The Impaired Clinician
When Frontline Staff Raise Workplace Risks

#metoo: Sexual Harassment of Nurses by Inmates
Legal Affairs: Epileptic Detainee Dies From Seizure
Spring Conference Preview

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Features

4 Spring Conference Preview
6 Legal Affairs: Epileptic Detainee Dies From Seizure; Clinical Staff Absolved
12 The Impaired Clinician: When Frontline Staff Raise Workplace Risks
16 Sexual Harassment of Nurses by Inmates: How to Deal With These #MeToo Offenses

Departments

2 NCCHC News
3 Chair Notes: 2018 – A Year of Technology and Progress
17 JCHC Preview: Excited Delirium Death After Four Days in Custody
18 Field Notes
20 CCHP Page: Test-Takers Laud Convenience and Speed of Computer-Based Testing
22 Exhibitor Opportunity
23 Classified Ads and Ad Index
24 Standards Q&A

Our Independence Matters

The National Commission on Correctional Health Care has no membership or dues. NCCHC does not require any affiliation to be considered for accreditation, certification or employment as a consultant or surveyor, or to serve on committees or the board of directors. NCCHC staff and spouses are not allowed to accept gifts or consulting fees from those we accredit or certify. NCCHC is impartial, unbiased and expert. And dedicated only to recognizing and fostering improvements to the field of correctional health care.
Please Join Us in Minneapolis and Learn About Our Efforts to Serve You

Dear Friends of NCCHC,

I want to take this opportunity to extend a personal invitation to our Spring Conference on Correctional Health Care in April. We are excited to have you join us in Minneapolis, Minnesota – a new conference destination for NCCHC. For the past several months, we have been working to make this a truly memorable educational and networking event.

While there, please take the time stop by the NCCHC booth in the exhibit hall to learn more about accreditation for health services, mental health services and opioid treatment programs. I am pleased to report that a recent survey of our accredited facilities showed that virtually all plan to continue seeking NCCHC accreditation. This year’s conference will also feature a free training session on our soon-to-be unveiled online accreditation portal. This portal will streamline the accreditation process and is just one of the many ways by which we strive to improve our customers’ experience and satisfaction.

NCCHC is the only organization in the nation to offer a certification program for correctional health care professionals and specialty certification for mental health professionals, nurses and physicians working in corrections. In an effort to make the certification process more convenient, we recently rolled out the option of computer-based testing. CCHP candidates are now able to take the exam at hundreds of computer-based exam centers nationwide. Make sure to visit the CCHP booth at the conference with any questions. (See the CCHP column on page 20 for a Q&A with several people who have taken the exam at the PSI test centers.)

NCCHC is proud to be the leader in correctional health care accreditation and certification. We are honored to help you provide the highest quality care to the patients you serve. And I would be delighted to have you join us at the Spring Conference.

Sincerely,
Jim Pavletich, MHA, CAE, CCHP
Chief Executive Officer, NCCHC

2018 Jail and Prison Standards Are Now Available!

The new editions of NCCHC’s landmark Standards for Health Services for jails and prisons are now available. First published in 1976 and 1979, respectively, NCCHC’s nationally recognized standards lay the foundation for constitutionally acceptable health services systems and can help facilities improve health services delivery.

These editions have been revised and reorganized to improve their usefulness. Sections have been consolidated into seven categories (previously there were nine), and introductory descriptions have been added to explain the intent of each section. New standards are being introduced and several closely related standards have been combined. In addition, the wording of the standards has been simplified.

For an in-depth discussion of the 2018 Standards, attend the preconference seminar at the Spring Conference on Correctional Health Care, April 21-24 in Minneapolis. See pages 4-5 for information or visit https://spring-conference.ncchc.org. To order the Standards, visit www.ncchc.org/ncchc-store or call 773-880-1460.

Need Continuing Education Hours? We’ve Got ‘Em!

Webinars for CE Credit. NCCHC is hosting a series of educational webinars that offer professional continuing education credit. The first webinar, Use of Behavior Management Plans to Reduce Self-Injury, was presented by Sharen Barbosa, PhD, CCHP-MH, and offered 1.0 hour of credit. It was very well attended, with 120 participants. Registration fees are $49 per webinar. For future topics, please check your email or visit www.ncchc.org/events/conferences.

Save the Date! The 2018 Correctional Mental Health Care Conference is shaping up to be a must-attend event, with an outstanding lineup of topics and speakers. The meeting is being held July 15-16 at the Loews Hollywood Hotel in Los Angeles and offers 15.25 hours of CE credit. For details, check your email for the preliminary program or visit https://mental-health-conference.ncchc.org. Register by June 15 to save on registration fees.
2018 – A Year of Technology and Progress

by Barbara A. Wakeen, MA, RDN, CCHP

The year is off to a great start at NCCHC, with lots of “new”—from our new CEO, Jim Pavletich, to advances in technology for accreditation and the Certified Correctional Health Professional program, and the 2018 Standards for Health Services. These initiatives will help correctional health professionals and their facilities in their efforts to improve health services.

A System to Simplify Accreditation Tasks
A new online portal aids accredited and soon-to-be accredited facilities in streamlining the accreditation process. This customized system enables facilities to access all of the information they need about their accreditation status, and to use their personal dashboard to monitor communications, document requests, deadlines, updates and more. For surveyors and staff, this portal will streamline activities and maintain continuity of communication—a win-win for all!

Another online service promises to simplify the documentation needed for accreditation. Jails and prisons that subscribe to the PowerDMS policy management software can access the Standards for Health Services online and organize their documentation for each standard, eliminating the need for binders of paper records. The system helps facilities to prepare for the on-site survey and can enhance the review process for both the facility and NCCHC surveyors. Please note that use of this system is not mandatory for the accreditation process. Learn more and request a demo at www.powerdms.com/customers/healthcare.

Is CCHP on Your 2018 List?
Have you thought about becoming a Certified Correctional Health Professional, but cannot make it to an NCCHC conference to take the exam? Computer-based testing is now available at 300 strategically located sites nationwide. This enables candidates to take the test at their convenience without having to travel to a remote test site. Exams available are CCHP, CCHP-MH, CCHP-P and CCHP-RN. All categories of exams, including Advanced, continue to be offered at NCCHC and partner conferences in pencil-and-paper format.

