Horticulture Therapy: Letting Nature Nurture

BY JAMIE SHINKUS

What used to be a barren plot of dirt on a drab street across from the Cook County (IL) Jail now holds life, delight, triumph, hopes and goals. That may be a stretch, but not much when one considers that the life—flowers and herbs—has been sown and nurtured by women who, by society’s measure, don’t have much going for them: All are former jail detainees who take part in its furlough program. Their success in growing and harvesting these plants, and donating them to local end-users, has proven a subtle but tangible factor in their own healing and growth.

Now in its second year—and having expanded to a site on the jailgrounds—this horticulture therapy is the latest initiative of the expressive arts program at Cermak Health Services, a county agency that provides the jail’s health care. The expressive arts program, part of the mental health services department, seeks to help inmates through creative outlets such as poetry and journaling, visual art and music.

While gardening is different, conceptually, it’s well-known to have therapeutic effects. According to the American Horticulture Therapy Association, “[HT is] a process in which plants and gardening activities are used to improve the body, mind and spirits of people.” (See page 14 for more information from the AHTA.)

That definition describes perfectly what expressive therapist Eric Dean Spruth, MA, ATR, sought to convey in his proposal for Cermak’s horticulture program. However, the idea first struck him at a visceral level. As his proposal noted, “[T]hink about how seeing nature bloom lifts your spirits…. Making things grow can boost self-esteem and be a jolt of independence…. Even if it is only to help relax and unwind, horticulture therapy can improve any person’s life.”

A home gardener himself, Spruth had long seen wasted potential in the empty planting beds. But since they are in front of the county courthouse administration building—in an open, public area—it was not feasible for detainees to work there. However, security was less of a concern for the furlough participants, who must check in daily at the jail but are free to live and work in the community. Before approaching the Department of Women’s Justice Services and the other agencies that had to be on board, Spruth found a large landscaping firm to donate most of the materials and to prepare the plots. He then presented a plan that spelled out logistical details, objectives and therapeutic benefits. For the most part it wasn’t a hard sell: “[DWJS executive director] Terrie McDermott is a gardener herself, and she said OK before I even finished the presentation.”

From Idea to Reality

With the necessary approvals in place, Spruth invited women in the furlough program to lend a hand, and on June 4, 2003, the Blooming Entrepreneurs English Garden was born. Initially there was some grumbling from skeptics, but no more: “People are seeing results, and that is changing their life.”

Continued on page 14
New Guidelines Aid in Schizophrenia Treatment

To help correctional mental health care providers manage patients with schizophrenia, NCCHC has developed new clinical guidelines that are based, in part, on the American Psychiatric Association’s Practice Guideline for the Treatment of Patients with Schizophrenia. The need has never been greater. On any given day in the United States, 2% to 4% of state prisoners and about 1% of jail detainees have schizophrenia or another psychotic disorder, compared with 0.8% of the U.S. population as a whole. Providing adequate treatment to inmates with schizophrenia not only helps the individual by reducing bizarre and disruptive behaviors but also may make the environment safer for other inmates and for staff.

High-Risk Population

The high prevalence of mentally ill inmates is believed to be related to the deinstitutionalization of patients in mental health facilities and the dismantling of mental health programs across the country. Left to their own devices on the street, these former patients often engage in behavior that leads to their incarceration. Many of these inmates also have other risk factors associated with a higher incidence of violent behavior (e.g., substance abuse, neurological impairment, poor impulse control) that may be exacerbated by psychotic symptoms. Because of their idiosyncratic and sometimes provocative behaviors, people with schizophrenia may be at higher risk of being victimized in correctional settings, and often their clinical conditions are intensified by overcrowding, hostility and loss of basic freedoms.

Specialized Guidance

NCCHC’s Clinical Guidelines on the Treatment of Schizophrenia in Correctional Institutions are intended to supplement the APA’s guideline by focusing on treatment issues that are unique to a correctional setting. (For useful principles and guidelines on providing psychiatric services in these settings, consult the APA publication “Psychiatric Services in Jails and Prisons,” which can be purchased at the NCCHC Web site or by calling our headquarters.) The schizophrenia guidelines address the following areas:

- background
- diagnosis
- management overview (including treatment goals)
- assessment on entry to the system
- frequency of follow-up visits
- content of follow-up visits (including assessment and levels of function)
- use of the assessment to guide treatment efforts (including continuity of care, treatment strategies and environmental controls)
- correctional barriers
- quality improvement monitors

Free Guidance Online

The seventh in a series of clinical guidelines geared toward health care providers working in correctional settings, the schizophrenia treatment guidelines are the first developed by NCCHC that deal with mental illness. The others offered to date address the following areas:

- quality improvement monitors
- frequency of follow-up visits
- content of follow-up visits (including assessment and levels of function)
- use of the assessment to guide treatment efforts (including continuity of care, treatment strategies and environmental controls)
- correctional barriers
- quality improvement monitors

Odds & Ends

Catalog keeps growing. The large number of registrants for NCCHC’s mental health conference demonstrates the pressing need for more resources geared toward mental health assessment and treatment in correctional settings. To help, we’ve added three valuable new titles from the well-regarded publishing arm of the American Psychological Association. For product descriptions and ordering information, visit the Publications section of our Web site.

- Treating Adult and Juvenile Offenders With Special Needs, edited by Joseph B. Ashford, Bruce D. Sales, and William H. Reid. 2001, 518 pages, hardcover; $49.95
- Acting Out: Maladaptive Behavior in Confinement, written by Hans Toch and Kenneth Adams, with J. Douglas Grant and Elaine Lord. 2002, 446 pages, softcover; $29.95
- Treating Chronic Juvenile Offenders: Advances Made through the Oregon Multidimensional Treatment Foster Care Model, written by Patricia Chamberlain. 2003, 186 pages, hardcover; $39.95

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New Guidelines Aid in Schizophrenia Treatment

With the recent launch of its accreditation program for opioid treatment programs based in correctional facilities, NCCHC has published a set of standards that represent the requirements for opioid treatment services in such facilities. In developing the standards, we used federal regulations and community standards as a guide and modified them to take into account the issues unique to providing services in a correctional facility.

Conforming with NCCHC’s Standards for Health Services, the OTP Standards are divided into nine general areas:

- A – Governance and Administration
- B – Managing a Safe and Healthy Environment
- C – Personnel and Training
- D – Health Care Services and Support
- E – Care and Treatment
- F – Health Promotion and Disease Prevention
- G – Special Needs and Services
- H – Health Records
- I – Medical-Legal Issues

All of the standards are linked to specific federal regulations and therefore are essential for achieving NCCHC accreditation. However, some may not apply, in whole or in part, to a given facility’s program.

Accreditation by NCCHC allows OTPs to obtain legally required certification from the federal Substance Abuse and Mental Health Services Administration. OTPs seeking accreditation are eligible for technical assistance consultation, funded by SAMHSA, that assesses what may be needed to comply with the standards. An OTP seeking accreditation need not be in a facility whose health services are accredited by NCCHC.

To learn more or to order the standards (which cost $29.95) call NCCHC at (773) 880-1460, or visit the Web at www.ncchc.org.
Health Literacy: The Challenges and Opportunities

BY JANN KEENAN, EdS

For Susan, a petite, 100-pound woman, taking her daily medication for high blood pressure with a light snack is easy. Each afternoon she grabs a banana and a handful of peanuts as she takes her pills.

Yet, for Ned, a strapping, 240-pound man who also suffers from high blood pressure, eating a light snack means downsizing two chicken sandwiches accompanied by a glass of milk, crackers and cheese.

