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Online Portal Simplifies Accreditation Tasks

Great news for correctional facilities! NCCHC is streamlining the accreditation process through an individualized online system that will make tasks smoother and easier for accredited facilities and those seeking accreditation.

By logging in to the online portal, facilities will have access to all of the information they need about their accreditation status. All notes, reminders and communication will be stored on the facility’s convenient personal dashboard.

The system also streamlines activities for accreditation surveyors and staff, making for a smoother process overall.

Benefits for facilities include the following:
• Track where you stand with accreditation processes and activities
• Take note of upcoming deadlines
• Upload requested documents
• Update contact information
• Collaborate with staff on the Annual Maintenance Reports
• Maintain continuity of communication with NCCHC in the event of staff turnover

Facilities should have received an email with more information and login instructions so they can file their AMRs using the new system.

Melvin Wilson Joins NCCHC Board as NASW Liaison

The National Commission welcomes Melvin H. Wilson, MBA, LCSW, to its board of directors as the liaison of the National Association of Social Workers. The appointment took effect Nov. 5 during the NCCHC board meeting.

Wilson has worked for NASW since 2006 and for the past five years has served as senior manager in the department of social justice and human rights. In that role, he is in charge of developing and implementing activities related to criminal justice, juvenile justice, immigration reform, economic justice and voting rights. He has extensive experience working with national coalitions that deal with criminal justice policies, legislation and practices that intersect with conditions of incarceration.

“I believe that having a representative from the country’s largest social work organizations has a mutual benefit to NCCHC and NASW,” says Wilson. “I will assist NCCHC in improving services and standards of care for incarcerated individuals with health, mental health and physical disabilities, including standards for the use of segregation, especially as it relates to mental health implications.”

NASW is a professional organization with 120,000 members and chapters in every state. The NCCHC board of directors is comprised of liaisons from supporting organizations from the fields of health, law and corrections.

Fagan Becomes Chair-Elect

In other board news, Thomas J. Fagan, PhD, CCHP-MH, is now chair-elect and will assume the position of chair in 2018-2019. The liaison of the American Psychological Association since 1996, Fagan also served as chair in 2003-2004. He serves on executive, education and finance committees, as well as the CCHP–Mental Health subcommittee. Fagan is recently retired as associate dean of the College of Psychology at Nova Southeastern University, Ft. Lauderdale, FL, and previously had a long career with the Federal Bureau of Prisons.

NCCHC Position Statements

The board of directors approved two position statements at its Nov. 5 meeting.

•Breastfeeding in Correctional Settings recommends making accommodations for nursing women in custody, including at short-stay facilities, that will enable them to maintain their breast milk supply. This is for the physical and psychological benefits for newborns and mothers. The complete statement appears on page 4.

•Charging Inmates a Fee for Health Care Services was reaffirmed with a few changes. This statement notes that fee-for-service programs may interfere with access to health services, and recommends that such programs be founded on the principle that access to care will be available to all inmates regardless of their ability to pay.

Along with the Standards for Health Services, NCCHC position statements may assist correctional facilities in designing policies and procedures. All statements are available at www.ncchc.org/positionstatements.
New Board Chair Barb Wakeen Promotes NCCHC’s Strengths—and Healthy Diets

Barbara A. Wakeen, MA, RDN, CCHP, became chair of the NCCHC board of directors on Nov. 5, after one year as chair-elect. She has served on the board as liaison of the Academy of Nutrition and Dietetics since 2001 and has rich experience on NCCHC’s executive, education, juvenile health and policy and standards committees.

Internationally recognized as an authority on correctional nutrition, Wakeen has practiced as a consultant, corporate dietitian and district manager in the correctional food-service industry since 1989. She owns and operates Correctional Nutrition Consultants, Ltd., which provides food-service and nutritional consultation to prisons, jails, detention facilities and other corrections-related food arenas across the country. She also has experience as an instructor and expert witness and has participated in clinical trials research.

During her one-year term as board chair, one of Wakeen’s priorities is to advance NCCHC’s mission of improving the quality of health care provided in correctional facilities by promoting the Standards for Health Services and other best practices, and by providing additional educational opportunities to the field. Other goals are to increase awareness of and participation in NCCHC accreditation, and to usher in the use of new technologies to enhance services for accredited facilities, such as the online portal (see page 2).

Commitment to Corrections

It was in 1989, after eight years as a dietitian in community settings including long-term care, that Wakeen entered a correctional facility for the first time, assigned to oversee the medical diet program at a maximum-security prison as part of a court order.

When the court order ended a year later, she moved on to a food contract management company whose client roster included correctional facilities. Before long, she became its corporate dietitian for corrections, responsible for more than 50 facilities in the eastern two-thirds of the country. Those six years of experience in corrections clinched it: In 1995, Wakeen committed her career to correctional nutrition and food service and established a consultancy.

“Nutrition is an extremely important component of inmate health,” she says. “Not only are meals generally the highlight of the day for those who are incarcerated, but for some people, what’s served behind bars may be the healthiest food they’ve ever had. Nutrition can impact medical outcomes as well as health care costs.”

Wakeen’s packed appointment calendar underscores her tireless work as she travels around the country working with clients, attending and speaking at educational events and serving in leadership roles for several professional organizations. A Certified Correctional Health Professional since 2008, she has written about Belize, Honduras, Palau and Australia. To date she has written about Belize, Honduras, Palau and Australia.

At the helm of NCCHC, Wakeen knows that it is unusual for a registered dietitian nutritionist to take on this role. But she sees it as part of a larger effort, enhanced by her long corrections experience and deep understanding of the Commission. “Corrections and diet programs have evolved over time, and communications among various health care disciplines have grown stronger,” she says. “Our disciplines work together to meet NCCHC’s mission to provide for the health care needs of those we serve.”

Barbara A. Wakeen, MA, RDN, CCHP

Correctional Experience

• Correctional Nutrition Consultants, Ltd., principal – 1995 - present
• Service America Corp., several roles culminating in corporate dietitian for corrections – 1989 - 1995
• Canteen Corp., manager of health care / regional dietitian – 1988 - 1989

Leadership Activities

• Academy of Nutrition and Dietetics – since 2001
• Association of Correctional Food Service Affiliates, Dietitians in Corrections, chair – since 2000
• NCCHC board of directors – since 2001
• Ohio Consultant Dietitians in Health Care Facilities – since 2009

Selected Certifications

• Certified Correctional Foodservice Professional – since 2009
• Certified Correctional Health Professional – since 2008
• Certified HACCP (Hazard Analysis Critical Control Points) Manager – since 2010
• Food Safety Manager – since 2010

Education

• Master of arts, food & nutrition, minor in business – Kent State University
• Bachelor of science, home economics specializing in general dietetics – Ohio State University
• Pre-pharmacy studies (3 years) – University of Akron

Nutrition and Dietetics. She lends her expertise to every edition of the Standards manuals as well as to NCCHC position statements and other resources. She also has written for CorrectCare and many other publications and is a peer reviewer for the Journal of Correctional Health Care.

In her personal life, Wakeen dives right into challenges—literally, as she is an avid scuba diver. In her travels to diving sites, she often visits the local correctional facility and may write an article about food and diets there. To date she has written about Belize, Honduras, Palau and Australia.

At a Glance
NCCHC Adopts Position Statement on Breastfeeding in Correctional Settings

NCCHC position statements serve to augment its Standards for Health Services or to express NCCHC’s expert opinion on important issues that are not addressed in the Standards. Along with the Standards, these statements may assist correctional facilities in designing policies and procedures. The statement that follows was adopted by the NCCHC board of directors at its Nov. 5 meeting.

Introduction
Breastfeeding has well-established physical and psychological benefits for newborns and mothers, and enhances long-term bonding. A woman’s breast milk supply relies heavily on being able to continue to produce milk, either through direct feeding or expressing milk. Although the logistical constraints of correctional settings pose challenges for breastfeeding, there are many ways to make breastfeeding possible. The National Commission on Correctional Health Care supports and recommends making accommodations for nursing women in custody, including at short-stay facilities, that will enable them to maintain their breast milk supply.