For insights from several professionals who have used the computer-based testing method, see pages 20-21.

Updated Standards Coming Soon
The 2018 Standards for Health Services for jails and prisons will be published in April and available at NCCHC’s Spring Conference on Correctional Health Care (see pages 4-5). These editions were carefully updated to improve usability for achieving accreditation and optimizing inmate health care. The standards were reorganized to be more concise, and the language has been simplified throughout. For facilities undergoing an accreditation survey in 2018, compliance with the new standards is based on your survey date. For compliance dates, please see www.ncchc.org/compliance-dates-for-2018-standards.

CEUs All Around
Watch for upcoming NCCHC webinars to earn your continuing education credit between attending NCCHC conferences. Also, visit www.ncchc.org/NCCHC-University for past recorded presentations and webinars. The Journal of Correctional Health Care’s self-study exam is another great way to earn CEUs—and CCHPs receive a complimentary online subscription to JCHC as a benefit of certification!

Speaking of NCCHC conferences and progress, “Purpose Progress Perspective” is the theme of the Spring Conference April 21-24 in Minneapolis—a new destination for us. I look forward to seeing you there!

Barbara A. Wakeen is the chair of NCCHC’s board of directors and principal of Correctional Nutrition Consultants, Ltd.
Renew your sense of purpose, gain a fresh perspective and be part of progress! Whether you’re new to the field or a correctional health care veteran, you’ll find valuable connections, inspiration and ideas at the 2018 Spring Conference on Correctional Health Care. With sessions geared toward basic, intermediate and advanced levels of experience, the Spring Conference delivers unparalleled education and professional development opportunities.

Who Should Attend?
Correctional health professionals from around the country will be heading to beautiful Minneapolis for special learning experiences, continuing education, networking and the opportunity to exchange ideas with like-minded colleagues.

The Spring Conference delivers unparalleled education and professional development opportunities for:

- Administrators
- Custody staff
- Health educators
- Nurses
- Pharmacists
- Physician assistants
- Psychologists
- All correctional health professionals
- Counselors
- Dentists
- Legal professionals
- Nurse practitioners
- Physicians
- Psychiatrists
- Social workers

Meeting Venue and Hotel
All activities will take place at the Hyatt Regency Minneapolis, 1300 Nicollet Mall, so rooms are just steps away from the conference action. Experience the best of the city from this downtown hotel, recently redesigned in sleek mid-century Scandinavian décor and close to everything. Make your reservation at https://aws.passkey.com/go/ncchc2018.

MINNEAPOLIS, MARRIAGE OF CITY & NATURE
Ahhh, Minneapolis in the springtime. The Minnie-Apple is known for its marriage of the urban and nature. Where else can you bike to a store, buy some designer fashions, hop in a kayak to paddle the Mississippi River, then get out and experience a Broadway play, all within a 7 block radius? None other than Minneapolis.

The City of Lakes is also a uniquely beautiful place, where nature, art, Fortune 500 companies, fine dining and funky shops happily coexist. With 12 lakes and the Mighty Mississippi, countless parks and people so friendly they’re called “Minnesota nice,” it’s bound to become a favorite conference destination.
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TOP 5 REASONS TO ATTEND

- Targeted education from the only organization dedicated solely to correctional health care
- Up to 26.75 hours of CE credit
- Networking with peers and experts from every segment of the correctional health field: clinicians, administrators, security
- More than 50 sessions and preconference seminars to fit your educational interests
- Comprehensive coverage of all aspects of correctional health

Your Registration Includes

- A choice of more than 50 concurrent sessions
- Educational luncheons
- Educational breakfast program
- Informative exhibits
- Exhibit hall reception
- Breaks and refreshments in the exhibit hall
- Final program and session abstracts
- PowerPoint presentations for download
- Up to 27 hours of continuing education credit (includes preconference seminars)

Preconference Seminars

- In-Depth Review of the 2018 Standards for Health Services in Jails
- In-Depth Review of the 2018 Standards for Health Services in Prisons
- In-Depth Review of the Standards for Opioid Treatment Programs
- Managing Cultural Competence: Diagnostic and Treatment Implications
- Continuous Quality Improvement: Strategies to Measure Change
- A Multidisciplinary Approach to Pain Management
- Trauma-Informed Care: How We Can Better Support Our Patients

For More Information

Epileptic Detainee Dies From Seizure; Clinical Staff Absolved

by Fred Cohen, LLM

S teven Stiles died confined at a Grand Rapids, MI, jail because of the failure of medical officials to provide him with his antiseizure medication. Stiles was arrested on a warrant for failure to pay child support. He was taken into custody on May 31, 2011, at 4:48 a.m. and pronounced dead following a seizure at 8:41 p.m., discovered by jail staff delivering prescriptions, including his.

The district court entered summary judgment for the defendants and in Esch v. County of Kent (699 Fed.Appx. 509; 6th Cir. 2017), that judgment is upheld. The Sixth Circuit determined that the outcome would be the same whether it used the 14th Amendment, a due process test that requires a finding of deliberate indifference, or the Fourth Amendment, a privacy-based standard of objective reasonableness that does not require a serious medical condition. Seriousness is one of several factors in measuring reasonableness.

Facts

Stiles was medically screened by a nurse when he arrived at the jail. He indicated that he suffered with grand mal seizures from his epilepsy, that he was then under the influence of alcohol and that he had suffered a seizure two weeks earlier.

He was to take Dilantin twice a day and had not taken his night dose. The information was entered but not yet acted upon. The next nurse on duty verified the prescription but then took no further action.

The physician came on duty and prescribed the medication but did nothing further. Yet another nurse came on duty and while she received Stiles’ chart, there is no evidence she consulted it or was in any way involved in Stiles’ case.

The Standard

There is no certainty over the standard of liability for medical care if the plaintiff was an arrestee, detainee or convicted inmate. The Fourth Amendment test (which should apply here) is much easier for the plaintiff than the due process/cruel and unusual punishment test, but the plaintiff’s claim falters in either case.

As for objective reasonableness, then, we do have clinical staff aware of the decedent’s medical condition and his need for Dilantin. The court emphasizes that Stiles did not exhibit physical signs showing an exigent situation.

Parenthetically, the onset of seizure is nearly always obvious, but not so for the appearance of the sufferer who is in fact on the threshold of a seizure.