Two patients, two approaches to follow the same medication instructions. But which patient is doing the right thing? Unfortunately, that’s open to interpretation.

In the example above, the medication instructions are vague and non-descript but most likely will not result in a deadly medication error. In other cases, however, medication noncompliance or an adverse drug reaction due to unclear instructions can result in a deadly outcome. It happens every day in America.

The inability to read, understand and act on health information is called low health literacy. A person with limited health literacy may have difficulty reading labels on pill bottles, understanding directions offered by the doctor or given informed consent because of the form’s lofty language.

Low health literacy has a negative impact on patient care, confuses patients and providers, and takes a heavy financial toll on the health care industry. And it is becoming an alarming public health issue.

According to a recent study by the Institute of Medicine, low health literacy affects 90 million people in the United States and by some estimates costs the health care system more than $58 billion annually.

For the 2 million inmates residing in the nation’s jails and prisons and the 11.5 million inmates released each year—populations more likely than the general public to have serious infectious diseases, newly diagnosed health problems, and language and cultural issues—low health literacy can be dangerous.

Fortunately, there is good news. Concern about low health literacy and how it affects patient care is becoming mainstream with legislators, public health interest groups and others. As a result, grass roots are being made to quell the problem, with grassroots health literacy initiatives springing up nationwide to enhance communication in health.

The movement is also taking hold in the pharmaceutical industry, where, for instance, marketers are developing reader-friendly package inserts.

Simple Strategies

Despite this explosion in awareness, day-to-day progress is slow. Part of the challenge is to educate health care providers, who may take it for granted that their patients understand them. In fact, providers themselves may be the best weapon in the fight against low health literacy—and potential errors that can result.

The following strategies, while not comprehensive, are simple and practical ways that health care providers can improve their daily interactions with inmates to strengthen health communication and comprehension.

Use plain medical English

Always use easy-to-understand terms when talking with patients. For example, providers should use terms such as “high blood pressure” instead of “hypertension,” “both sides” instead of “lateral” and “a cough that lasts too long” instead of “persistent cough.”

Be specific and avoid jargon

When giving medication instructions, say “in the morning” or “at night” instead of “a.m.” or “p.m.” When a pill must be taken with “plenty of water,” show the patient an 8-ounce glass of water or two Dixie cups full rather than leave them guessing.

Draw a picture or use models

People retain and understand information better when they are shown a picture or model rather than just talking about a subject. To help inmates understand a complicated health issue such as arteriosclerosis, draw or show a picture. In the case of high cholesterol, draw an artery with plaque clogging blood flow. Mention an easy-to-understand analogy, such as a pipe that is clogged.

Focus on key points

To help inmates clearly understand the gist of the matter, providers should select three specific points to summarize the patient’s illness or medication compliance.

Understand what the patient understands

Take extra effort to make inmates really understand what is being said. Try asking patients to repeat or explain the information just delivered. This “teach-back” technique helps providers know what has successfully sunk in and what is still missing in their instruction.

Take a fresh look at prepared materials

When using informational pamphlets or brochures, take a fresh look at the materials alongside the patient. Use a highlighter to call out important information. For example, if a patient has high blood pressure, mark the section in the brochure that says to avoid saltless food.

Similarly, highlight pictures or action words to help the patient understand specific activity. If your patient needs to do a foot check, circle the picture of a person checking his feet and write “do foot check” in the margin.

Ask the patient to write his or her name on the brochure

Making the brochure personal will help raise the patient’s compliance.

Know your intended audience

If you will be using the brochure with Latino patients, for instance, it is a good idea to have some Latinos in the photographs or illustrations. If you aim to reach older inmates, make sure the materials show older adults. This approach helps patients see this is “for them.”

Better Outcomes

Undoubtedly, conquering low health literacy will not happen overnight. However, if health care providers take a critical look today at how they communicate information and the best way to do it in a culturally sensitive way, chances are good that their patients, whether they will remain in a correctional institution or are preparing to reenter society, will have a better chance at positive health outcomes.

Jann Keenan, EdS, is president of The Keenan Group, Inc.—Experts in Health Literacy, a communications firm based in Ellicott City, MD. Reach her by e-mail at jkeenan@erols.com.

It’s Official: New AMA Policy Backs NCCHC Standards, Accreditation

The American Medical Association has adopted a policy of support for the National Commission on Correctional Health Care’s standards for health services and its accreditation program. The policy “encourage[s] all correctional systems to support NCCHC accreditation,” and calls for finding ways to increase funding for correctional health services.

Resolution 440 (A-04), Support for Health Care Services to Incarcerated Persons, was adopted by the AMA’s House of Delegates at its annual meeting in June. The House of Delegates is the association’s principal policy-making body.

The policy was introduced by the American Association of Public Health Physicians, which holds a seat on the House of Delegates. AAPH’s also is a supporting organization of the National Commission.

Improvement Needed

According to a report in AMA News, physicians widely supported the policy in part because of “recognition that illness in prison can spill over to affect the community at large.”

The resolution, which describes NCCHC as “the leading organization working to improve the quality” of correctional health care, also offers powerful arguments for the policy—including the fact that the U.S. Surgeon General views this as an important public health issue. Other key concerns include the following:

• Correctional health care should meet prevailing community standards, and providers should practice in keeping with contemporary standards.

• Incarcerated people have a high prevalence of disease and serious mental illness, as reported in NCCHC’s Health Status of Soon-to-Be-Released Inmates study.

• “Drastically curtailed” correctional budgets have resulted in “insufficient resources.”

A Long History

“The AMA has for over 30 years strongly supported the need for improved health and mental health care in jails and prisons,” says Jonathan B. Weissbuch, MD, MPH, who is AAPH’s delegate to the AMA. He also serves on NCCHC’s board of directors.

The AMA and NCCHC have a long history dating to 1970, when the medical association first began to look into the conditions of health services in jails and didn’t like what it found. The AMA collaborated with other organizations in a program to establish jail health care standards and advise on accreditation. In the early 1980s, that program evolved into the independent NCCHC.

“When those of us who labor in the vineyards of correctional medicine and public health thank the AAPHP for introducing the resolution and the AMA for adopting it,” Weissbuch adds.

The resolution is posted online at www.ama-assn.org/meetings/ public/annual04/440a04.doc. However, this version does not contain the sole amendment to the resolution, which expands the phrase “health care services” by adding “including mental health services.”
Oregon MD Treats the ‘Family Disease’ of Incarceration

BY KRISTIN PRINS, MA

In 2000, Elizabeth Sazie, MD, MPH, made a big career leap: After almost 20 years as medical director at the Benton County (OR) Correctional Facility as well as a county public health officer, Sazie joined the Oregon Department of Corrections as chief medical officer at the Coffee Creek, Mill Creek and Santiam facilities.

As CMO, Sazie is responsible for clinical care, consultation, administrative duties and public health activities. While this makes for a very busy schedule, these duties are quite familiar to others in her position.

What stands out about Sazie is her commitment to working at the forefront of correctional health care. In 2003 this commitment was reinforced when she became a Certified Correctional Health Professional. Why would such a seasoned professional seek certification? Sazie explains: “[Taking the exam] gave me more confidence in my ability to make decisions in gray areas.”

Her hard work in the many gray areas of correctional health care is sustained by her belief that this setting facilitates reaching a largely underserved population. “Inmates are sober and faced with reality, and may choose to address their health and substance abuse problems. This can have a positive effect on them, and on their families and the community. Assisting them and witnessing these changes are extremely rewarding. The challenges lie in motivating and sustaining these changes.”