Acceptance of the medical and social importance of breastfeeding has become more widespread, and the Fair Labor Standards Act (29 U.S. Code 207) now requires employers in community workplaces to provide reasonable break time and clean, private space (excluding a bathroom) for an employee to express breast milk for her nursing child for 1 year after the child’s birth each time the employee needs to express milk. These laws also apply to employees working in correctional facilities. This accepted community and legal standard for employees highlights the importance of making accommodations for postpartum inmates who wish to breastfeed.

This position statement addresses the unique issues surrounding breastfeeding for postpartum inmates in correctional settings.

Background
The majority of incarcerated women are of reproductive age. Some women enter jails, prisons, and juvenile facilities already pregnant and then give birth while in custody, and others have recently given birth and are breastfeeding their infants. While postpartum women represent a small proportion of the incarcerated population, they and their newborns have unique needs that the correctional facility should address. One of those needs is accommodating breastfeeding for postpartum women who want to provide their infants with breast milk.

Breastfeeding and breast milk have many short-term and long-term benefits for both the infant and the mother. The American Academy of Pediatrics recommends exclusive breastfeeding for the first 6 months of life, then introduction of other foods along with breast milk until at least 12 months (American Academy of Pediatrics, 2012). The Agency for Healthcare Research and Quality conducted a comprehensive analysis of scientific literature that concluded that, compared to infants fed commercial formula, breastfed infants have fewer incidents of respiratory tract infections, ear infections, GI tract infections, necrotizing enterocolitis, sudden infant death syndrome, infant mortality, allergic disease, celiac disease, obesity, diabetes, childhood leukemia, and lymphoma (Breastfeeding and Maternal and Infant Health Outcomes, 2007).

For the mothers, improved health outcomes include less postpartum blood loss, less postpartum depression, and greater postpartum weight loss (American College of Obstetricians and Gynecologists [ACOG], 2013). Breastfeeding is also protective against later development of breast and ovarian cancer, cardiovascular disease, diabetes, and other conditions (ACOG, 2013). Psychological benefits include improved bonding between mother and child, which is particularly important when the mother is incarcerated (ACOG, 2013).

Whether or not they are breastfeeding, postpartum women may experience several breast-related medical issues that correctional health staff must be prepared to address. For instance, pain from breast engorgement, blocked milk ducts, and mastitis may require frequent breast milk expression as part of medical care.

There are very few contraindications to breastfeeding. Breastfeeding is safe for women with hepatitis C and is encouraged for women who are taking methadone or buprenorphine as there are benefits to their infants. However, breastfeeding is not recommended for HIV-positive women (American Academy of Pediatrics, 2013). Most common medications are safe with breastfeeding, although women should consult with their providers. While smoking is not a contraindication to breastfeeding, it can reduce a mother’s milk supply. In addition, exposure to tobacco smoke is harmful to children.

Proper nutrition is essential for breastfeeding mothers. They should receive a well-balanced diet with additional calories, calcium, vitamin D supplementation, prenatal vitamins, no more than three cups of caffeinated beverage per day, and increased fluid intake.

Facilitating Breastfeeding in Custody
Correctional facilities can enable postpartum women to provide breast milk for their infants in numerous ways, all of which require collaboration among medical and custody staff, and, in some cases, social services. One way is to allow women to have contact visits with their newborns as often as possible and with appropriate privacy so that they can directly breastfeed them. Skin-to-skin contact is an important factor in breast milk supply and also is psychologically important to maintain bonding and commitment to breastfeeding. Some prisons and jails have special nursery programs where newborns reside with their mothers, enabling full breastfeeding. Some facilities create systems

continued on page 6
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Psychiatrists, LaTreese Phillips at (916) 691-4818 or LaTreese.Phillips@cdcr.ca.gov.
Psychiatric Nurse Practitioners, Nurse Practitioners, and Physician Assistants, Jeana Sosa at (916) 691-1965 or Jeana.Sosa@cdcr.ca.gov.
Physicians, Danny Richardson at (916) 691-3155 or Danny.Richardson@cdcr.ca.gov.
so women can pump and store breast milk that can later be delivered to the infant. If it is not possible to store the breast milk, lactating women should be allowed to pump breast milk so that they can maintain their milk supply for when they are reunited with their infants. This is especially important in short-stay facilities.

To enable pumping and storage of breast milk, facilities need to acquire the appropriate equipment, allow women to pump frequently in a private and clean space, devise protocols for appropriate handling and storage of milk, and coordinate transfer of breast milk to infant caregivers. If a woman is released and has milk in storage, it should be provided to her upon release. Because breast milk supply is highly sensitive to the frequency of expressing breast milk, women should be able to pump or nurse at least every 4 hours.

**Position Statement**

Wherever possible and not precluded by security concerns, correctional facilities that house pregnant and postpartum women should devise systems to enable postpartum women to express breast milk for their babies and to breastfeed them directly.

The following practices are ways to support this objective:

1. Screen women on entry to determine if they are postpartum and breastfeeding.
2. Counsel pregnant women on the benefits and nutritional needs of breastfeeding and inform them of the systems and supports in place at the facility.
3. Provide breastfeeding women a special diet with appropriate caloric, fluid, and calcium intake, and a prenatal vitamin and vitamin D supplementation.
4. Allow immediately postpartum women to breastfeed their babies and have lactation support services from the hospital.
5. Support visiting arrangements that allow direct contact between infants and mothers.
6. Provide accommodations to express breast milk, since regular breastfeeding on infant demand is rarely feasible for women in custody. Accommodations may include providing a manual or electric breast pump and storage bags, a private place to pump on a frequent basis, a freezer, and a system for proper storage of the breast milk and, when possible, transfer to the infant.
7. Establish nursery programs or alternative programs for postpartum women that will allow the infants to stay with their mothers, making breastfeeding much easier.
8. Develop an arrangement for lactation specialist services to provide support to women who need it.

Adopted by the National Commission on Correctional Health Care Board of Directors, November 5, 2017

For references, please see the statement online at www.ncchc.org/position-statements.
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Missed Diagnosis of Meningitis: Not Deliberate Indifference

by Fred Cohen, LL.M.

Dang v. Sheriff, Seminole Co. Fla. (11th Cir. 2017), ultimately endorses the lower court, finding that jail staff was not deliberately indifferent in failing to diagnose, and thus properly treat, detainee Dang’s meningitis. Dang claims that his rough treatment during his arrest caused his meningitis and the failure to diagnose his condition led to multiple strokes and permanent injuries.

Meningitis is an inflammation of the lining of the brain and spinal cord. When it is suspected, a doctor will invariably do a lumbar puncture to collect spinal fluid and check for bacteria and viruses. In the reported decision, no such procedure was done with Mr. Dang.

When Dang experienced headaches and neck pain, he started taking large doses of Aleve. When he was taken to the ER weeks after initial confinement, he declined recommended testing for meningitis, although the court’s opinion does not view that as significant in its overall endorsement of summary judgment for the defendants.

The decision, indeed, should be classified as “failure to diagnose.”

What Transpired

On Jan. 29 (he was arrested December 22), Dang was seen by Sandra Wilt, LPN, pursuant to a “nurse sick call.” Dang advised Wilt that he was experiencing “moderate to severe head and neck pains,” possibly a “pinched nerve” and a “stiff neck.” After checking Dang’s eyes and the range of motion of his neck, Wilt observed that he had minimal pain. Wilt ordered Motrin and a muscle rub and put in an order for Dang to be seen by a doctor to get a prescription for Robaxin, a muscle relaxant.

Dang saw Dr. Ogunsanwo, MD, on Feb. 1. Dang stated he was experiencing headaches, neck pain and neck stiffness. He told the doctor about the incident with the City County Investigative Bureau when he was allegedly “yanked out” of the car and “slammed on the ground.” After performing a physical exam, Ogunsanwo noted that Dang had full range of motion in his cervical spine with mild pain elicited, normal gait and no neurological deficit. His temperature was 98.9. Ogunsanwo continued Dang on the Motrin and muscle rub and prescribed Robaxin.