The nurse who screened Stiles upon arrival knew that he had a history of seizures, and that he was on Dilantin and under the influence of alcohol at the time, which increases the risk of seizures. He failed to ask about Stiles’ last ingestion of the drug.

Thus, it seems he knew everything necessary to create a clear and imminent duty to provide care i.e., Dilantin. The court disagrees primarily because they find no signs of an urgent need of care.

The jail’s ordinary verification and dispensation procedures were grinding their way forward but, unfortunately, too late for Mr. Stiles.

Comment

The court refused to bring needed future clarity to this area by simply clarifying its stand on the constitutional source. Using the Fourth Amendment’s reasonable test and still absolving staff strikes me as wrong and forgives some sloppy work in pursuing medication.

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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Becky Luethy, RN, MSN, LNC, CCHP  |  Director of Operations Development
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Indications and Important Safety Information:\n
VIVITROL is indicated for:

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

For additional Important Safety Information, please see Brief Summary of Prescribing Information on adjacent pages.
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**Contraindications**

VIVITROL is contraindicated in patients:

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

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

VIVITROL® (naltrexone for extended-release injectable suspension) Intramuscular


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

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

WARNINGS AND PRECAUTIONS: Vulnerability to Opioid Overdose: After opioid detoxification, patients are likely to have reduced tolerance to opioids. VIVITROL blocks the effects of exogenous opioids for approximately 28 days after administration. However, as the blockade wanes and eventually dissipates completely, patients who have been treated with VIVITROL may respond to lower doses of opioids than previously used, just as they would have shortly after completing detoxification. This result could frustrate attempts to treat patients who have stopped using opioids in compliance with a treatment plan. Either the patient or the clinician may believe that the patient is responding to a lower dose of an opioid medication. In some cases, the patient may experience symptoms of opioid withdrawal. Patients should be counseled on the signs and symptoms of opioid withdrawal (which are associated with the discontinuation of opioid in a dependent individual) and that they are not generalizable to be severe or necessitate hospitalization. However, when withdrawal is precipitated abruptly by the discontinuation of an opioid antagonist to an opioid-dependent patient, the resulting opioid 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 administration, and in some cases, management in the intensive care unit. To prevent occurrence of precipitated withdrawal in patients dependent on opioids, or exacerbation of a pre-existing subclinical withdrawal syndrome, opioid-dependent patients, including those being treated for alcohol dependence, should be opioid-free (including tramadol) before starting VIVITROL treatment. An opioid-free interval of a minimum of 7–10 days is recommended for patients previously dependent on short-acting opioids. Patients transitioning from buprenorphine or methadone may be vulnerable to precipitation of withdrawal symptoms for as long as two weeks. If a more rapid transition from agonist to antagonist therapy is deemed necessary and appropriate by the healthcare provider, monitor the patient closely in an appropriate medical setting where precipitated withdrawal can be managed. In every case, healthcare providers should always be prepared to manage withdrawal symptomatically with non-opioid medications because there is no completely reliable method for determining whether a patient has had an adequate opioid-free period. A naloxone challenge test may be helpful; however, a few cases have been reported that patients with a history of experience precipitated withdrawal despite having a negative urine toxicology screen or tolerating a naloxone challenge test (usually in the setting of transitioning from buprenorphine treatment). Patients should be made aware of the risks associated with precipitated withdrawal and encouraged to give an accurate account of last opioid use. Patients treated for alcohol dependence with VIVITROL should also be assessed for underlying opioid dependence and for any recent use of opioids prior to initiation of treatment with VIVITROL. Precipitated opioid withdrawal has been observed in alcohol-dependent patients in circumstances where the prescriber had been unaware of the additional use of opioids or co-dependence on opioids. Hepatotoxicity: Cases of hepatitis and clinically significant liver dysfunction were observed in association with VIVITROL exposure during the clinical development program and in the postmarketing period.Transient, asymptomatic hepatic transaminase elevations were also observed in the clinical trials and postmarketing period. Although patients with clinically significant liver disease were not systematically studied, clinical trials did include patients with asymptomatic viral hepatitis infections. When patients presented with elevated transaminases, there were often other potential causative or contributory etiologies identified, including pre-existing alcoholic liver disease, hepatitis B and/or C infection, and concomitant usage of other potentially hepatotoxic drugs. Although clinically significant liver dysfunction is not typically 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 hepatitis injury and advised to seek medical attention if they experience symptoms of acute hepatitis. Use of VIVITROL should be discontinued in the event of symptoms and/or signs of acute hepatitis. Depression and Suicidality: Alcohol- and opioid-dependent patients, including those taking VIVITROL, should be monitored for the development of depression or suicidal thinking. Families and caregivers of patients being treated with VIVITROL should be alerted to the need to monitor patients for the emergence of symptoms of depression or suicidality, and to report such symptoms to the patient’s healthcare provider. Alcohol Dependence: In controlled clinical trials of VIVITROL administered to adults with alcohol dependence, adverse events of a suicidal nature (suicidal ideation, suicide attempts, completed suicides) were infrequent overall, but were more common in patients treated with VIVITROL than in patients treated with placebo (1% vs 0). In some cases, the suicidal thoughts or behavior occurred after study discontinuation, but were in the context of an episode of depression that began while the patient was on study drug. Two completed suicides occurred, both involving patients treated with VIVITROL. Depression-related events associated with premature discontinuation of study drug were also more common in patients treated with VIVITROL (−1%) than in placebo-treated patients (0). In the 24-week, placebo-controlled pivotal trial in 624 alcohol-dependent patients, adverse events involving depressed mood were reported by 10% of patients treated with VIVITROL 380 mg, as compared to 5% of patients treated with placebo 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 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 anesthetics or analgesia, patients should be continuously monitored in an anesthesia care setting by persons not involved in the conduct of the surgical or diagnostic procedure. The opioid therapy must be provided by individuals specifically trained in the use of anesthetic drugs and the management of the respiratory effects of potent opioids, specifically the establishment and maintenance of a patent airway and assisted ventilation. Irrespective of the drug chosen to reverse VIVITROL blockade, the patient should be monitored closely by appropriately trained personnel in a setting equipped and staffed for cardiopulmonary resuscitation.