Children in Need

In answer to such challenges, Sazie has been deeply involved in an ODOC program to aid children of prison inmates. In 2002, she took advantage of “momentum” in this area and joined with ODOC’s public affairs director and other individuals and groups to form the Children of Incarcerated Parents Project. Today, more than 20 organizations support this project, which Sazie says is “intervention to keep these kids out of the system.”

This is fortunate for the children the project is focused on: According to the Oregon DOC, more than two-thirds of female inmates and nearly one-fifth of male inmates have minor children, and these children are five times more likely to be incarcerated than their peers.

The child of an inmate is at risk for many reasons. She may have witnessed a parent’s criminal behavior and arrest. He may have to move to live with a relative, leaving behind school and friends. For some children, foster care is the only alternative. Unfortunately, foster kids get moved 4 to 6 times a year on average. Regardless of living arrangements, a child of an incarcerated parent is often uncertain where the parent is, what jail or prison is like, and what her own actions had to do with Mom’s or Dad’s arrest.

To help the people caring for youth with incarcerated parents, the project partners developed “How to Explain Jails and Prisons to Children: A Caregiver’s Manual.” Sazie, who was the guide’s lead author, hopes that encouraging caregivers to talk with the children—and helping them figure out how to do this—will reduce the number of these children who end up in the corrections system themselves.

“I had always wanted a booklet or fler to give to inmate families,” says Sazie. “In my 20 years at the county jail, I sometimes had three generations in jail. Incarceration is a ‘family disease,’ like substance abuse.”

Help for Parents

The Caregiver’s Guide has been provided to all Oregon DOC facilities and county jails and is displayed in the clinic and visiting areas of these facilities. It also is available at the popular parenting classes developed by ODOC in 2002. Sazie believes that parenting classes—as well as the many other family-focused activities run by ODOC and other supporting organizations of the Children’s Project—are popular because “Many inmates have not had models to learn how to be parents. These skills can be learned, and most inmate parents want to do a good job—they care about their kids.”

Participants in the parenting class have told Sazie that prison was the best thing that had ever happened to them. “It taught them to be good parents.”

The success of the Caregiver’s Guide cannot be measured yet, but it is getting off to a positive start. The guide soon will be available in Spanish, and it is already available online (see Web address below).

As she continues her work at the forefront of the correctional health care field, Sazie maintains that family health is a key element for the health of correctional populations. “It may not be a medical issue,” she says, “but it is a health issue.”

To learn more about the Children of Incarcerated Parents Project or to download the Caregiver’s Guide, visit the Web at www.doc.state.or.us/index.cfm?tree=children.cust Prisoner.incarceration&imb=0&inst=azier&guide=0

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For more information, call (773) 880-1460.
The Academy of Correctional Health Professionals’ commitment to advancing the profession was acknowledged and strengthened by two opportunities this year. The Academy received invitations to participate with national representatives in the revision of the Centers for Disease Control and Prevention’s tuberculosis guidelines for corrections, and to take part in the U.S. Surgeon General’s Call to Action on Correctional Health Care.

In March, the CDC convened a working group consisting of experts from the agency as well as from the corrections and public health arenas to revise the 1996 TB guidelines. The Academy is represented on two of the working group’s eight subgroups: diagnosis and treatment, and training and education.

The major work on the revision is now complete, and the working group will meet in December to review the guidelines before they are issued in 2005.

By invitation, the Academy visited the Justice Department in Washington, D.C., for the May 10 meeting on the Call to Action, which was issued last summer by the Surgeon General. Richard Carmona, MD, MPH, CCHP, convened a panel of experts from corrections and public health to discuss the current and anticipated state of correctional health care. The goals of the Call to Action include the following:

- Identify opportunities to raise awareness in the community, and especially among its leaders and major stakeholders, about the relationship between corrections and the health of the community at large.
- Identify barriers that impede development and implementation of transitional programs and health care delivery, including mental health and substance abuse treatment.
- Demonstrate how effective health, mental health and substance abuse programs impact disease and health care costs for our communities.
- Encourage policies that lead to collaboration among corrections, public health service organizations and the larger community.

With these goals in mind and the leadership of Admiral Kenneth Moritsugu, MD, MPH, CCHP, who is the deputy surgeon general, the panel committed to a day of frank discussion, making recommendations and identifying opportunities to support these and related goals.

Work included further clarifying some goals, and identifying and validating evidence-based scientific programs and actions for possible use in future programming. Most important, perhaps, was the validation of correctional health care issues, concerns, barriers, risks and the population served, strengthened by input from national experts.

In a profession marked by endless change and significant complexity, navigating one’s career can be a difficult task. Wouldn’t it be nice to have a wise, experienced and trusted colleague to turn to for help? Now you can, through the Academy’s mentor program. To learn what mentoring is and how it can help you, or to sign up for the program, visit the Academy online at www.correctionalhealth.org.
The Searching for Common Ground project, an effort funded by the JEHT Foundation and conducted in collaboration with the National Commission on Correctional Health Care, announces an essay competition to recognize best practices in transitional planning. Up to three entrants will receive air transportation, hotel lodging and registration to NCCHC’s National Conference on Correctional Health Care, being held Nov. 14-17 in New Orleans, LA.

There is a great need to have effective and efficient transitional planning in our prisons and jails. It is estimated that 97% of incarcerated individuals will eventually be released to our communities. This translates into staggering numbers: In 1999, nearly 600,000 prison inmates were released. Many of those being discharged from prisons and jails suffer from asthma, diabetes, cardiovascular disease, epilepsy, hepatitis C, HIV infection, serious mental illness and physical disabilities. It is vitally important that effective discharge planning occurs to ensure continuity of health care, through participation in employment, housing, school and church opportunities.

Across the country, many initiatives are taking place to improve the transition process. Some projects help inmates to prepare for a life beyond confinement, other projects work to improve the discharge process and yet others help releasees to adjust to life in free communities. A goal of the Searching for Common Ground project is to identify and widely communicate replicable models and best practices that measurably improve continuity of care for recently released inmates with serious medical and mental health conditions. The essay competition will help to identify the best of these models and practices.

Essay Guidelines

The Searching for Common Ground Project will accept essays on Best Practices in Transitional Planning from entrants who work in criminal justice institutions, human service agencies, community and neighborhood organizations, and other agencies that have an interest in improving transition into communities.

Essays must address efforts that contribute to improved public safety by offering better inmate transition through assessment, classification, programming, resource allocation and release preparation practices. Essays may address any of the following seven elements of the transition process:

• assessment and classification
• transitional accountability plans
• release decision making
• community supervision and services
• responding to violations of conditions of release
• termination of supervision and discharge of jurisdiction
• aftercare

The essay should make clear how the described model improves continuity of care for recently released inmates with serious medical and mental health conditions. It also should provide sufficient detail about the success rates of inmates who transition from the correctional institution to the community.

Entrants may wish to describe the collaborative efforts of corrections, law enforcement, human service agencies and other stakeholders in the transition process.

Competition Rules

A panel of correctional health experts will review the entries and select up to three winners. Essays will be evaluated on the basis of clarity and detail relating to the entrant’s success in measurable improvements in continuity of care for recently released inmates with serious medical and mental health conditions. All decisions are final, including the decision to select no winners if none of the entries are judged worthy.

One person per winning entry will receive the travel, lodging and registration award. Essays will become the property of NCCHC and may be used by the Searching for Common Ground Project to highlight special practices in discharge and transitional planning.