On Feb. 7, Brenda Preston-Mayle, RN, evaluated Dang and completed a history and physical health evaluation. Dang informed her about the incident with the CCIB and that he had been experiencing head and neck pain. He also described vision and hearing problems. Preston-Mayle took his vitals and noted a temperature of 98.9. His weight was recorded as 132, eight pounds less than his intake weight. Preston-Mayle offered to have Dang see a dental, mental health or medical doctor, but he declined.

On Feb. 9, Alecia Scott, LPN, saw Dang, who stated he had a headache and that “no one was doing anything for him.” Scott assessed Dang and checked his vitals. She recorded that he had full range of motion to his neck with no swelling or redness. He was ambulatory and did not appear to be in distress. However, he had a fever of 101.5. Scott provided Dang with his Motrin and Robaxin, advised him to drink plenty of fluids and observed him for 15 to 20 minutes before releasing him to his pod.

Shortly after Dang left the medical unit, Scott went to the hallway and saw him on the floor against the wall. An officer told Scott that Dang had “snatched away and slid down on the wall and sat on the floor.” He did not respond verbally to the officer’s request that he “get up.” Scott found Dang’s behavior “bizarre” and told him that if he continued to behave that way, he would end up on suicide prevention. Dang got up and walked away. Scott later directed him to mental health segregation for observation and directed that his blood pressure be monitored for five days. Later that night, Scott checked on Dang and noted his temperature was down to 97.9. His behavior and appearance were normal and he noticed no problems.

On Feb. 20, Sharyle Roberts, LPN, was notified of a “code orange” medical emergency regarding Dang. Roberts documented that his pupils were equal and reactive to light, his blood pressure was 136/85 and he had a temperature of 99. Roberts noted that Dang appeared to be passed out.
was drooling and exhibited fluttering eye syndrome. She believed the behavior was voluntary because Dang wiped the drool from his mouth and when the room was quiet, he "would open his eyes, look around, and then close his eyes again." Roberts heard from Scott that Dang had engaged in similar behavior two weeks prior. Roberts admitted him to the infirmary and referred him to both medical and mental health doctors.

On Feb. 21, Valerie Westhead, MD, a psychiatrist, conducted a mental status examination of Dang. He had a headache and a drop in blood pressure and felt odd, but denied hallucinations, delusions or mood complaints. Westhead concluded that Dang had an idiosyncratic reaction to the muscle relaxants but no psychiatric issues. Westhead cleared him psychiatrically.

On Feb. 22, Martha Densmore, RN, saw Dang during her morning rounds. He was rocking back and forth in his hard plastic "boat" bed, but Densmore was able to check his vitals and determined they were normal. Densmore testified that he was alert and oriented, and voiced no complaints.

The next morning, Dang informed Densmore of his two-week headache. After observing that Dang had white patches on his tongue and a 99-degree temperature and was unsteady when he attempted to stand, Densmore requested that Dr. Ogunsanwo see Dang. A few hours later, Densmore observed Dang with his head in the toilet trying to spit. He was incontinent and very weak. Densmore asked Ogunsanwo to see him right away. Ogunsanwo examined Dang and suspected he could have meningitis. Ogunsanwo directed that Dang be transported to the ER, where he was diagnosed with meningitis several days later.

The district court found no constitutional violation by any of the health care providers and no supervisory liability against the sheriff. Assuming a “serious condition” existed, there was no deliberate indifference to Dang’s needs, as the court put it. By “needs” the court appears to mean treatment vis-a-vis diagnosis.

Immunity

It is qualified immunity that ends up protecting the health care providers. They are found to have been operating within the scope of their discretion and plaintiff has not shown the clear deprivation of a constitutional right. Again, that required deliberate indifference in the care provided or in the failure to provide care.

Dang alleges that each health care provider was aware of his “symptoms consistent with meningitis” and “knew that meningitis was a serious and life-threatening condition that warrants immediate medical treatment.” Nonetheless, Dang claims that each provider “ignored clear signs and symptoms of Dang’s serious medical needs and life-threatening condition which prevented Dang from timely getting the critical medical care he required . . .”

A review of each of the named defendant’s actions was undertaken and in each case—even Nurse Wilt’s failure to take “vitals”—there is no deliberate indifference. Indeed, the court equates deliberate indifference with being so “incompetent or inadequate as to shock the conscience.”

Significant risks that are not perceived, finds the court, do not equate with deliberate indifference.

Summary judgment upheld.

Comment

Plaintiff argued that Kingsley v. Hendrickson (2015) now applies to medical care and excessive force used on detainees. Kingsley decided that a pretrial detainee need prove only that the use of force by law enforcement was excessive according to an objective reasonableness test. Previously, the detainee also had to show that the officer’s state of mind was to inflict punishment. (See Jailer’s Duty to Protect Municipal Liability and Impact of Kingsley Revamped, Correctional Law Reporter, April/May 2017.) Whether or not detainees will now have an easier time in assessing deliberate indifference as to medical care is not clear.

The present court simply finds “we are not persuaded” that Kingsley extends as argued. If deliberate indifference is modified for medical care provided to pretrial detainees, there would be an avalanche of rulings favoring the detainee.

Fred Cohen, LLM, is editor of the Correctional Law Reporter. This article is reprinted from CLR in slightly abridged form with permission of the publisher. All rights reserved.

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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 post marketing period, additional cases of injection site reactions 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 customized 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 proper 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 naltrexone 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 naltrexone 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 recognized as a manifestation of opioid withdrawal, 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 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 attempt) were reported by 5% of opioid-dependent patients treated with VIVITROL. Approximately 700 patients have been treated for 6 months or more, and more than 400 for 1 year or longer. In the 24-week, placebo-controlled pivotal trial in 624 alcohol-dependent patients, 6% of patients treated with VIVITROL experienced suicidal ideation, suicide attempt, or suicidal behavior (0.4% of patients treated with placebo). In some cases, the suicidal thoughts or ideation, suicide attempt) were reported by 5% of opioid-dependent patients treated with VIVITROL. Approximately 700 patients have been treated for 6 months or more, and more than 400 for 1 year or longer. In the 24-week, placebo-controlled pivotal trial in 624 alcohol-dependent patients, 6% of patients treated with VIVITROL experienced suicidal ideation, suicide attempt, or suicidal behavior (0.4% of patients treated with placebo).

Renal Impairment: Because naltrexone and its primary metabolite are excreted primarily in the urine, the elimination of naltrexone is decreased in patients with renal impairment. The effects of naltrexone and its active metabolite have been studied in patients with renal impairment (creatinine clearance ≤30 mL/min). The elimination of naltrexone is decreased in these patients. The plasma concentration of naltrexone and its active metabolite is increased in patients with renal impairment. The free fraction of naltrexone and its active metabolite is increased in patients with renal impairment. The plasma concentration of naltrexone is increased in patients with renal impairment. The pharmacokinetics of VIVITROL do not change significantly in patients with mild renal impairment (creatinine clearance 31–50 mL/min). When Reversal of VIVITROL Blockade Is Required for Pain Management: In an emergency situation in patients receiving VIVITROL, suggestions for pain management and sedation include the use of naltrexone and other opioid antagonists. When Reversal of VIVITROL Blockade Is Required for Sedation: In an emergency situation in patients receiving VIVITROL, suggestions for sedation and anxiolysis include the use of naltrexone and other opioid antagonists. In patients with 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 recognized as a manifestation of opioid withdrawal, 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 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 attempt, 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, 38% as compared to 5% of patients treated with placebo injections. 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 with VIVITROL.
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 anesthetics 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 thrombocytopathy 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, 5% of alcohol-dependent patients treated with VIVITROL discontinued 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.
One of the most commonly requested topics on a recent survey of nursing education needs was detection of malingering among inmate-patients (the survey results were reported in the Summer 2017 issue of CorrectCare, page 20). The nurses making these requests are concerned that many inmate-patients fake illnesses and exaggerate symptoms.