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

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

 Intramuscular Injections: As with any intramuscular injection, VIVITROL should be administered with caution to patients with thrombocytopenia or any coagulation disorder (eg, hemophilia and severe hepatic failure). Alcohol Withdrawal: Use of VIVITROL does not eliminate nor diminish alcohol withdrawal symptoms. Interference with Laboratory Tests: VIVITROL may be cross-reactive with certain immunosassay methods for the detection of drugs of abuse (specifically opioids) in urine. For further information, reference to the specific immunosassay 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 overdosage 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 frequent 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 frequent 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, 2% of opioid-dependent patients treated with VIVITROL discontinued treatment due to an adverse event, as compared to 7% of the alcohol-dependent patients treated with placebo. Adverse events in the VIVITROL 380-mg group that led to more dropouts than in the placebo-treated group were injection site reactions (3%), nausea (2%), pregnancy (1%), headache (1%), and suicide-related events (0.3%). In the placebo group, 1% of patients withdrew due to injection site reactions, and 0% of patients withdrew due to the other adverse events. Opioid Dependence: In controlled trials 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: Plasma concentration data 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.

Information (rev. December 2015)
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www.vivitrol.com
Marteen, a fourth-year warden of administration, feels the familiar tension in her shoulders and stomach every Sunday evening as she checks her work email. She feels that to function at her job she must “troubleshoot as much as she can” on Sunday nights. She once enjoyed this opportunity to prepare for and gain some control over the unpredictable workweeks.

But within the past five months, the rush of emotions and anxiousness about her job sets off a pattern of events. Marteen drinks four or five glasses of wine every Sunday night at her computer. She averages three or four hours of interrupted sleep, stays late at work an average of three days per week and has few friendships outside of work. Marteen is increasingly agitated and feels overwhelmed with her ever-changing work duties and fosters an increasing sense that she will never catch up.

From Stressed to Impaired

The average employee spends 50 or 60 hours per week at work, according to the U.S. Department of Labor. For many employees, the idea of work–life balance seems unattainable and unrealistic, and this adds to workplace stress. In the correctional environment, employees face many additional stressors: the threat of violence (observed and experienced), high volumes of inmate health services, crisis situations, staff shortages with increasing workload expectations and constant changes to standards of care. Negative or dysfunctional relationships with colleagues also add to stress.

Job stress is defined as harmful physical and emotional responses that occur when the job requirements do not match the capabilities, resources or the perceived needs of the employee.

However, there is a substantial difference between job stress and impairment. The Bureau of Labor Statistics states that prolonged job stress leads to further employee damage, whether emotional or physical. The World Health Organization defines impairment as “any loss or abnormality of psychological, physiological or anatomical structure or function.”

The impact of an impaired employee can be widespread throughout the workplace. Impaired employees can single-handedly and negatively distribute their workload duties to healthier colleagues. In the correctional setting, employee impairment presents immeasurable risks and negatively impacts safety and security for the employee, other staff and inmates, not to mention quality of care.

A smoothly running facility depends on the consistency of every individual operating under a standard of care and expectations. Consistency is essential to adhering to stan-
dards and managing the daily stresses of our unpredictable environment. Impaired employees can greatly increase the workload (and stress) of colleagues, thereby reducing the effectiveness of the department or shift.

Who is vulnerable to impairment? Everybody. Length of service, work role, education and prior work experience do not eliminate the risks for impairment. One of the vulnerabilities in our work culture is the constant exposure to a largely impaired population (untreated medical or mental illnesses, grossly limited education) that often has unresolved legal issues. With job stress ranking among the top risk factors for impairment, how can we address this threat?

Three Scenarios

These vignettes illustrate how impairment may manifest in a correctional setting.

**Michael,** a corrections GED teacher for 21 years, refuses to accept a recent medical diagnosis. He continues to struggle with mobility and stamina, chronic absenteeism and non-attendance to mounting paperwork. He feels ashamed with his colleagues but will not disclose any limitations. He is increasingly reliant on a female education orderly. He has begun to disclose his frustrations to this inmate and allows her access to personal files of other inmates and community volunteer teacher aides.

**Nurse Renee,** a 19-year director of nursing, also spearheads two critical subcommittees at the prison and is responsible for new hire orientation. Her 12-person staff is aware of the recent death of Renee’s husband. She returned to work two days after the funeral. She appears distracted and flustered with menial paperwork. She has uncontrollable crying spells while performing her nursing duties. Her colleagues attend to her emotional needs for two or three hours throughout the 10-hour workday. She refuses to go to EAP, instead preferring the care of her “team.”

**Dr. Ney,** a highly skilled sixth-year psychologist, consults with three institutions regarding high-risk offenders. She supervises four graduate interns and all new-hire staff. Dr. Ney is in the midst of a lengthy custody battle with her soon-to-be ex. Her no-show rate for clients is double that of the other full-time psychologists. She consistently cancels supervision with the interns, one of whom requests a different supervisor, stating “she is cynical” and “just stares at us” and “she falls asleep during my supervision.” Her colleagues begin to absorb Dr. Ney’s workload with little insight from her. Her colleagues attempt to coax her into taking some time off. Dr. Ney counters their attempts with hostility and threatens to “notify the board.”

A Framework for Intervention

Intervening with an impaired colleague ranks as one of the highest inducers of stress for staff members and yet sometimes it must be done. First, someone must evaluate information or behaviors (often quickly) to determine whether an intervention is essential to the welfare of the patients and staff and to organizational productivity. This five-step framework can assist in preparing to intervene.

1. **Gather and evaluate information**
   Although this stage seems simple, often it will increase stress for those who intervene. Organizing fact from fiction in a correctional work environment can be a sobering task. Behaviors to evaluate may include excessive tardiness, unattended job duties, changes in prosocial behaviors and deviations from the employee’s healthier behaviors.

2. **Organize the intervention**
   Inform two or three trustworthy participants of the location and time of the intervention. It is better to invite individuals in the same professional discipline (teacher/impaired teacher, psychiatrist/impaired psychiatrist, nurse/impaired nurse) rather than randomly assigned staff. Do not include subordinates or new hires. It is likely that once-positive relationships with this impaired employee have deteriorated, and a trusted third-party may be necessary.

3. **Set a strength-based supportive tone**
   Our work often uses a strength-based approach with inmates. This approach is also needed when intervening with an impaired employee. There is a wide range of interventions we could employ; however, our salient duty is to ensure workplace safety and restore this employee’s efficacy.