Typed essays of 500 words or less will be accepted through Friday, August 27, at 5 p.m. Entrants may submit the essays via e-mail at ncc@ncchc.org, by fax at (773) 880-2424, or by mail to R. Scott Chavez, PhD, NCCHC, 1145 W. Diversey Parkway, Chicago, IL 60614. Questions about the essay competition may be directed to scottchavez@ncchc.org.
One Size Does Not Fit All at Indiana Women’s Prison

BY JAIME SHIMKUS

What can we do to help you?” It’s a good bet that many inmates in the Indiana Women’s Prison had heard that question seldom, if ever, before being admitted there. Yet it’s a primary concern of service providers at the maximum security facility, where, along with the inherent security mandate, the mission statement explicitly “encourages rehabilitation through quality programming.”

Medical and mental health treatment are fundamental to this rehabilitation, but, given the needs of the diverse population it serves, the programming is defined broadly, aiming to improve “health” in areas such as parenting, self-esteem and coping with past abuse.

“Until recently the prison functioned with the ‘one size fits all’ philosophy,” explains assistant superintendent James Hendrix, MA, a trained psychologist whose duties include oversight of health services. “In the last few years, the composition of the incoming population has changed, resulting in a facility mission change.”

As the reception and diagnostic facility for all women entering the state’s Department of Corrections, IWP expects to process some 1,800 inmates this year, more than twice as many as in 1997. Most will be transferred to other facilities, but the assessment process will identify those to remain at IWP, which houses not only new intake but also all special populations. These populations reside in six separate “zones”: • Intake unit • Special needs units for mentally ill and developmentally challenged inmates • Youthful offender unit • Medical management unit • Maximum security complex that houses the general population • Disciplinary/administrative zone, which includes segregation and death row

In addition, the “progressive” unit has 20 beds for special needs inmates in transition to general housing. This structure enables the staff, led by a zone supervisor, to specialize operations and services for each group. “Consequently,” Hendrix says, “each population can successfully address the nuances associated with its unique inmates.”

From visionary idea to volcanic eruption: That’s how family services director Janet Schadee, RN, MAH, describes the program’s evolution over eight years from a child visitation program to a vast network of multidisciplinary services, both in the prison and outside, geared toward fostering healthy families.

The program was conceived by facility superintendent Dana Blank—who saw that “children are victims of their mothers’ incarceration,” as Schadee notes—and was implemented with the assistance of the social services director and a longtime volunteer at the prison. The first step in developing what has grown into a comprehensive program of wraparound services was establishment of the visiting room within the prison confines. Described by Hendrix as “a first of its kind,” the center offers a warm, inviting environment where mother and child can bond.

From there, the prison contacted agencies that assist families in the community and explained that these incarcerated mothers, who usually do not lose their rights to their children, are in dire need of services such as counseling in family planning, prenatal care and parenting skills. From there the program grew into its current form with five major components:

1. Therapeutic education and support groups address parenting skills for mothers and grandmothers.

2. Responsible Mother, Healthy Baby provides case management and more for the prison system’s pregnant inmates, all of whom live at IWP. Supervised by an RN designated as the prenatal care coordinator, the program includes the following:

   • In-patient and intensive intake assessment to identify the needs of mothers, caregivers and children
   • A family care plan for each pregnant inmate, with goals based on issues identified in the assessment, including placement of the child
   • Prenatal and parenting education
   • Newborn care classes
   • Support groups held weekly
   • A birthing coach

This program provides an outreach family care program that connects caregivers with community agencies and resources and follows the child’s progress at home.

3. Parental bonding provides ways for inmates and their children to develop and maintain bonding during the mother’s incarceration. These settings and events also enable children to spend time with others who have similar family circumstances.

The children’s visitation center operates year-round, providing a supportive, child-friendly setting with toys, books and activities to foster interaction and nurturing.

4. A summer day camp held at the prison for five days each July provides ample time for relationship-building activities in a stimulating environment with music, crafts and pets and play with zoo animals.

5. Parent-enf day, held twice a year, invites youth aged 13 to 17 to spend the day with their mothers or grandmothers and engage in problem-solving activities that require teamwork.

4. Outreach initiatives link mothers with home, children and caregivers via an outreach family care coordinator, who not only works with community agencies to obtain needed resources, including transportation for visits, but also meets with the children and their caretakers at their homes to ensure that the environment is healthy and safe.

5. Family planning offers education and family planning service for inmates who are soon to be released from the facility. The program is staffed with a full-time registered nurse who has both academic and practical experience in public health and receives board certification. The Family Preservation Program, formal education is available to all inmates, some of whom earn degrees from a state university.

This is not all a one-way street, though. “Giving back” programs develop inmates’ sense of pride and responsibility by enabling them to help those less fortunate. For instance, they make clothing for poor children and sleeping bags for homeless shelters. Students in the building trades have made items such as bookcases and rocking horses. “I’m very proud of the work that so many of these ladies do,” says Hendrix. “For many, it serves as a means of restoring themselves to the fabric of mankind.”

Creative Funding

As intricate as the programming itself are the myriad relationships that Schadee builds between correctional and community service agencies and funders. This is essential because the programs are not DOC funded but rather are funded almost exclusively by grants or by the service agencies themselves.

While state support helped launch the Family Preservation Program, the vagaries of governmental budgets led Schadee to look elsewhere for funding. Thinking creatively, she has secured numerous foundation and other grants for which IWP would not qualify on its own, but that instead support the not-for-profit agencies that provide the services. It’s a nonstop juggling act, but two years ago major help arrived in the form of another $300,000 from the Health Resources and Services Administration. With this money Schadee is working to “institutionalize” the infrastructure that underlies the programing. Key to this is development of an electronic case management and tracking system, which not only facilitates linking inmates with services but also enables the program to track outcomes: in effect, to prove its worth.

One indicator, for example, is the recidivism rate at IWP; about 9% after three years, compared to 39% of women who returned to prison in 1994, according to a 2002 Bureau of Justice Statistics report.

“It makes sense,” says Schadee. “Women do better upon return to the community if they maintain their family’s and children’s needs.” Just as important, Hendrix addrs, it helps to end the cycle of incarceration within families.
New Mexico MDs Support Opioid Treatment in Corrections

The New Mexico Medical Society House of Delegates has unanimously passed a resolution in support of opioid replacement therapy in the state’s jails and prisons. Setting its sights on passage of state legislation, the society wants to “require the initiation of a voluntary (for inmates) opioid replacement treatment, including methadone and buprenorphine maintenance treatment.”

Mindful of the need for proof of efficacy, the resolution also calls for formal evaluation of the ORT programs “to determine whether such treatment modalities decrease recidivism, crime and transmission of infectious diseases among populations at risk in New Mexico.”

According to Barbara J. McGuire, MD, who introduced the resolution, “This may be the first time in this country that the physicians members of a state medical society have passed a resolution regarding opiate replacement therapy for jail and prison inmates. It could represent a landmark step in the advancement of inmate health care.”

McGuire is president of the Greater Albuquerque Medical Association, whose board unanimously endorsed the resolution before sending it to NMMS.

The NMMS House of Delegates, which comprises about 75 physicians representing all of the county medical societies across the state, took the move at its annual meeting in May.

ORT Gaining Acceptance

While opiate addiction plagues correctional facilities across the nation, the situation is particularly dire in New Mexico. According to the resolution, in 2001 nearly 16% of men and 19% of women newly admitted to the Bernalillo County jail tested positive for opiates, primarily heroin. The situation is exacerbated by high rates of hepatitis C in the state, and of recidivism among inmates with substance abuse problems.

