to be conducted by a paramedic in either option.

15-Minute Suicide Checks

Q We perform 15-minute checks on our potentially suicidal inmates. Is this practice in compliance with the G-05 Suicide Prevention Program standard?

A Nonacutely suicidal (potentially or inactive) inmates are those who express current suicidal ideation and/or have a recent prior history of self-destructive behavior. These inmates should be monitored on an unpredictable schedule with no more than 15 minutes between checks (e.g., 5, 10, 7 minutes).

To answer your question, we would need clarification on a couple of points: what you mean by “15-minute checks” and who completes the checks. If the observation is occurring regularly every 15 minutes, this is not in compliance with the standard. The idea is to check on the nonacutely suicidal inmate at irregular, unpredictable intervals, with no more than 15 minutes in between each check (see compliance indicator #1d). If the nonacutely suicidal inmate is placed in isolation, then constant observation is required. In addition, the monitoring must be done by staff.

Other supervision aids (e.g., closed circuit television, inmate companions or watchers) can be used to supplement but never substitute for staff monitoring.

Process and Outcome CQI Studies

Q Our question relates to A-06 Continuous Quality Improvement Program, compliance indicator #4. We understand that we need to conduct process or outcome studies. Can you explain the difference in the two types of studies and what evidence is required to meet this indicator?

A A study is a process of reviewing an identified problem to assess potential causes. A CQI study is one in which a facility problem is identified, a baseline study is completed, a corrective action plan is developed and implemented, and the problem is restudied to assess the effectiveness of the corrective action plan. Subsequent corrective action is documented and evaluated to see if the intervention was effective in addressing the problem.

Process studies normally answer the question “Is what we are doing effective and efficient?” They focus on implementation of policies and procedures (usually involving more than one category of staff) and the effectiveness of those processes. For example, examining your chronic care procedure might involve looking at how you identify chronic care patients, how you schedule them for clinics, whether security escort problems cause delays, how documentation is kept and so forth. Process studies often focus on timeliness and efficiency.

Outcome studies answer the question “Are our patients getting better?” or determine whether the expected outcomes of patient care were achieved (degree of control is a helpful consideration). Looking again at chronic care, an outcome study might focus on whether the chronic care patients’ symptoms are actually decreasing or at least are not worsening as a result of the care.

Documentation for these studies must address all components listed under compliance indicator #2, including the established thresholds, and all components outlined in the definitions of process and outcome studies.

Tracey Titus, RN, CCHP-RN, is NCCHC’s vice president of accreditation. If you have a question about the standards, write to accreditation@ncchc.org or call 773-880-1460.

For an archive of past Standards Q&A columns, visit the Standards and Resources section at www.ncchc.org.

For more in-depth information about the standards, attend one of the preconference seminars at NCCHC’s National Conference on Correctional Health Care, being held Nov. 4-8 in Chicago.
Newly revised, the 2014 standards present NCCHC’s latest recommendations for managing health services delivery in adult correctional facilities throughout the nation.

The standards were updated to reflect the latest evidence and best practices in meeting professional, legal and ethical requirements in delivering correctional health care services.

Notable updated topics include continuous quality improvement, clinical performance enhancement, patient safety, pharmaceutical operations and women’s health. The new editions support facilities in achieving and maintaining compliance with NCCHC accreditation and constitutionally required correctional health care.

National correctional health care experts have spent thousands of hours researching, editing and evaluating feedback from the field to ensure that NCCHC standards remain the most authoritative resources for correctional health care services.

To order or to see a list of all NCCHC publications, visit www.ncchc.org.
The Centurion Difference

Centurion is committed to improving the health of the community one person at a time through healthcare programs for incarcerated patients. Our commitment includes specialty services that support our focus on whole health. To help us achieve this Centurion offers specialty services collectively referred to as Envolve™.

Envolve™ is a service offering unique to Centurion, encourages inmates to take a more active role in their overall health, and better prepare them for managing their health in the community after release from prison.

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