4. **Realign**
   Reiterate workplace expectations and duties of the impaired employee and present copies of ethics specific to the employee’s discipline. Provide a safe environment where the employee can discuss barriers and non-work-related events that impact the workplace, and listen to these concerns. Document the intervention.

5. **Follow up**
   Establish measures for return to satisfactory work performance, and follow up to ensure that progress is being made in meeting work expectations. This follow-up will model to healthier employees that healthy work behaviors are valued.

Workplace Positivity

One of many factors that impacts the severity of workplace stress is the relationships among colleagues. Positive relationships are the nucleus to the vitality of any organization. Positivity among colleagues can be described as professional respect, attentiveness, warmth and healthy doses of humor. These relationships have the added benefit of reducing overall stress, increasing workplace cohesion and promoting organizational loyalties. Research also suggests that positive workplace relationships often mitigate personal life stress and the impact of catastrophic events.

continued on page 14
Barriers to Intervention
Workplace colleagues often empathize with one another when these unavoidable shared experiences occur. We know firsthand the impact of staff shortages and the burden of having too much to do in too little time. We manage those day-to-day stressors primarily through the support of our colleagues.

Although it is natural to feel empathy for an impaired colleague, we must avoid overidentification with their plight. Overidentification prevents us from effectively evaluating our colleagues and thus prevents us from ensuring safety and reducing work stress for others.

The role that impaired employee has within the institution or team can be a barrier to intervention. Those in leadership roles are least likely to receive interventions. In the case of the intern, the interns are unlikely to intervene or readily report her behaviors. They are subordinates dependent on her recommendations and they are likely to feel intimidated by her level of education and role.

Another barrier for teams can be limited knowledge of the organization's policies and guidelines that govern its multidisciplined members' workplace behaviors, or of the professional practice guidelines and ethics applicable to the discipline. This lack of knowledge will often deter those outside of the impacted departments from intervening.

Fostering Wellness
There will never be a prescription for eliminating the daily stressors and risks inherent to working in the correctional setting. It is imperative that colleagues evaluate workplace behaviors that raise stress levels and undermine overall effectiveness. Colleagues committing to one another, adherence to policy and, most importantly, a sense of workplace wellness will generate safety and support.

The benefits of intervening with an impaired colleague are innumerable. An increase in workplace morale, delineation of workload responsibilities and fostering colleague efficacy are immeasurable gains. The foundation of the effectiveness of our work is the effectiveness of our correctional workforce.

Healthy Expectations
A well-organized intervention even in the most chaotic of work settings will improve safety and care for healthier employees. Modeling support through healthy expectations for work behaviors and work safety via a supportive team breeds ethical behaviors and demonstrates how rehabilitative workplaces should operate.

Ethical Guidance for Our Three Scenarios
Professional organizations' codes of ethics provide clear guidance for our case studies.

**In the case of Michael**
The professional educator maintains sound mental health, physical stamina, and social prudence necessary to perform the duties of any professional assignment.

**In the case of Nurse Renee**
The nurse's duty is to protect the patient, the public, and the profession from harm when a colleague's practice appears to be impaired. The nurse should support the return to practice of any individual who is ready to resume their role within the profession after seeking appropriate resources. If the impaired person represents a threat to self or others, then the nurse should report the problem to those in authority to address the situation. This must occur regardless of whether the impaired person has sought help or not. Nurses who advocate for colleagues whose job performance carries a risk for harm should be protected from negative consequences. Advocacy is not always an easy process and the nurse should follow workplace policies.
— Modified from American Nurses Association, Code of Ethics for Nurses, Provision 3, Statement 3.6, Patient Protection and Impaired Practice (see also Statement 5.2, Promotion of Personal Health, Safety, and Well-Being)

**In the case of Dr. Ney**
When psychologists become aware of personal problems that may interfere with performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties.
— American Psychological Association, Ethical Principles of Psychologists and Code of Conduct, Section 2.06 (b)
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Nurse Practitioners, and Physician Assistants, Jeana Sosa at (916) 691-1965 or Jeana.Sosa@cdcr.ca.gov.
Sexual Harassment of Nurses by Inmates: How to Deal With These #MeToo Offenses

by Catherine Knox, MN, RN, CCHP-RN

A nursing colleague asked for advice about how to address the problem of inmates masturbating and making verbal threats during nursing encounters. It is a problem nearly all correctional nurses will face at some point in their careers.

While nurses put up with some antisocial behavior in almost any setting, they really can be challenged with the pervasiveness of this in a correctional setting, especially in restricted housing. Nurses have to deal with inmates who expose themselves or masturbate while the nurse administers medication, evaluates a health care complaint or responds to a man-down call. Some nurses will confront the behavior, others will ignore it and some dish it right back, all in an effort to control the offensive behavior and get nursing care delivered.

However, unchecked exhibitionism is a form of violence toward others that is not acceptable even in a correctional facility. In 2006, the Ninth Circuit Court of Appeals agreed with the lower court’s ruling under Title VII of the Civil Rights Act finding for the employee and noted that prison officials in the California Department of Corrections and Rehabilitation may “not ignore sexually hostile conduct and must take corrective action to safeguard the rights of victims, whether they be guards or inmates.” Similar litigation has been successful in Florida.

Nurses should not attempt to confront the problem alone and have good cause to look to their immediate supervisor as well as prison officials to address the problem of sexually hostile conduct. In gathering advice for my nursing colleague, I conferred with two corrections experts. They recommend addressing the problem in an integrated way that includes making expectations for behavior explicit and delineating graduated consequences that include criminal charges and involvement of the local prosecutor. Behavioral treatment and policies based on basic learning principles should also be used to minimize the probability of repeated incidents. Trained mental health staff should be consulted and assist in the development of these policies.

Policies for Prevention

The following measures provide correctional facilities with the means to address sexual misconduct:

- The inmate handbook includes written rules of conduct that specifically address the issue of exhibitionist masturbation and other forms of sexual misconduct.
- The handbook also delineates disciplinary measures—what specific offenses bring what penalties—including a description of the inmate disciplinary process.
- The handbook is available in the languages of those who are incarcerated and written at a fifth-grade level for those with low literacy skills.
- The orientation that inmates receive at intake (by video or in person) goes over the rules, including the rules regarding exposure, masturbation and other forms of sexual misconduct.
- This information is repeated by the housing unit officer and is posted on the housing unit or televised in the living areas.
- Policies and procedures for staff describe the following:
  - Inmate housing unit management
  - Inmate rules of conduct, including exhibitionism, masturbation in public and other forms of sexual misconduct
  - How rules of conduct will be enforced
  - The inmate disciplinary process
- Staff training about the facility policies and procedures takes place and is repeated as necessary.
- Clear expectations are set for staff regarding their roles in the enforcement of facility policies and the consequences for staff if they fail to enforce those policies.