Even acknowledging these challenges, the medical society’s vote was a bold one, says Judith A. Stanley, MS, CCHP-A, director of accreditation at NCCHC.

“Traditionally, community providers have been strongly divided over methadone therapy, with some viewing it as replacing one drug with another,” explains Stanley, who worked in correctional mental health care for years before joining NCCHC. “However, the medical literature and practice is slowly recognizing the physiological underpinnings of addiction and the validity of methadone therapy. For a state medical society to address this need in incarcerated populations is progress indeed.”

The resolution itself cites studies by the National Institutes of Health and the Institute of Medicine concluding that, to date, methadone maintenance treatment is the most effective treatment for heroin addiction. Another important factor is the FDA’s approval of buprenorphine, which is administered orally, for treatment by primary care providers in office-based settings.

Next Steps

Now come the tasks of education and persuasion. At the state level, the society will be lobbying the legislators who are involved with health care and funding for corrections. The resolution also will be forwarded to the American Medical Association for consideration in implementing new health policy, according to McGuire. Among its own members and those of specialty societies, the NMMS is distributing information on a home study program by which providers can become certified to dispense buprenorphine.

Efforts are also underway to increase public awareness and support, which is important because of concerns about drug-related crime in the state, McGuire says. For example, she has had articles on the subject published in local newspapers.

“If we are ever to break the drug-related cycle of hepatitis C and other infectious diseases, gang violence, burglaries, car-jackings and drive-by shootings, we must have medically supervised opiate replacement therapy—methadone or the newer and safer buprenorphine—to offer to addicted inmates while incarcerated,” says McGuire. “Only with effective medical therapy of substance abuse will there be a reasonable chance that these inmates could enter addiction recovery and return to productive lives upon release.”
Mental Health Emergency Strikes Las Vegas

Mental illness rates in Clark County, NV, have long been at “crisis” levels, but so many psychiatric patients are flooding hospital emergency rooms that on July 9 the county declared a state of emergency. County officials report that normally about 50 such patients occupy the 330 local ER beds but the number had doubled in recent weeks, to about one-third of all beds. This poses a public health threat because it limits the ability to deal with other medical emergencies that may arise, the county says.

As a short-term fix, some patients were treated at a temporary facility set up by a local social services agency. The state also agreed to provide $100,000 for emergency assistance.

Jails Also on the Front Line

“This is is not a new issue,” says David Luxnor, MA, health administrator at the Clark County Detention Center in Las Vegas. “The ERs break these records all the time. But it does magnify a situation that is worsening everywhere in the country.”

Indeed, counties nationwide are struggling with a rising tide of un- or undertreated mentally ill people, but in Las Vegas the numbers are particularly catastrophic. For example, the suicide rate is about twice the national average, Luxnor says, and that points to a disproportionate number of seriously ill people.

Dealing With the Problem

To ease its own mental health crisis the jail has taken a number of steps. It has boosted the number of social workers and, to identify detainees in need of treatment, mental health screenings are done at booking, where a mental health professional is assigned round-the-clock.

Last year Luxnor opened a 64-bed mental health unit to supplement two existing units for psychotic patients and another for suicidal patients. (This has paid off: The jail just observed a full year with no suicides.)

The jail also has aided the justice system in establishing a mental health court to divert certain offenders from jail. The small program has proven so successful that Luxnor plans to appeal to the government for funds to expand it tenfold.

was established, along with the many other activities and programs that constitute the NCCHC we know today.

Well-Deserved Recognition

Last October Bernard and Jaye were the recipients of the National Academies’ Institute of Medicine’s 2003 Gustav O. Lienhard Award.

The citation for this prestigious award recommended the following: “Outstanding leaders...for their profound contributions to improvements in the quality and humanity of the medical care systems for the incarcerated.”

Their work to develop comprehensive standards for correctional health services and to initiate the concept of voluntary accreditation provided “the incentive for states, counties, and the federal government to upgrade health care conditions in correctional facilities.”

Lauding their ability to marshal support from key organizations and constituencies to build awareness of the issue, the IOM citation goes on to state: “[Harrison] and Anno demonstrated the interrelatedness of problems posed to the health of the public beyond jails and prisons, and the inadequacy of care that was being provided to inmates....In concurrence with their work, the Supreme Court ruled that states have an obligation to ensure that an individual’s basic needs are met, including health care.”

Santa Fe Consultant

In 1991 Bernard and Jaye retired from NCCHC and established a busy consulting practice based in their home. The following year they moved to Santa Fe with their young daughter Kari, and we were then neighbors as well as friends. Jaye is a Western gal from Cody, Wyoming, who likes horses, but Bernard, who was born in Chicago and lived there all of his life, now became a Westerner, too. He adapted readily, sharing in the care of their horses, and dressed accordingly. On many our visits to Wyoming we spent our vacation with a contract that state. He was a cowboy hat and boots. We spent many hours in the car on those expeditions to widely dispersed prisons. We had scary adventures in blinding snowstorms, and we had fun singing together as we drove along. Bernard had a good voice, and we knew the same oldies—You Are My Sunshine, Sweet Adeline and others. We’d tell jokes. He had a great sense of humor.

As we worked together, my respect and admiration for Bernard steadily increased. He was a classy guy, humble and always courteous, affectionate, strong but gentle. When Bernard’s death was approaching, he reassured Jaye of how much his efforts were appreciated. His only wish was that we would remember him with a smile.

Steven S. Spencer, MD, CCHP-A, is an independent consultant and a surveyor for NCCHC’s accreditation program. A former medical director for the New Mexico Department of Corrections, Spencer received the 1998 Bernard P. Harrison Award of Merit for his long history of dedication, contribution and leadership in the correctional health care field.
Why Attend the 2004 National Conference?

The educational objectives for this conference are to enable you to:

- Demonstrate increased understanding of common correctional health care issues by exchanging ideas with colleagues about new developments in specialty areas
- Identify strategies for improving the quality, how to avoid legal actions, tips on staff recruitment and retention. But like the ever-changing nature of correctional health care, this year’s program offers much that is new. Below are some of the many intriguing titles:
  - Digging Out of Disasters
  - Managing Intersexuality in the Correctional Setting
  - Meditation Behind Bars
  - Release Planning: Developing an Integrated and Comprehensive System
  - Reporting Correctional Staff Violence: Legal and Ethical Considerations
  - Weight Management Programs in Juvenile Facilities

Extras Extras Extras

Preconference Seminars: Set the Tone

Get your educational experience off to a good start by attending one or more of the preconference seminars to be held on Saturday and Sunday. The in-depth sessions address subjects essential to the delivery of high quality correctional health care: NCCHC’s recently revised standards for health services (prison, jail and juvenile), its mental health care guidelines, and quality assessment at health care facilities.

Saturday:

- Managing Intersexuality in the Correctional Setting
- Reporting Correctional Staff Violence: Legal and Ethical Considerations
- Weight Management Programs in Juvenile Facilities

Sunday:

- Digging Out of Disasters
- Meditation Behind Bars
- Release Planning: Developing an Integrated and Comprehensive System
- Reporting Correctional Staff Violence: Legal and Ethical Considerations
- Weight Management Programs in Juvenile Facilities

Share a Little, Learn a Lot

For a great networking session, be sure to attend the Shared Interest Groups sponsored by the Academy of Correctional Health Professionals. These small, informal groups enable you to meet with colleagues for focused discussions moderated by leaders in correctional health care. The SIGs will take place during the concurrent sessions on Monday, 2:15 p.m. to 3:30 p.m.