There are good reasons for them to be concerned. For example, malingering behavior can pose threats to the security of the facility—transports to outside facilities can result in escapes or hostage situations, and medication diversion can result in morbidity and mortality due to drug side effects or suicide.

Nevertheless, malingering is one of the most loaded and controversial terms in any health care setting. The mere suspicion that a patient is malingering instantly turns the nurse–patient relationship into an adversarial one as the nurse tries to gain an upper hand in the interaction and to “prove” that the patient is faking the symptoms. As well, the consequences of wrongly concluding that the patient is malingering can be catastrophic.

Defining the Problem
Before approaching a patient suspected of malingering, the nurse needs to be clear about what constitutes malingering behavior. Generally, malingering has been defined as intentionally faking illness for some practical purpose, such as avoiding work, seeking compensation or obtaining drugs. In his correctional health care blog, Jail Medicine, Jeffrey Keller, MD, CCHP-P, reported that three criteria must be established to satisfy the definition of malingering:

• The patient must be pretending to have an illness or injury
• The patient must be doing this deliberately; it must be planned in advance
• The patient must have the goal of obtaining something significant through the deception

Dr. Keller and other experts also note that possible malingering must be differentiated from factitious disorders (faking an illness for attention or amusement), exaggerating real symptoms and hypochondriasis, all of which have emotional bases.

There are no completely foolproof ways, techniques or tricks to screen for or determine malingering. The literature on this topic repeatedly cautions that both overidentification and underidentification of malingering are possible, even when multiple screening methods are used. A number of studies have described the use of certain psychological tests—the Structured Interview of Reported Symptoms and the Minnesota Multiphasic Personality Inventory are two—but to administer these tests requires time and resources, both of which are often in short supply in many correctional facilities. Additionally, these tests have been used primarily in cases of suspected mental health malingering and, even then, show great variability in accuracy.
Implications
As already noted, expressing any suspicion that a patient is malingering has huge implications that will redefine the nurse—patient relationship. From the very moment that the suspicion of malingering enters the picture, the nurse—patient relationship becomes adversarial and confrontation al. Far from reducing the amount of time spent with such patients, the time spent will increase exponentially—from a time management standpoint, accusing a patient of malingering can be very time consuming. These patients will increase the number of their complaints, argue endlessly, file repeated grievances, and threaten and carry out legal actions, all in an effort to “prove” that they are as sick and in need of medical care as they say they are.

The other potential reality—what if you are wrong?

Case Study
PJ was a “frequent flyer” at the county jail; often arrested drunk and disorderly, he thought it was amusing to play games with the jail staff by complaining of chest pain. He was repeatedly sent to the local hospital, only to be returned when the emergency staff found no physical basis for his complaints.

One evening, nurse KG was assigned to cover intake assessments and emergency calls and, once again, she received a call from security saying that PJ was complaining of chest pain. There were many inmates in booking that night, so KG told the security staff that she would see PJ after she finished them. Within an hour, security called KG again, saying that PJ was now unresponsive and not breathing. PJ was sent to the local emergency department, but attempts to revive him were not successful.

The outcomes of this situation were that KG was terminated, the inmate’s family brought a lawsuit against her and the county jail and they reported KG to the state board of nursing, which conducted an investigation of her actions.

Legal Considerations
The first factor that nurses need to consider is that there is no nursing diagnosis for malingering. Malingering is a medical and mental health diagnosis and must be determined by an advanced provider such as a physician, a mental health clinician or an advanced practice nurse. Simply put, determination of malingering is not within the nurse’s scope of practice.

As can be seen in our case study, even inmates who frequently “cry wolf” may eventually have real symptoms and the consequences of ignoring them can be catastrophic. Far from considering an inmate’s many false complaints a mitigating factor, most judges, juries and boards of nursing will judge the nurse’s actions on that one event.

Nursing Role
Even though nurses may not diagnose malingering, nursing does have a role. So, what is that role? Easy, it’s the same role that nurses have in all medical conditions. Nurses assess, report and/or document their findings and carry out the directions of the advanced provider.

Assessment
Nurses assess patients who they believe may be malingering the same way that they assess patients who they believe may have any illness or injury. That includes approaching the patient with an open mind to avoid making a judgment error. The most expert nurses generate several possible problems when assessing patients. These problems should range from a best case scenario (the patient has no health problem or the problem is minor) to a worst case scenario (the patient has a very severe, potentially lethal health problem). The nurse then proceeds to gather information to narrow down the problem list.

Assessment always starts with a careful and methodical subjective assessment. Nurses start with a history of present illness—how long the problem has been present, description of symptoms, measures that have made it better or worse. Using the information gained during the subjective assessment, the nurse proceeds with a careful objective assessment, using the subjective information to guide the physical examination. The assessment must be very thorough, including all possible causes of the patient’s complaints. The next logical step is to refer the patient to an advanced provider, ensuring that all relevant information is carefully and clearly documented.

Diagnosis
Even advanced providers need to be very cautious about deciding that a patient is malingering. One correctional physician, Scott Savage, DO, asserted that malingering must always be considered a diagnosis of exclusion—literally every other possible cause of the patient’s symptoms must be ruled out before deciding that the patient is malingering (personal communication, 2007).

Even when a physician determines that a patient is malingering in a given situation, nurses and other medical staff need to keep their minds open any time the patient returns with complaints to avoid liability should the patient subsequently become ill.

Documentation
When malingering is suspected, the need for meticulous documentation is crucial. All information gathered must be documented in the patient record. Nursing documentation should describe in detail the subjective complaints that the patient makes and physical signs noted during the exam— for instance, “S – the patient complains of severe foot pain with slight pressure, O – patient is able to walk heel-to-toe for 15 feet without noticeable difficulty.” Documentation should also include the nurse’s actions, which should include referral to an advanced provider.

As nurses may not determine that a patient is malingering, no mention of malingering can be entered into the nursing notes. Likewise, nursing documentation should not contain references to “faking,” “feigning,” “exaggerating” or other synonyms of malingering.

continued on page 24
It is important that all staff have confidence in their abilities to handle a medical emergency. Confidence follows competence. At the Wisconsin Resource Center, we created a Code Blue Committee to establish baseline knowledge for staff and provide further education and practice drills to assist in competency. A related goal was to enhance teamwork and encourage self-efficacy.

Before the committee’s first meeting, we developed a survey with questions about the medical emergency response at WRC. This survey was sent to all care and treatment staff. Nursing staff were very critical of their efforts. Almost all of the care and treatment staff agreed that practice drills would improve the handling of medical emergency responses.

**Developing the Drills**

At the committee’s first meeting, we set expectations and developed a plan for monthly drills. One topic was selected for each month of the year. It was decided that the nurses on the committee would work in pairs and focus on a topic. We felt that it was important for the nurses to choose their own topics to build engagement with the committee and the sustainability for this effort.

Drills have been conducted on chest pain, the Prison Rape Elimination Act, heat-related injury, overdose/naloxone and an escape attempt that resulted in a sucking chest wound, electrocution and multiple fractures.

The nurses worked together to develop the pretest, posttest and drill for each topic. They also collected educational materials to share with staff. In the first week of each month, a pretest is sent to staff. Educational material is sent to staff in the second week. The drill is conducted in the third week. The posttest is sent to staff in the fourth week.

We had the ability to send the educational material to only nurses or to all staff. This material was shared by email through an email address and inbox created for this committee. We also posted the educational information on the inmate housing units.

The nurses running the drills are in training status for the day and off coverage. This gives them time to complete the drill, the write-up and the debriefing and to check the emergency equipment. They also grade the tests. Anyone who scores below 85% on the posttest is given more educational material.