Responding to the Abuse

Policies are essential to set the expectations, but what happens when the offenses occur anyway? Here are some recommendations:

- Inmates who engage in prohibited behavior receive disciplinary notices, participate in a disciplinary process and, if found guilty, serve disciplinary sanctions. These sanctions may include but are not limited to disciplinary segregation.
- For offenses such as exhibitionist masturbation, one effective strategy is to develop behavior contracts. For example, if the inmate serves X days of disciplinary sanctions without incident, he gets X days off his sentence.
- Appropriately trained mental health staff should take the lead in developing behavioral treatment programs to treat sexually deviant behavior.
- The disciplinary notices, hearings, sanctions and other responses to these offenses are documented.
- There is a process by which staff notify their supervisors and/or the leadership about offensive inmate behavior.
- The facility can withhold programming and other services from inmates who violate policies and procedures and are found guilty of disciplinary infractions. Policies should also be developed to reward those who do not engage in sexually deviant behavior.
- There are provisions for management of inmates with mental illness, or suspected of mental illness, that address objectionable in-custody behaviors in a therapeutic context as part of the treatment plan (which may include discipline).
- Inmates who engage in this behavior repeatedly are charged via law enforcement and referred for prosecution. At one facility, a prosecutor actually speaks to the inmates about how if they engage in this behavior and are administratively and/or criminally charged, it will affect their sentencing at trial, parole consideration and conditions of release. Most inmates don’t think about the longer term consequences on their own, so it helps to point it out.

continued on page 18
Excited Delirium Death After Four Days in Custody: Case Study

The medical literature and mainstream news have reported on the sudden, arrest-related deaths of individuals experiencing excited delirium. Although the cause is often attributed to use of force or restraint, the actual cause may be the delirious state, often brought on by use of a drug stimulant, according to the authors of a study in the January issue of Journal of Correctional Health Care.

Such deaths typically occur during or soon after a struggle with officers. Reports of deaths occurring a few days later are rare. Yet that’s the situation that authors Kennedy and Savard describe in their article: The individual died four days after being taken into custody in a county jail without being restrained and not actively having been under the influence of a drug stimulant.

What Happened

In this case, a 37-year old male was arrested by the police and brought to a medium-sized jail. He was behaving in an agitated and incoherent manner, and therefore was denied entry until he was examined at a local hospital.

The patient was already diagnosed with bipolar disorder and schizophrenia and was known to use cocaine, marijuana and methamphetamine at times. At the hospital, he was diagnosed with brief psychotic disorder or brief reactive psychosis, treated with Haldol, an antipsychotic drug, for the first time and medically cleared for jail admission.

It was unclear whether the patient was high on drugs, experiencing a psychotic break or beginning an alcohol withdrawal process, so he was placed in an observation cell where he was continuously monitored by corrections officers and medical staff.

The patient removed his clothes and would slam his body into a door, but he did eat and drink. He also would remain motionless for periods of time, and then emerge from that state, flail around and urinate on the floor before becoming motionless again. He refused medication.

On Day Two his behavior was similar, vacillating between periods of inactivity and agitation and masturbation. At one point he fell backward off the bench and laid on his back for about 90 minutes. He continued to refuse medication, and would eat and drink only sporadically. Nurses would enter to take his blood pressure, but he ignored them. He also threw himself into a puddle of urine. Because of a hand injury from punching the wall, he was transported to the hospital, again treated with Haldol and returned to the jail.

On Day Three the patient still appeared to be confused, pacing and removing his pants to masturbate. Officers and a nurse would come into his cell to check on him, but he refused food and drink. The jail physician ordered a third dose of Haldol.

On Day Four, he attempted to eat but fell backward, laid on the floor and urinated. He then began to eat again, but after 20 minutes started to breathe heavily, had a seizure and collapsed. CPR failed to revive him. The county medical examiner cited excited delirium as the cause of death, but in litigation a forensic pathologist cited sudden cardiac arrhythmia as a result of acute exacerbation of mental illness and dehydration based on an autopsy.

The authors say this case illustrates that excited delirium may be a pernicious condition that can emerge precipitously from apparent remission or can appear as a separate episode not immediately preceded by drug consumption or violent struggle.
Field notes

RIP to Our Correctional Health Colleagues

Margaret Collatt
A longtime supporter of the National Commission, Margaret Collatt, BSN, RN, CCHP-RN, CCHP-A, died in February after a long illness. Before her retirement last year, she had worked in correctional health care for more than 30 years, 26 of them as a health services training specialist with the Oregon Department of Corrections. Collatt was a tireless volunteer, presenting at countless NCCHC conferences over the years and mentoring others on nursing, administration and professional development. She was an accreditation surveyor for nearly 20 years and a longtime member of the education committee and the nurse advisory council. Collatt was honored with NCCHC’s Award of Merit in 2017 (see www.ncchc.org/award-of-merit-2017).

Ruth Wyatt
Another close friend of the Commission, Ruth Wyatt, RN, CCHP-RN, passed away in January. She had been the health services administrator for Hinds County Detention Center, Jackson, MS, since 1994. Wyatt’s leadership was evident in her many contributions to the CCHP program, where she served on the board of trustees 2007-1010 and, as a member of the CCHP-RN task force, helped develop the first specialty certification program; she then continued as a member of the CCHP-RN subcommittee. Wyatt became an NCCHC accreditation surveyor in 2000 and six years later was chosen to be a lead surveyor. She also was a warm, friendly presence at nearly every NCCHC conference since 1995.

Sexual Harassment (continued from page 16)

• Finally, the facility should be aggressive in referring for prosecution. If the prosecutor declines, then focus on ways to convince the prosecutor to change that position.

Check the Handbook

Are these measures in place at the correctional facility where you work? You might want to review the inmate handbook to see if there are explicit guidelines about sexually hostile behavior and the consequences. If not, initiating dialogue with correctional authorities and advocating for revisions to include these suggestions would be a good place to start.