Sunday Morning Stress Relief

With an emphasis on deep breathing and mental imagery, Tai Chi integrates mind with body to restore vitality, inner strength, balance and natural health. The slow, dance-like moves create balance, flexibility and calmness and help to relieve stress. Led by Carl Bell, MD, noted mental health authority, NCCHC board member and Tai Chi instructor, the free class will take place at 7 a.m. on Sunday at the convention center. Wear loose-fitting clothes.

Get an Eyeful in the Exhibit Hall

The National Conference features the nation’s largest and most comprehensive commercial exhibit in this field. Set aside plenty of time to visit the exhibit hall during one of the many scheduled breaks. There you can meet with knowledgeable representatives from 150 companies showcasing state-of-the-art products and services, career opportunities and professional services.

Registration Categories

Register online via secure server at www.ncchc.org. The last day to preregister is Oct. 29. After that date you must register on site.

Academy Member: $235 for early birds, $285 on October 1 or later. Academy members save $85 off the regular fee!

Nonmember: $310 for early birds, $360 on October 1 or later. If you are not an Academy member but wish to join, simply sign up using the conference registration form.

One Day: $185. Select the day you wish to attend: Monday, Tuesday or Wednesday. The one-day fee entitles you to participate in all events that day.

Guest: $45. This special registration enables guests to attend all exhibit hall events, including the opening reception on Sunday and lunch on Monday. It does not provide access to educational sessions.

Preconference Seminars: Full day seminars, $170; half day seminars, $95.

Worth a Look

Many presentations pack the room from year to year: updates on chronic and infectious disease treatment, cost-cutting strategies that don’t compromise quality, how to avoid legal actions, tips on staff recruitment and retention. But like the ever-changing nature of correctional health care, this year’s program offers much that is new. Below are some of the many intriguing titles:

- Digging Out of Disasters
- Managing Intersexuality in the Correctional Setting
- Meditation Behind Bars
- Release Planning: Developing an Integrated and Comprehensive System
- Reporting Correctional Staff Violence: Legal and Ethical Considerations
- Weight Management Programs in Juvenile Facilities

Conference Site, Accommodations and Travel

Hotel

All educational sessions will be held at the Hyatt Regency. Situated in a perfect locale downtown, it is adjacent to the Louisiana Superdome and New Orleans Shopping Center, and a short walk from the French Quarter, Bourbon Street and the Mississippi Riverfront. The hotel is offering a special conference rate of $148 single/double (plus taxes) for reservations made before October 22.

Hyatt Plaza at Loyola Avenue, New Orleans, LA 70113-1805
Hyatt reservations (800) 233-1234; direct (504) 561-1234
http://neworleans.hyatt.com

Air Travel

Meeting attendees traveling within the United States are eligible for a 10% discount on round-trip tickets. To book your travel contact our official carriers:

- American Airlines (800) 433-1790 refer to ID A19N4AA
- Southwest Airlines (800) 433-5368 refer to ID Code V0265
Evidence-based Medicine

Don’t Squander Your Antibiotics on Respiratory Viruses

BY JEFFREY KELLER, MD

I suspect that almost every physician in the United States would agree that antibiotics are overprescribed. Unfortunately, since the total number of antibiotic prescriptions given to people with “cold” has been estimated at $44 million per year in this country, it would seem that most physicians have not actually amended their own prescribing habits.

I can see how this would be the case. Too many physicians are stuck in the inertia of “I have always done it this way.” Also, “my patients expect an antibiotic when they come in and they won’t be happy if I don’t prescribe one.” Finally, “The antibiotic can’t hurt and it might help!”

Multiplying each incident of an unneeded prescription by, oh, a few million, and it adds up.

Of course, inappropriate antibiotic use can and does hurt. It hurts every patient who has an adverse effect from an inappropriate antibiotic prescription, stuff like diarrhea, yeast infections, nausea and allergic reactions. It hurts the community by breeding antibiotic-resistant bugs. And it hurts the economy because inappropriate antibiotic use is expensive, to the tune of $1.1 billion per year! That figures comes from a study published in the Feb. 24, 2003, Archives of Internal Medicine.

How much of that money is being wasted at your facility?

Better Care, Less Waste

One of the neatest things that I have discovered about the evidence-based medicine movement is that using evidence-based principles almost always saves money. There is no better example of this than in the area of antibiotic use.

Three years ago, the Centers of Disease Control and Prevention published evidence-based guidelines for the appropriate use of antibiotics for upper respiratory infections. The guidelines were developed by a panel of experts that included representatives from infectious disease, family practice, emergency medicine, internal medicine and from the CDC itself. The panel used evidence-based principles to review the huge amount of literature on these subjects.

The guidelines they came up with, titled “Principles of Appropriate Antibiotic Use for Acute Respiratory Tract Infections in Adults,” were published in the March 20, 2001, issue of the Annals of Internal Medicine and can be found online at www.cdc.gov/drugresistance/community/technical.htm. The final report included pharyngitis (which I reviewed in the last issue of CORRECT-CARE), acute bronchitis and rhinosinusitis. Below I will summarize recommendations for the latter two.

Acute Bronchitis

A patient presents to your medical clinic complaining of a cough, productive of green sputum that she has had for three days. She should get an antibiotic, right? Not so fast!

The CDC panel defines acute bronchitis as an acute respiratory tract infection with prominent cough, with or without sputum production. As we all know, complaints of cough that we diagnose as “acute bronchitis” are common. The CDC panel’s recommendations apply to otherwise healthy adults without other complications, such as COPD. In other words, they apply to the vast majority of the patients we see. With that in mind, here is a summary of the CDC’s recommendations regarding bronchitis:

1. Viruses cause the vast majority of bronchitis. The only significant nonviral causes of bronchitis are pertussis, mycoplasma and chlamydia.

2. The main clinical objective for the practitioner evaluating a patient with cough is to rule out pneumonia. In healthy adults, this can be accomplished by finding symmetric breath sounds and normal vital signs (no fever, a respiratory rate less than 24 and a heart rate less than 100). Chest x-ray should be ordered only in those with cough of greater than three weeks duration or asymmetric breath sounds or abnormal vital signs.

3. Antibiotics should not be prescribed for routine, uncomplicated acute bronchitis. Finally, the patient is a healthy adult who does not have pneumonia, do not give antibiotics! The CDC points out that a long series of meta-analyses and randomized trials consistently fail to show any benefit of antibiotics when given for uncomplicated acute bronchitis.

4. Finally—and this is important—the CDC notes that patient satisfaction with physicians’ care for acute bronchitis depends more on physician-patient communication than on whether the patient received an antibiotic. If you will explain to your patients why they do not need antibiotics, they most often will be happy with your care. I have found it helpful to refer to the CDC guidelines when talking to patients.

Let us now return to our patient who has been coughing up green sputum for three days. She was found in clinic to have normal vital sounds and symmetric breath sounds. The PA on duty explained to the patient the CDC criteria for antibiotic use and then discharged her without an antibiotic prescription.

Rhinosinusitis

The next patient who comes to the jail medical clinic complains of “sinusitis.” He has “stuff running down the back of my throat” and has had a stuffy nose for three days. He states “my doctor on the outside always gives me Augmentin for this.” So what do you think? Should this guy get an antibiotic?

The CDC panel defines rhinosinusitis as an inflammation of the mucosa of the sinuses and paranasal structures. Sinusitis involving the maxillary and ethmoid sinuses is usually self-limited. However, sinusitis remains the fifth most common diagnosis for which antibiotics are prescribed.