The committee meets monthly to review the most recent drill. There’s also a presentation on the topic. For example, in June 2017, we conducted a chest pain drill. The scenario included the death of the inmate, prompting staff to run through the facility’s death protocol. At the following committee meeting, the local medical examiner’s office gave a presentation.

**A Multidisciplinary Effort**

Nursing staff working with custody staff is important. Currently, the committee includes 15 nurses, one nursing supervisor, two doctors, one captain, one correctional ser-

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**About the Wisconsin Resource Center**

**Mission Statement:** The Wisconsin Resource Center engages and treats individuals with severe and persistent mental health needs in a secure setting to enhance public safety, promote healing and support personal recovery.

Opened in 1983 and based in Winnebago, WRC treats state prison inmates in need of specialized mental health services. These services are focused on safety and wellness and the inmate-patient’s potential to live a full, rewarding life during incarceration and in the community upon release. WRC serves males. The attached Wisconsin Women’s Resource Center serves females.

The housing units at WRC/WWRC are divided into five service areas: psychiatric services, medium-security services, maximum-security services, alcohol and other drug abuse and release services, high management services and women’s services. Each service area shares a common mission. Treatment is coordinated to meet the needs of the inmates within the service area. Units typically house 18 to 30 inmates in the men’s units and 8 to 20 in the women’s units. The approximate daily total is 375 inmates.

WRC is accredited by the National Commission on Correctional Health Care. It is managed by the Wisconsin Department of Health Services in partnership with the Department of Corrections.
Managing Opioid-Dependent Patients: What Are the Options?

**by Kevin Fiscella, MD, MPH, Brent Gibson, MD, MPH, CCHP-A, and Tracey Titus, RN, CCHP-RN**

Each day, people addicted to drugs and/or alcohol are admitted to detention centers and jails across the country. These individuals may enter the system intoxicated, and symptoms of withdrawal may appear hours or even days after admission. This poses a challenge for correctional health staff who must obtain a history from the patient and assess current symptoms so that treatment for potential overdose or for ensuring safe withdrawal may be initiated.

NCCHC standard G-07 Intoxication and Withdrawal requires that protocols exist for managing inmates under the influence of alcohol or other drugs and those undergoing withdrawal from alcohol, sedatives or opioids. The protocols must be approved by the responsible physician and be consistent with nationally accepted treatment guidelines.

One significant issue of concern is the many people who enter the correctional system dependent on opioids. In many correctional systems, staff members are unsure of the most appropriate—and legal—method to ensure that these patients do not experience withdrawal symptoms.

While practices and perspectives vary on which patients should undergo medically supervised withdrawal, it certainly is appropriate to ensure that no patients are compelled to withdraw from opioids cold turkey. For many facilities, the treatment team’s objective when treating an opioid-dependent inmate is to prevent withdrawal symptoms and the associated serious medical consequences. For inmates currently enrolled in a community opioid treatment program, every effort should be made to continue treatment. Doing so increases reengagement in treatment following release and reduces the risk for overdose and death in the week or two after release.

In addition, the consensus among experts is that pregnant women should never go through withdrawal because of the risks to the fetus. Standard G-07 requires that if a pregnant inmate is admitted with opioid dependence or on treatment (including methadone and buprenorphine), a qualified clinician is contacted so that the opioid dependence can be assessed and appropriately treated.

**Management and Treatment Options**

U.S. Drug Enforcement Administration regulations prohibit the use of any opioid to treat withdrawal symptoms in the absence of an appropriate license (such as an OTP facility license or an “X” license for buprenorphine). Accordingly, options for correctional facilities are as follows.

**Bridging**

One legal option is for a DEA-licensed prescriber to provide narcotic medication of any schedule for up to 72 hours to alleviate withdrawal symptoms. This is known as the DEA’s three-day rule. It typically involves use of methadone (a Schedule II medication) or buprenorphine (a Schedule III medication), which are approved by the U.S. Food and Drug Administration to alleviate the symptoms of opioid withdrawal. Note that the three-day rule requires administering/dispensing (not prescribing) the drug daily for a maximum of three days. It can be useful during transitions, transfers and weekends, or serve as a bridge until the patient can be enrolled in a local opioid treatment program. It should not be used for medication-assisted withdrawal or rapid detox.

Common pain medications, such as Tylenol #3, are often used for purposes of bridging. However, experts strongly discourage this practice and say that these medications are an inappropriate choice for decreasing withdrawal symptoms.

**Adjunctive Treatment**

When the correctional facility’s health care clinic is licensed by the state and federal government as a “hospital/clinic,” methadone and buprenorphine can be used an adjunct to treating another condition, such as pregnancy, infection or AIDS. However, only a handful of health care facilities within corrections are so licensed.

**Buprenorphine Waivers**

Another option is for the prescriber to obtain a Drug Addiction Treatment Act (DATA) 2000 waiver license. This “X” license allows for prescribing of buprenorphine for medication-assisted withdrawal or for treatment. The license is available to physicians, nurse practitioners and physician assistants with verified specific medical training and experience who have also received specialized training approved by the Substance Abuse and Mental Health Services Administration.

**OTP Facility License**

Outside of the three-day rule or the adjunct exception, methadone or buprenorphine (to treat addiction or for medication-assisted treatment) can be used by facilities that operate licensed opioid treatment programs. NCCHC accredits OTPs in corrections, which enables facilities to obtain a license through SAMHSA. This option provides facilities with the greatest flexibility.

**Coordination With Community OTPs**

There are various options for methadone (or buprenorphine) dosing under the auspices of a community-based OTP. This requires that the inmate be registered in the program. There also must be a means for dispensing the methadone, such as the OTP establishing a satellite dispensing facility (i.e., co-location) or simply transferring the custody of a supply of methadone (with full accounting). In this case, methadone is administered by correctional health care staff under the license of the community OTP.

One challenge is the security needed to transfer the doses. Another challenge is payment: OTPs cannot bill Medicaid for methadone maintenance when a person is incarcerated, so the correctional facility is responsible for payment.

[continued on page 18]
Inmate Transport for Treatment

The correctional facility could transport the inmate to the community-based OTP daily for treatment. As noted above, Medicaid cannot be billed for an incarcerated person. The only exception is if the inmate is hospitalized outside of the correctional facility for at least 24 hours and requires treatment of opioid dependence as an adjunct to the primary condition. In this case, the hospital could bill Medicaid (assuming inmate eligibility) for hospital care.

Deciding on an Approach

Given the time frames, how should most jails and prisons proceed? The following steps are based on estimates of how long each step will take to implement.

1. Make arrangements with local OTPs, whether for coordination and transport of doses or transport of inmates
2. Ensure that their clinicians—i.e., physicians, nurse practitioners and physician assistants—obtain waivers for buprenorphine
3. Obtain an OTP license

Whatever specific approach to treating this important problem is taken, prescribers should also review the NCCHC position statement on Substance Use Disorder Treatment for Adults and Adolescents as well as consult SAMHSA and the DEA websites for additional information.

Standard G-07’s compliance indicators also require that

Correctional Health Care’s Response to the Opioid Crisis

by Susan Laffan, RN, CCHP-RN, CCHP-A

In October, the White House declared that “Drug addiction and opioids are ravaging America: Hundreds of thousands of Americans have lost their lives to drug abuse, and it will only get worse unless action is taken.” The statement noted that in 2016, more than 2 million Americans had an addiction to prescription or illicit opioids, and that in the past year more than 11.5 million Americans aged 12 and older reported misuse of prescription opioids and nearly 950,000 Americans reported heroin use.

Intervention must be accomplished in many arenas, including correctional facilities. It is also well-documented that opioid use disorders are highly prevalent among those serving time in correctional facilities.

According to the World Health Organization’s Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, “Prisoners should not be denied adequate health care because of their imprisonment... Opioid withdrawal, agonist maintenance and naltrexone treatment should all be available in prison settings...”