Catherine Knox, MN, RN, CCHP-RN, is an independent consultant and a longtime NCCHC accreditation surveyor. She also is coauthor of Essentials of Correctional Nursing. This article is reprinted with permission from the correctional nursing blog at https://essentialsofcorrectionalnursing.com. It has been updated for CorrectCare.
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Test-Takers Laud Convenience and Speed of Computer-Based Testing

by Katie Przychodzen, MA

Last year, NCCHC partnered with PSI/AMP to offer computer-based testing to those taking the Certified Correctional Health Professional exam or one of the CCHP specialty exams (Mental Health, Physician, Registered Nurse). PSI/AMP offers testing services solely to health care certification organizations and has more than 30 years of experience and more than 100 clients. Prior to NCCHC’s partnership with PSI/AMP, candidates had to take the written exam at an NCCHC conference or at one of the regional sites organized a few times per year.

With computer-based testing, candidates can opt to take the exam at one of 300 testing centers nationwide, at a time that fits their schedule. For both computer-based and written exams, candidates receive their results within two weeks.

We asked a few recent testers to share their experiences with the new computer-based format.

Patricia Blair, PhD, JD, CCHP-RN, CCHP-A
Health Law Attorney, The BLAIR Firm, Tyler, TX, and NCCHC board member
Testing details: CCHP-RN exam, Jan. 2, Houston

CC: What inspired you to take the CCHP-RN exam?
PB: I am a registered nurse as well as an attorney. As an NCCHC board member, I represent the organization and believe that I should have all the credentials that NCCHC offers in order to show my commitment to its mission.

CC: What was the process for finding a testing center and scheduling the exam?
PB: I was given the website address. I followed the instructions. It was a matter of clicking on the exam I wanted to take with a particular certifying organization. Scheduling required that I know what dates and times I could be available to take the exam and comparing that with available testing dates, so scheduling was not a problem.

CC: What did you like and not like about the computer-based testing process?
PB: The process was straightforward. The testing center representative gave clear instructions prior to my entering the computer room. I followed the directions and had no problems. Although I took care of personal needs—bathroom, eating, etc.—prior to testing, it’s worth knowing that a break would cut into the testing time. [Note: This policy also applies to the written exam.]

CC: Did you prefer the computer-based test to the written exam?
PB: Yes, I prefer computer-based testing. For me, it’s easier to take on a computer than in longhand. It also allows for corrections without too much stress. And it’s convenient as far as time and location.

CC: Did you interact with PSI staff? If so, what was the reason for the interaction? Were they helpful?
PB: Yes. I needed to give information to confirm my identity and also to make sure that I was not bringing any material in that would potentially compromise the testing process. The PSI staffer was very helpful, professional and easy to communicate with.

CC: What comments or questions do you have about the computer-based exam?
PB: I am happy to know that NCCHC has progressed to this level of testing. I also appreciate not having to wait for a long time for test results; I got my results in a week.

Mandy Altman, MPA, CCHP
Correctional Health Program Manager, Hepatitis Education Project, Seattle
Testing details: CCHP exam, Jan. 19, Bellevue, WA

CC: Why did you decide to test when and where you did?
MA: I appreciated the convenience of being able to take the test locally. I also like electronic tests more than paper tests.

CC: What inspired you to take the CCHP exam in the first place?
MA: Many colleagues have suggested that I achieve certification to gain more opportunities to work in correctional health. I am a health educator and work in various correctional facilities in Washington State and work with correctional health care professionals across the country and internationally. I think having a standardized credential that is recognized by correctional health care staff and administrators is an asset to me as I work in so many different facilities.
Rio Manalang, MSN, APRN, CCHP-MH
Clinical Mental Health Provider, High Desert State Prison, Indian Springs, NV
Testing details: CCHP-MH exam, Jan. 25, Las Vegas
CC: Why did you decide to test when and where you did?
RM: I initially planned on taking the exam at the National Conference in Chicago last November. Due to budgetary constraints, plus the fact that I was not able to prepare adequately for the test, I decided to take it later after it was announced that the exam can be taken at local testing centers.
CC: Describe the testing facility. What did you like or not like about it?
MA: The facility was in a convenient location with easy parking. There were several different testing and education businesses in the building, which made it a bit confusing to find the right place. The testing center was a bit impersonal, and there are many different people taking tests for a variety of subjects. Also, the testing facility required several forms of identification and took my picture, which I wasn't expecting. There wasn't a sense of trust in the test taker, but that is understandable given the variety of important exams administered.
CC: Would you recommend the computer-based exam to a colleague?
RM: I would absolutely recommend the computer-based exam to anyone taking the CCHP or CCHP specialty exam. It's very convenient to take in your own community, and taking the computer-based exam feels faster and easier than an old-school pencil and Scantron that paper-based exams are administered on.

CC: Did you prefer the computer-based test to the written exam?
RM: I took the initial CCHP exam in one of your regional sites in Los Angeles last June. There was not really much difference in terms of the exam content. However, I am old school, so I feel I had more confidence answering the written one than the computer-based exam. I found it easier to go back to my “uncertain” answers with the written examination. But if computer-based exams are the way to go, then I have no reservations taking another one.
CC: Would you recommend the computer-based exam to a colleague interested in taking the CCHP or specialty exam?
RM: Yes, I would recommend taking the computer-based exam at a local PSI testing site, particularly to examinees who are adept with technology. Aside from the convenience and savings of not having to book a hotel room, one could use any extra time for “cramming” (like I always need) if the test site is nearby.

CC: What comments or questions do you have about the computer-based exam?
RM: Nothing except keep up the good work of being proactive for those aspiring to be good correctional health providers!

Katie Przychodzen, MA, is marketing and communications manager for NCCHC.
Correctional health professionals from around the country will head to beautiful Minneapolis, a new NCCHC destination, for special learning experiences, continuing education, networking and the opportunity to exchange ideas. These conference attendees will also visit the exhibit hall to find ways to improve health services in their facilities. NCCHC conferences are the ideal venue for your company to build recognition and relationships with these important professionals who represent all segments of the correctional health community. Sign up for a cost-effective exhibition booth today!

Who Attended in 2017?