The CDC panel makes the following recommendations:

1. Viruses account for the majority of cases of rhinosinusitis.

2. Patients with bacterial sinusitis tend to have the following:
   a. Symptoms for more than 7 days
   b. Tenderness of the face or teeth
   c. Purulent nasal discharge

3. The CDC does not recommend sinus x-rays for the diagnosis of sinusitis since x-rays perform poorly compared to sinus puncture and culture. If the clinician suspects frontal or sphenoid sinusitis, CT scanning of the sinuses is prudent.

4. Most cases of rhinosinusitis resolve spontaneously without antibiotics. Antibiotics should be reserved for patients with moderate or severe symptoms.

In the case of our clinic patient, the PA notes that he has had symptoms for less than seven days. He also has no significant tenderness to percussion of the face or teeth.

Finally, the PA cannot find any true purulent discharge. After a discussion about the CDC’s recommendations on the appropriate use of antibiotics for rhinosinusitis, the patient is discharged with analgesics but no antibiotics.

Tally It Up

Here is the question for your facility: How much money are you paying for antibiotics prescribed for sinusitis, bronchitis and pharyngitis? I recommend that you find out by pulling all of the charts with one of those diagnoses over the past couple of months and adding up the antibiotic costs. Then, I highly recommend that these CDC guidelines be required reading for all of the prescribing clinicians in your jail or prison.

Jeffrey Keller, MD, is president of Badger Correctional Medicine, a contract management company based in Idaho Falls, ID. Reach him by e-mail at badgermed@datawave.net.
Historically, prison health care has been isolated from the larger public health care community. Many institutions are in remote rural places, far from medical libraries or tertiary care centers. Prisons have experienced enormous difficulties recruiting and retaining qualified medical personnel, in large part because of low salaries and the lingering social stigma still falsely associated with practice in corrections. Perhaps part of the problem is also that the notion of integration of correctional health and public health is implanted too late. Giving correctional health care a place at the academic and clinical tables of medical schools is a promising innovation.

Three Perspectives
The next issue of the Journal of Correctional Health Care features a symposium discussing the rotation of osteopathic medical students through practice and training in corrections from three perspectives. Together, they illustrate the synergy that made this experiment work and encourage its replication.

The first article, "Developing a Correctional Medicine Rotation for Medical Students," discusses the genesis of a rotation program from early planning through successful implementation. It addresses obstacles that had to be overcome, including student fears and initial academic misgivings. Finally, the article surveys the results of its successful program and its prospects for replication.

Next, "The Value of Correctional Medical Training for Correctional Management and Enhanced Delivery of Services" looks at medical student rotation from the point of view of the prisons' health care managers. It describes the benefits to the system, to the students and to the inmate patients from a well-run program. Cost and control factors are explored, as are the educational prospects for learning—not only by the students from the prison health care staff but also by the staff from their students—in an academic setting of student/faculty interaction at its best.

Finally, "The Student Perspective on Correctional Medical Rotation" is a personal account of a medical student's experiences on a correctional rotation. His enthusiasm shines as he recounts his daily work—some of which is routine to the seasoned practitioner—and the breadth of his hands-on exposure to nearly every aspect of medicine in a way not usually available in more traditional rotations. His experience is a lesson to other students to take advantage of the same opportunity.

William J. Rold, JD, CCHP-A, is guest editor of this Journal symposium.
perceptions," Spruth says.

Those results come in several forms. Most visible, perhaps, are the plants themselves. The first-year garden relied on starter plants rather than seeds to improve the odds of success. It contained herbs and flowers chosen for their marketability.

Before long county staffers began to express their appreciation: "It adds beauty and life to the facility. It is wonderful to have something nice to look at," wrote one clerk.

While the aesthetic appeal to staff is welcomed, the real purpose is to cultivate the well-being of the gardeners. By design the program is informal, with no fixed assignments for work or plant type. From 8 to 20 gardeners may show up on a given day, and they are gently encouraged to pitch in wherever help is needed. All work is done by hand or by spade, which enables the gardener to connect quite literally with the soil.

From time to time, especially when the weather does not permit work outdoors, Spruth brings in speakers to teach the women about the fine points of gardening or the therapeutic uses of plants.

"I now know what will help me sleep," wrote one woman. "I know that rosemary oil is good for the hair and skin. I have an herb book so I'm going to study it when I get home."

Like the garden itself, interest in the project has flourished, and this year detainees are being invited to try their hand at a plot within the jail confines. More local organizations, including the Chicago Botanical Garden, have signed on as supporters. Spruth has received stacks of commendation letters from local dignitaries and others.

But, at the end of the growing season, the most important result, articulated by Cermak's chief psychologist (and Spruth's boss) Carl Alaimo, PsyD, is this: "The gardening program has proven to facilitate not only an opportunity for our patient population to look beyond themselves but also deep into the future of how consistent nurturing will provide a positive outcome in their lives."

Digging In to HT

What Is Horticultural Therapy?

A process in which plants and gardening activities are used to improve the body, mind and spirits of people. HT is an effective and beneficial treatment for people of all ages, backgrounds and abilities.

Where Is It Used?

Worldwide in hospitals, rehabilitation and vocational facilities, nursing homes, prisons, community gardens, botanic gardens, schools, farms, horticultural businesses and prisons.

How Is It Used?

As a cognitive therapy, HT helps clients learn new skills and regain those lost. Improved memory, initiation of tasks and attention to detail are recognized HT benefits. Social growth occurs: People caring for plants learn responsibility and experience hopeful and nurturing feelings. HT used in physical rehabilitation retrains muscles and improves coordination, balance and strength. In vocational HT settings, people learn to work independently, solve problems and follow directions.

Who Uses HT?

Adults and children with physical, psychological and developmental disabilities. Those recovering from illness or injury. People wishing to improve their quality of life in hospice or nursing home settings. Victims of abuse and their abusers, public offenders and recovering addicts all find HT rewarding.

What Are Its Advantages?

HT is a simple and "lo-tech" treatment to implement with proven positive outcomes. It is nonthreatening to the client, encourages social activity, improves memory, provides sensory stimulation and exercise, reduces stress and tension, improves self-esteem and rewards nurturing behavior. HT prepares the disadvantaged and disabled for employment in horticultural businesses and farms, by teaching how food and other plant-related commodities are grown and marketed.

From a medical standpoint, gardening creates physical results such as reducing stress and lowering blood pressure, says Cermak psychiatrist Maria Mynott, MD. But it also has less tangible effects: "In an environment like this you lose power. This garden lets the women reconnect with their roots and establish community. They can progress to the point where they are providing not only for themselves, but also for the community. This is very empowering."

The women take pride in knowing that the herbs and flowers they have harvested are put to good use. To date they have been donated to local restaurants and to a business that uses dried flowers in specialty soaps. One restaurant has even hired one of the gardeners as an apprentice chef.

From an aesthetic standpoint, HT creates a sense of beauty and life to the facility. It is wonderful to have something nice to look at, as written by one clerk.

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HCV-Related Disease on the Rise

While the exact prevalence is not known, hepatitis C may affect from 16% to 49% of U.S. prisoners, in stark contrast to a 2% prevalence rate in the population as a whole, according to estimates in the June issue of the **HEPP Report**. Further, because of a lag between HCV infection and resultant disease, the prevalence of chronic liver disease is rising in a time when overall infection rates are declining. These trends have important implications for correctional health care, the article on “hot topics” in HCV treatment notes. A second article discusses factors to weigh in deciding whether to treat an inmate with HCV. The free report (an acronym for HIV & Hepatitis Education Prison Project) carries a continuing medical exam and is available at www.hivcorrections.org.