Resources for the Field

NCCHC has been on top of this issue and offers a variety of resources for the field. Foremost, its Standards for Opioid Treatment Programs in Correctional Facilities provide valuable guidance on steps necessary to establish and maintain an OTP. In addition, a position statement titled Substance Use Disorder Treatment for Adults and Adolescents addresses screening, evaluation, evidence-based treatment and prerelease coordination of care. NCCHC also provided education at its National Conference held in Chicago in November 2017, including the following sessions:

- Opioid Treatment Programs in Corrections: The Why, the What and the How: This preconference session emphasized that substance use disorders are treatable medical conditions, described medication-assisted treatment and outlined the benefits and requirements of obtaining OTP accreditation by NCCHC.
- Treatment Guidelines for Opioid Addiction in Pregnancy: Given the importance of appropriate treatment for pregnant women, the speakers reviewed clinical guidelines for methadone and buprenorphine and the federal requirements to obtain the necessary licenses.
- Medication-Assisted Treatment for Opioid Use Disorder for Individuals Leaving Jail or Prison: Topics included medication-assisted treatment programs, assessing the effects of MAT when initiated in a correctional facility and the challenges and solutions to providing MAT in corrections.
- Heroin Use in America: Update for Nursing Care in Correctional Facilities presented statistics on the heroin epidemic, the etiology of heroin addiction and nursing assessments and treatment for heroin withdrawal and overdose. The last two of these talks are available at NCCHC’s Live Learning Center at http://ncchc.sclivelearningcenter.com.

Kevin Fiscella, MD, MPH, is dean’s professor, Family Medicine and professor, Public Health Sciences and Community Health at the University of Rochester (NY) Medical Center. Brent Gibson, MD, MPH, CCHP-P, is NCCHC’s chief health officer. Tracey Titus, RN, CCHP-RN, is NCCHC’s vice president of accreditation.

Find NCCHC’s position statements at www.ncchc.org/position-statements.

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Medication Misuse: Which Drugs Are at Risk? What Are the Inmate Risk Factors?

Substance use disorders are common among incarcerated individuals, and prescribed medications are sometimes abused, diverted or otherwise misused in correctional settings. But the specific drugs in question are not always the “usual suspects.”

As reported in the October issue of the *Journal of Correctional Health Care*, Anthony Tamburello, MD, and colleagues sought to identify the prescribed medications at great risk of misuse at the New Jersey Department of Corrections, with the hypothesis being that these would be medications with sedating properties (such as quetiapine) or stimulating properties (such as bupropion). In this study, “misuse” is a broad term that include all use of a medication outside of that intended by the prescriber.

A second objective was to determine inmate-specific risk factors for abuse or diversion, with the researchers hypothesizing that these inmates would have higher rates of substance use disorders, malingering and antisocial personality disorder (related to deception); would, on average, be prescribed more medications than other inmates (“med seeking”); and with regard to psychotropic medications, would have higher rates of mental health disorders and psychiatric treatment.

**Gabapentin Tops the List**

The study method was retrospective chart review of electronic medical records and reports on institutional charges for misuse of authorized medication by male and female adult inmates between 2003 and 2013. The cases were selected by random sample, with the final sample being 287 (82% men, 12% women).

Overall, the misused medication was identified in 205 of the cases, of which 46 cited more than one medication. Most frequently cited were gabapentin (14%), diphenhydramine (8%), clonidine (6%) and ibuprofen (6%). A post-hoc analysis found no statistically significant correlations between how often prescribers order a particular medication in NJ DOC and citations for its misuse.

In 67% of cases, the cited medication was found to be prescribed to the inmate, whereas in 14% of cases, the cited medication was clearly not prescribed to the inmate. In the remaining cases, the intended recipient could not be determined.

When compared with the entire current inmate population, the cases cited for misuse of authorized medication were more likely to:

- Have a history of a substance use disorder diagnosis, 62%
- Be in treatment for a mental illness (i.e., be on the mental health special needs roster), 44%
- Have a diagnosis of antisocial personality disorder, 39%
- Have any history of malingering, 16%

The most common primary, active psychiatric diagnosis was none (42%), followed by antisocial personality disorder (9%), major depressive disorder (9%), adjustment disorder (7%), personality disorder not otherwise specified (6%), dysthmic disorder (4%), bipolar disorder (4%), schizoaffective disorder (4%), depressive disorder not otherwise specified (3%) and panic disorder (2%).

At least one medication was prescribed to 96% of those charged with misuse of authorized medications, with the average number of medications being 5.2. In comparison, 43% of the total inmate population were prescribed at least one medication, with the average number being 3.8. At least one psychiatric medication or another medication with psychoactive properties was being prescribed to 80.8% of the subjects at the time of the infraction.

The authors note that the medications most frequently cited for misuse were more often those prescribed by non-psychiatrists (i.e., medications with a primary indication of pain). They advise that caution should be taken to manage this risk, such as improving supervision (such as via DOT) of these medications.

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**JCHC Vol. 23, Issue 4: October 2017**

- Preventing Suicide in Forensic Settings: Assessment and Intervention for Inmates With Serious Mental Illness — *Georgia M. Winters, MA*; *Emily Greene-Colozzi, MA*; *Elizabeth L. Jeglic, PhD*

- Assessing the Mental Health, Substance Abuse, Cognitive Functioning, and Social/Emotional Well-Being Needs of Aboriginal Prisoners in Australia — *James R. P. Ogloff, JD, PhD*; *Jeffrey E. Pfeifer, PhD*; *Stephane M. Shepherd, PhD*; *Joseph Ciocciari, PhD*

- Continuum of Care for Inmates Taking Psychiatric Medications While Incarcerated in Minnesota County Jails — *Britney Rohrer, PharmD*; *Timothy P. Stratton, PhD*; *BCPS, FAPhA*

- Public Health and Vulnerable Populations: Morbidity and Mortality Among People Ever Incarcerated in New York City Jails, 2001 to 2005 — *Amber Levanon Seligson, PhD*; *Farah M. Parvez, MD*; *MPH*; *Sungwoo Lim, DrPH, MS*; *Tejinder Singh, PhD*; *Maushumi Mavinkurve, MPH*; *Tiffany G. Harris, PhD*; *Bonnie D. Kerkar, PhD, MPH*

- Correctional Officers and Workplace Adversity: Identifying Interpersonal, Cognitive, and Behavioral Response Tendencies — *Justin S. Trounson, PhD*; *Jeffrey E. Pfeifer, PhD*

- Characteristics of Inmates Who Misuse Prescription Medication — *Anthony C. Tamburello, MD*; *Archana Kathpal, MD*; *Rusty Reeves, MD*

JCHC offers continuing education credit through an online self-study exam. Academy of Correctional Health Professionals members receive JCHC as a member benefit and CCHPs receive a complimentary online subscription.
2017 Award Winners Demonstrate Commitment and Achievement

NCCHC’s annual awards pay tribute to leaders and innovators that have enriched the correctional health care field. We applaud this year’s recipients of the most prestigious awards in this field. The awards were presented Nov. 6 during the opening ceremony of the National Conference on Correctional Health Care in Chicago.

**Bernard P. Harrison Award of Merit**

NCCHC’s highest honor, this award is presented to an individual or group that has demonstrated excellence and service that has advanced the correctional health care field, either through an individual project or a history of service. The award is named after NCCHC’s cofounder and first president.

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

For more than three decades, Margaret Collatt has demonstrated the unique combination of brains, heart and energy that make a great correctional nurse. As a caregiver, manager, educator, advocate and friend, she excels.

Ms. Collatt’s value was quickly recognized at the Oregon State Penitentiary, where in her first year of employment she was promoted from nurse manager to charge nurse to health services manager. In 1991 she accepted a position as a training specialist with the health services division of the Oregon Department of Corrections, a job she held for 25 years. In this position, she designed and implemented educational programs for health care professionals within the division.

In all her endeavors, Ms. Collatt consistently advocates for NCCHC’s Certified Correctional Health Professional program. She proctors two CCHP exams annually to make it as easy as possible for correctional health professionals from around Oregon to become certified. She has been a member of the CCHP board of trustees and chair of the CCHP-RN subcommittee. She is a CCHP-RN herself, as well as one of a handful of people to hold as CCHP-Advanced certification. She is a frequent volunteer at the CCHP booth at NCCHC conferences, where she puts people at ease with her warmth and sense of humor.