<table>
<thead>
<tr>
<th>Category</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse/nurse practitioner</td>
<td>35%</td>
</tr>
<tr>
<td>Physician/physician assistant</td>
<td>24%</td>
</tr>
<tr>
<td>Social worker, therapist, counselor</td>
<td>11%</td>
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<tr>
<td>Psychiatrist/psychologist</td>
<td>10%</td>
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<tr>
<td>Administrator</td>
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Decision Makers With Authority

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<tr>
<th>Category</th>
<th>Attendance</th>
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<tbody>
<tr>
<td>State medical director</td>
<td>20%</td>
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<tr>
<td>Health services administrator</td>
<td>19%</td>
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<tr>
<td>Department manager/supervisor</td>
<td>13%</td>
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<tr>
<td>Facility medical director or director of nursing</td>
<td>5%</td>
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Who Do Attendees Represent?

<table>
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<tr>
<th>Facility</th>
<th>Attendance</th>
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<tr>
<td>Jail facility</td>
<td>35%</td>
</tr>
<tr>
<td>Prison facility</td>
<td>22%</td>
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<tr>
<td>State DOC/agency</td>
<td>12%</td>
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<tr>
<td>Private corporation</td>
<td>10%</td>
</tr>
<tr>
<td>Juvenile detention or confinement facility</td>
<td>5%</td>
</tr>
<tr>
<td>Federal agency</td>
<td>3%</td>
</tr>
</tbody>
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Categories Attendees Recommend or Buy

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

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Vice President of Correctional Healthcare - Augusta, Georgia

Georgia Correctional Healthcare (GCHC) was established in 1997 through a unique collaboration between Augusta University (formerly the Medical College of Georgia) and the Georgia Department of Corrections (GDC). For more than 20 years, we have successfully achieved our goal of delivering high quality health care to the state’s offender population while controlling the ever-increasing costs associated with healthcare management.

During the summer of 2017, GCHC expanded its role, taking on the healthcare responsibilities of the Georgia Department of Juvenile Justice (DJJ) in addition to the adult population with the GDC.

We are currently seeking a Vice President of Correctional Healthcare. This position has responsibilities for the two “arms” of correctional healthcare with a combined budget of approximately $200 million. The successful candidate will be responsible for directing and providing leadership to the administrative, financial and logistical healthcare operations for both GDC and DJJ.

The position will provide leadership in the conception, planning and development of strategies and objectives for implementation and consideration of the healthcare delivery for both organizations.

Position requires a Master’s Degree from an accredited college or university in Health Care Administration, Business Administration or related field. Minimum of 10 years of progressively responsible experience in a large health care organization including 5 years of management experience in Health Care Administration. Experience in adult and juvenile offenders in a correctional healthcare system and knowledge of NCCHC and ACA standards preferred.

Augusta is Georgia’s second-oldest and second-largest city. It is home of the globally-recognized Masters Tournament, birthplace of Soul Icon James Brown, and home of the US Army’s Cyber Center of Excellence at Fort Gordon. Augusta is where history meets high-tech, sports meets with southern hospitality, and industry meets with a growing technically-savvy workforce. Check us out at www.augusta.edu/gchc.
Mental Health Screening

Q If the psychiatrist trains the nurses who do health assessments to do mental health screenings, would this be an acceptable way to meet standard E-05 Mental Health Screening and Evaluation?

A This standard is essential for both jails and prisons and its intent is to “ensure that the inmate’s serious mental health needs, including those related to developmental disability and/or addictions, are identified.” To answer your question, we must distinguish between the “screening” portion of the standard and the “evaluation” portion.

Mental health screening: Within 14 days, all inmates must receive the initial mental health screening that addresses the issues listed in compliance indicator 2. This screening may be done by qualified mental health professionals or by mental health staff, defined as qualified health care professionals who have received instruction and supervision in identifying and interacting with individuals in need of mental health services. The training you describe by the psychiatrist would meet the intent of this part of the standard.

Mental health evaluation: Regardless of who does the initial screening, when the results are positive for mental health problems, the inmate must be referred to qualified mental health professionals (e.g., psychiatrist, psychologist, psychiatric nurse, psychiatric social worker) for further evaluation as stated in Compliance Indicator 4.

Juveniles in Adult Facilities

Q We are a large state prison for male adults but now have four juveniles. They were adjudicated as adults and are serving their time with us. Chronologically, however, they are adolescents. Which NCCHC standards do we follow for them?

A You should follow the standards for health services in prisons. You are not required to meet NCCHC’s standards for juvenile facilities in addition to the prison standards just because you house a handful of adolescents. However, standard P-G-02 Patients With Special Health Needs encompasses juveniles and requires the development of a treatment plan and special attention to diet, exercise and nutrition. The juveniles in your facility should be on your list of special needs patients.

Medical Autonomy or Access to Care?

Q We have been holding sick call in the afternoons. The warden now wants sick call held at 5 a.m. so that inmates can be screened before the workday starts. Isn’t it a violation of the standard on medical autonomy for the warden to tell us to change our sick call time when the existing schedule is preferred by the health professionals?

A The standard on medical autonomy (A-03) addresses clinical decisions and actions regarding health care provided to inmates. However, the time that sick call is held is not a clinical issue. The scenario you describe best fits under A-01 Access to Care. This standard requires the responsible health authority to identify and eliminate any barriers to inmates receiving health care. As mentioned in the discussion section of that standard, an unreasonable barrier includes deterring inmates from seeking care for their serious health needs, such as holding sick call at 2 a.m., when this practice is not reasonably related to the needs of the institution. It would be important to explore the reason for the proposed change during administrative meetings and that the decision be made jointly by the corrections administration and the responsible health authority.

2015 STANDARDS for Mental Health Services in Correctional Facilities

Newly revised, the 2015 Standards present NCCHC’s latest recommendations for managing mental health services delivery in adult correctional facilities.

This second edition represents the culmination of hundreds of hours of careful review by a large group of experts, including specialists in psychiatry, psychology, social work and professional counseling, to ensure that NCCHC standards remain the most authoritative resource for correctional mental health care services.

Notable updated topics include continuous quality improvement, patient safety, clinical performance enhancement, medication services, inpatient psychiatric care, mental health assessment and evaluation, continuity and coordination of care, emergency psychotropic medication and women’s health. This edition supports facilities in achieving and maintaining compliance with NCCHC accreditation and constitutionally required care.

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