Ms. Collatt’s commitment to lifelong learning led her to pursue a bachelor of science degree in nursing from Oregon Health & Sciences University — and graduate with high honors — when she was in her 40s.

Her involvement with NCCHC through the years has been deep and multifaceted. Ms. Collatt has presented at virtually every NCCHC conference since 1996 on a variety of nursing, administrative and professional development topics. She’s been an NCCHC accreditation surveyor for nearly 20 years and she is a longtime member of the education committee as well as the nurse advisory council.

**Douglas A. Mack, MD, MPH**

Throughout his public health career, Doug Mack has worked to make the community a better, safer and healthier place for all citizens, including the most disenfranchised. For him, that included advocating for incarcerated people during and after their time behind bars.

Dr. Mack understood how intrinsically correctional health and public health are linked. He spent more than 30 years as a county director of public health, most of those with the Kent County Health Department in Grand Rapids, Michigan, where he was also chief medical examiner. He was so well-respected as a leader that the Kent County Medical Society named an award after him: the Douglas A. Mack Award for Community Collaboration, given to an outstanding individual working to make a difference in the health of the community.

Dr. Mack has also been uniquely committed to NCCHC. He joined the board of directors in 1987 and was a member for almost 30 years. He is the only person to have represented, in sequence, three different national organizations on the board: he has been the board liaison for the National Association of Counties, the National Association of County and City Health Officials and the American Association of Public Health Physicians. He also is the only person to have been selected by his peers to serve as NCCHC board chair not once but twice. He has served on many NCCHC committees, including years of service on the accreditation, education and finance committees.

In 1994, Dr. Mack was one of three NCCHC board members who met with David Satcher, then director of the Centers for Disease Control and Prevention, and convinced him that the CDC should be actively involved in correctional health care.

In addition to his work with the county and with NCCHC, Dr. Mack served on several HIV/AIDS advisory groups and too many committees, task forces and associations to count. He also was a clinical professor at Michigan State University. He is a mentor, friend and inspiration to many.
B. Jaye Anno Award of Excellence in Communication

This award pays tribute to innovative, well-executed communications that have had a positive impact on the field of correctional health care, or to individuals for bodies of work. The award is named after NCCHC’s cofounder and first vice president.

Kenneth L. Faiver, MPH, CCHP

Kenneth Faiver has been actively involved in correctional health care since 1975 and has shared his vast knowledge of the field through extensive writings over the years.

His most recent work is Humane Health Care for Prisoners: Ethical and Legal Challenges, published in May. The book examines how differing roles and objectives of corrections and correctional health care give rise to ethical issues and disagreement regarding appropriate care strategies, and how those differing perspectives can be reconciled.

Another important work is Health Care Management Issues in Corrections. Originally published in 1997, it is an essential reference manual that addresses practical issues related to the structure and delivery of health care services in jails, prisons and juvenile correctional facilities and detention centers.

Mr. Faiver has held several senior positions in the field, including director of health care for the Michigan Department of Corrections and chief medical coordinator for the Commonwealth of Puerto Rico Department of Health.

He has helped replace a substandard prison hospital with a licensed, accredited unit; developed standards for health care services at a county jail; developed plans for medical and mental health services for the Texas Department of Criminal Justice; and directed evaluation of prison health services and design of a new correctional health care system in Michigan.

R. Scott Chavez Facility of the Year

This award is presented to one facility selected from among nearly 500 jails, prisons and juvenile facilities accredited by NCCHC. It is named after NCCHC’s longtime vice president.

Douglas County Jail, Minden, Nevada

The Douglas County Jail epitomizes the little jail that could – with some help from NCCHC Standards and accreditation. The facility has been a strong supporter of the Standards since it was first accredited in 1980, and its administrators and staff have maintained a high level of health care services, even as the standards have evolved.

With a daily intake of eight, an average daily population of only 120 and very short lengths of stay, the jail does not have health staff on-site around the clock, making teamwork between health and detention staff vitally important. Here, the jail shines.

A contracted physician serves as the responsible health authority. He visits the facility at least monthly and is on call 24/7. Two part-time contract nurses visit four times a week; they also rotate on around-the-clock call. A psychologist visits several hours per week. The health services administrator works 40 hours per week and is on call 24/7. Finally, two “medical deputies” serve as health care liaisons.

“The enthusiasm of the medical and detention staff to work together is obvious,” according to the accreditation surveyor who nominated the jail. "It provides for smooth delivery of health care even when health staff is not on-site. This seamless cooperation makes this jail stand out.”

NCCHC Program of the Year Award

This award recognizes programs of excellence among thousands provided by accredited jails, prisons and juvenile facilities.

Westchester County Department of Correction, Valhalla, NY

Individuals with mental illness often have a difficult time in the transition from jail to the community. To improve the odds of success, the Westchester County Department of Correction in 2014 established its Community Oriented Re-Entry Program for males with mental illness.

CORE provides focused interventions through a collaboration with a variety of county and community partners. Immediate aims are to increase access to services, improve functioning, foster understanding between staff and inmates and reduce security-related incidents. Long-term goals are to contribute to positive reentry outcomes and reduce recidivism.

Patients reside in a dedicated, 44-bed housing unit that has a full-time program coordinator. Programming is offered daily and includes cognitive behavioral therapy, life skills, job readiness, community health and wellness, 12-step meetings and more. Individualized, weekly meetings focus on reentry services and a discharge plan that includes comprehensive community-based services.

Feedback has been positive, and data suggest that security-related incidents have declined greatly. This success has led to a similar program for adolescent males, and women now also receive the same services, with program expansion planned.
Newly Elected CCHP Trustee Credits Credential With Career Advancement

by Katie Przychodzen, MA

When Tara Taylor, MSML, BSN, CCHP, was offered a position as a staff nurse at a correctional facility, she decided to try it for three months. “That was 21 years ago,” she says.

What has kept her working in correctional health care over the years? “I love what I do” she says. For Taylor, managing patient care means that teamwork and problem-solving are necessary to address daily challenges, and this makes each day unique and exciting: “No two days are the same.”

Throughout her correctional nursing career, Taylor rose through the ranks from staff nurse at Tipton (MO) Correctional Center to her current role as regional director of nursing for Corizon Health’s Missouri Regional Office. As regional director, she supports nursing functions at 22 correctional facilities in the state of Missouri, serving more than 32,000 inmate-patients.

Her day-to-day functions include developing nursing policies and procedures, overseeing the continuous quality improvement program, staff onboarding, auditing, overseeing the clinical education department and other duties. Since the facilities that Taylor supports are NCCHC accredited, she also assists with preparation for reaccreditation. It is in this latter role that she became passionate about NCCHC standards as the benchmark for quality health care.

Prepared to Lead

In 2004, Taylor attended her first of many NCCHC conferences, and that’s where she learned about the Certified Correctional Health Professional program. She recalls that her supervisor was very supportive and encouraged her to pursue certification. Upon realizing her desire to take on a leadership role, she says that becoming a CCHP was the natural next step.

Taylor credits her CCHP status for helping advance her correctional nursing career: “The CCHP credential is essential for leaders in correctional health care and I believe it has shown those making decisions on advancement that I have the knowledge required to lead others in providing quality care.” She says the CCHP credential also reinforces correctional health care as a specialty by recognizing the knowledge necessary to ensure quality patient care in these unique settings.

As a leader in her field, Taylor says it is imperative that she set high expectations for her staff while giving them the support and resources they need to provide the best possible care. “This will lead to better clinical outcomes and healthier patients,” she says.

A Passion for Quality

Taylor is passionate about quality correctional health care in large part because she understands its impact on public health. Over the years, she has seen an increased focus on helping inmates prepare for successful reentry to the community and reducing recidivism. This focus has, in turn, brought corrections and health care staff closer together in their mission to further improve community health. She knows that many of her patients will eventually return to the community and thus makes every effort to send them back healthier than when they arrived. “It is an opportunity to help our patients and our communities be better,” Taylor says.

As the newest member of the CCHP board of trustees, Taylor wants to move the CCHP program forward by continuing to improve the certification process to reflect the evolving needs of correctional health professionals.

Katie Przychodzen, MA, is marketing and communications manager for NCCHC.

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For more information or to obtain an application, visit www.ncchc.org/cchp-rn. Or contact us at cchp@ncchc.org or 773-880-1460.
Smoking Cessation: A Better Way

Re: “Tobacco Cessation Groups in Community Corrections Can Help People Quit” in CorrectCare, Summer 2017

My purpose in writing is to draw attention to the Allen Carr smoking cessation protocol (www.allencarr.com). By way of disclosure, I have no relationship with the Allen Carr program and have never received any financial or other support from them. I have, however, personally known people (especially in Europe, where this protocol is popular) who have quit smoking and maintained abstinence over a number of years through use of their book and CDs.

I have also been impressed by the findings of the two published studies dealing with use of this protocol in occupational settings.
• Smoking Cessation at the Workplace: 1 Year Success of Short Seminars. International Archives of Occupational and Environmental Health, Jan. 2006, 79(1), pp. 42-48
• Long Term Success of Short Smoking Cessation Seminars Supported by Occupational Health Care. Addictive Behaviors, July 2007, 32(7), pp. 1486-1493

This program has not been endorsed by federal authorities because efficacy has not, to date, been verified with multiple independently funded randomized clinical trials.

The Carr approach is very different from the usual “quit or die” health education message. It defines the problem as “the urge to smoke” and uses a pop-psychology approach to prepare smokers to quit with no pharmaceuticals or alternate nicotine products.

For my initial exploration of this protocol, I picked up a used copy of the book and CDs for less than a dollar on Amazon.

I think this approach would work better in correctional settings than the usual anti-smoking health education programs, and likely result in much longer-term abstinence.

Joel L. Nitzkin, MD, MPH
Principal Consultant, JLN, MD Associates, LLC
Senior Fellow for Tobacco Policy, R Street Institute
New Orleans, LA

Malingering (continued from page 15)

Follow the Evidence

Experienced correctional nurses have probably already noticed that the nursing sick call process is similar to detective work—you look for clues as to the patient’s health status and gather as much information as needed to determine the root cause of the patient’s complaint. As many detectives will tell you, there are no shortcuts and you do not jump to conclusions; instead, you follow the evidence.

There are good reasons for nurses to be concerned about patient malingering. But, as the saying goes, “terms and conditions apply.” As malingering is a medical diagnosis, nurses must be careful to stay within their scope of practice and proceed carefully through the nursing process, conduct a thorough examination of every patient and document their findings meticulously. Ensure that patients who do have real symptoms (even though exaggerated) receive treatment appropriate for those symptoms. Finally, always maintain an open mind when such patients return to sick call with new complaints—they just might be real.

Sue Smith, MSN, RN, CCHP-RN, is a correctional nurse educator. She serves as lead nurse planner for NCCHC educational activities and directs the NCCHC Nursing Advisory Council. Contact her at nsuesmith48@yahoo.com.

Man Down (continued from page 16)

giant, one correctional officer, two psychiatric care supervisors and two psychiatric care technicians. The four psychiatric care personnel are custody staff on the inmate housing units who provide support to the inmates.

Two community members also have joined the committee. One is a registered nurse in the local hospital’s emergency department. She reports back to her facility on our crisis response plans and drill performance. This has been helpful in bridging the gap between the two facilities.

The other committee member is a first responder who works for the local fire department. He acts as a liaison with the area’s first responders, providing them with information about our crisis response plans and drill performance. Both community members also provide valuable insights on how to respond to medical emergencies.

Staff have responded positively to this effort. Work is under way to add a higher skill level to our emergency protocols. Next year, we plan to send another survey to all care and treatment staff with questions about the medical emergency response at WRC. We are hopeful that the committee’s efforts will lead to positive changes in the survey results. Until then, we will continue working together to make medical emergencies a better experience for the inmates and staff.

Ranee’ M. Wright, MSN, RN, CCHP-RN, is Nurse Clinician 2 with the Wisconsin Resource Center, Winnebago, WI.
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Department manager/supervisor 13%
Facility medical director or director of nursing 5%

Who Do Attendees Represent?
Jail facility 35%
Prison facility 22%
State DOC/agency 12%
Private corporation 10%
Juvenile detention or confinement facility 5%
Federal agency 3%

Categories Attendees Recommend or Buy
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• Dialysis services
• Education and training
• Electronic health records
• Health care management
• Health care staffing
• Infection control products
• Information technology
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ADVERTISER INDEX

California Correctional Health Care Services.............5
Centurion.................................................................7
Certified Correctional Health Professional – RN.....23
Corizon Health..........................................................6
Correctional Health Care Practice, Administration & Law...8
Delaware Department of Correction........................28
GEO Group...............................................................9
InFocus Lists............................................................26
Journal of Correctional Health Care.........................27
Medi-Dose/TampAlerT............................inside front cover
NCCHC.................................................................back cover
PowerDMS............................................................25
Vivitrol.................................................................10-13
Wexford Health Sources............................inside back cover
Expert Advice on NCCHC Standards

Dates for Compliance With 2018 Standards

Q I understand that the 2018 Standards for Health Services in jails and prisons will be released soon. My facility is due for a reaccreditation survey in 2018. Will we have to be in compliance with the new standards?

A The answer depends on when the facility is due for a survey. The anticipated release date for the 2018 Standards for Health Services is April 21. Facilities have approximately six months to transition to the new set of standards. While exceptions may be granted, a general guide is this: If your survey is scheduled for between January 1 to July 31, it will be surveyed under the 2014 Standards. Facilities scheduled for a survey in August, September or October will have the choice of being surveyed under the 2014 or 2018 standards. Beginning November 1, all surveys for jails and prisons will be conducted under the 2018 Standards. Depending on the date of application, facilities that are applying for initial accreditation in 2018 will likely be surveyed under the new set of standards.

Accredited Health Care Companies?

Q We would like to identify accredited correctional health care companies for reference purposes. Can NCCHC provide such a list?

A NCCHC does not accredit any kind of company (such as health care contractors, electronic health records vendors or pharmacies), states or agencies. Rather, NCCHC accredits individual correctional facilities for compliance with the relevant Standards for Health Services. The accreditation is awarded to the facility itself for its established system of health care delivery and demonstrated compliance with the requirements of the standards.

Quality Improvement Studies

Q Our question is about P-A-06 Continuous Quality Improvement Program and compliance indicator #4, “When the committee identifies a health care problem from its monitoring, a process and/or outcome quality improvement study is initiated and documented.” Please explain what is meant by the term “study” and what evidence is required to meet this indicator.

A A study is a process of reviewing an identified problem—either a facility problem or a patient clinical care problem—and setting thresholds, conducting a baseline study, developing and implementing a corrective plan and restudying the problem to assess the effectiveness of the corrective action plan.

Process studies focus on facility problems. For example, if problems with the chronic care program are identified, baseline studies might look at how you identify chronic care patients, how you schedule them for clinics, whether any security escort problems cause delays and how documentation is kept. An outcome study on the same subject might focus on whether the chronic care inmate’s symptoms are actually decreasing or at least are not worsening as a result of the care. Typically, process studies answer the question “Is what we are doing effective and efficient?” whereas outcome studies answer the question “Are our patients getting better?”

The evidence would be documentation of the studies themselves that contain all parts of a study (see compliance indicator #2 and the definitions of process and outcome quality improvement studies). A word of caution: Pay attention to ensure that the CQI program is actually identifying problems and finding solutions. Often, routine monitoring of correctional health care processes is presented as a study and does not meet the intent of the CQI standard.

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.

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