Canada Breaks the Tattoo Taboo

To curb the rampant spread of blood-borne diseases among its prisoners, Correctional Service Canada is planning to set up official tattoo parlors in the federal agency’s prisons, according to Canada NewsWire reports. The tattooing would be done by the prisoners themselves, after training. The “Safer Tattooing Practices Initiative” came after a study found that 45% of federal prisoners had received a tattoo while incarcerated. The Union of Canadian Correctional Officers opposes the plan, saying it poses unacceptable risks and contradicts the goal of rehabilitation and community reintegration.

AJA Examines Jail Trends

“[J]ails are getting larger and the smaller ‘Mom and Pop’ jails (rated capacity 0-100) are declining.” That’s one key finding from a report in the May/June issue of **American Jails**. Published by the American Jail Association, the magazine analyzed data from the AJA’s 2003 Who’s Who in Jail Management directory. Other trends noted include an increase in regional jails, a decrease in city jails, and a growing number of women jail administrators.

Billions and Billions

In fiscal year 2001, the nation spent about $200 per U.S. resident on correctional services at all levels of government, an increase of over 400% from the $39 per capita expenditure in 1982. The total outlay for corrections in 2001 was about $60 billion. As of March 2001, corrections employed over 747,000 people vs. less than 300,000 in 1982. On average, state and local correctional agencies and institutions employed 25 personnel per 10,000 population. These figures come from a report on U.S. expenditures and employment in the justice system as a whole, with data breakdowns for its three sectors, police, corrections and judicial/legal. Issued in May by the Bureau of Justice Statistics, the report is available online at www.ojp.usdoj.gov/bjs/abstract/jeews01.htm.

**HEALTHCARE COSTS PER INMATE PER DAY**

| Year | Cost
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**HOW CAN STATES LOWER HEALTHCARE COSTS? JUST ASK GEORGIA.**

This past fiscal year, the Georgia Department of Corrections achieved the impossible: they lowered per inmate healthcare costs by 5.1% — nearly $7.5 million — without compromising patient care. How? By reducing their:
- Psychotropic drug costs by 3.4%
- Length of stay in mental health crisis stabilization units by 40%
- Rate of increase in hospital days by 4%
- Number of specialty care visits.

MHM Correctional Services is proud to have played a vital role in lowering GDCC’s costs. For four years, MHM managed the department’s psychotropic drug usage, mental health staffing and utilization. In 2002, we expanded our role — and our value to GDCC — with external physical health utilization management.

MHM can deliver remarkable results for your state system. To find out how, call Mike Brewer today at 800.416.3649. Or visit us online at www.mhm-services.com.
Clinical Performance Enhancement Made Clear

By Judith A. Stanley, MS, CCIFP-A

The Clinical Performance Enhancement standard (C-02), introduced in the 2003 edition of the prison and jail Standards for Health Services, was one of the most difficult to articulate. Now that it has been implemented, it is turning out to be one of those standards most often misunderstood.

While the NCCHC standards are not clinical performance standards per se, the expected outcome of compliance is provision of health care that not only meets constitutional requirements but also conforms with community standards. The NCCHC standards are based on the assumption that correctional health care providers practice their clinical skills as they would in any other health setting.

With that in mind, the NCCHC standards revision committee saw this new standard as a push to the correctional health care system to focus on clinical skills and practice at least once per year. It is an opportunity to pause, step back from the day-to-day demands of treating, and concentrate on quality practice issues with an experienced and understanding colleague.

In contrast to a healthy continuous quality improvement program, which raises red flags when a provider is not practicing according to usual expectations, the performance enhancement process is an opportunity to spotlight the professionalism and currency of clinical care.

The name chosen for this standard, the definitions used to clarify intent and the compliance indicators all were the result of much discussion by the revision committee.

The standard itself is succinct—"A clinical performance enhancement process evaluates the appropriateness of all primary care providers’ services"—as is its statement of intent: "to enhance patient care through peer review of the clinicians’ practice."

To clarify intent, three definitions are provided: Clinical performance enhancement is the process of having a health professional’s work reviewed by another professional of at least equal training in the same general discipline. Primary care providers are all licensed practitioners providing the facility’s primary care including medical physicians, psychiatrists, dentists, midlevel practitioners (i.e., nurse practitioners, physician assistants), and PhD-level psychologists. Finally, primary care is defined as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

Meeting the Intent

Despite these efforts at clarification, a number of accredited facilities and those seeking accreditation are engaging in practices that may be worthwhile in themselves but do not satisfy the intent of this standard. For example, an annual performance evaluation most often is done by a supervisor who focuses on administrative matters such as completion of work and compliance with attendance rules. Unless the supervisor is a clinician of equal or better qualification in the same discipline and the evaluation also includes a clinical performance enhancement process and the evaluation also includes a clinical performance enhancement process, the typical performance evaluation does not meet the intent of this standard.

In all cases, the reviewer should first inspect some treatment records and then provide a written evaluation and recommendations, if any. Ideally, the two parties will meet face-to-face, though a phone call may suffice. Exchange of written materials is less desirable but could work well in the hands of experienced professionals. At minimum, a written report is forwarded to the provider, who signs the evaluation to acknowledge the feedback.

Beyond that, two criteria must be met. First, the reviewer must be in the same general discipline as the provider being reviewed—for example, both are dentists or both are psychiatrists. Second, the reviewer has received the same or a higher level of training—e.g., an MD reviewing other MDs or midlevel practitioners; a PhD-level psychologist reviewing PhD-level psychologists.

Review of the responsible physicians, dentists and psychiatrists generally is conducted by corporate or system-level medical directors, dental directors or mental health coordinators. Where there are two or more providers in the same discipline, mutual reviews are fine. While it would be great for midlevel providers to be reviewed by a midlevel colleague, for purposes of this standard physicians are considered to be in the same discipline because of the unique relationship between physicians and PAs/NPs.

Other Considerations

Another common area of confusion relates to documentation. How much is needed? How much must be shared with the surveyors?

From an accreditation standpoint, clinical performance reviews are confidential communication. However, documentation is worthwhile only if it contains sufficient information to be able to understand any problems noted and follow up on any corrective actions recommended.

From an accreditation standpoint, while it would be ideal if the surveyors could review the evaluation report, only the following basic information must be shared: the names of reviewee and reviewer, title or position of the reviewer, the review date and confirmation that the findings were shared with the provider being reviewed. If corrective actions were recommended, a statement as to whether such actions were taken must be noted.

What lies in the future for this standard? Professional nurses on the revision committee were concerned that the standard did not require this type of clinical practice review for RNs despite the critical role they often play in the correctional facility. This raises the question of whether such reviews should be required for all licensed professionals. Another question is whether this important standard should move to the essential category. Stay tuned for updates!
By B. Jaye Anno, PhD, CCHP-A, and Judith A. Stanley, MS, CCHP-A

Documentation of Meetings

Our jail is seeking accreditation for the first time. How must we document the meetings we are required to have? Is there a form you require or recommend?

A

NCCHC does not specify the format for meeting minutes required by the standards. We try to give facilities as much flexibility as possible in such matters, as long as the format used provides an appropriate vehicle for documenting the necessary information or processes and the intent of the particular standard is met.

Information that needs to be recorded in the minutes depends on the type of meeting and the requirements of the individual standard(s). In the standards that require written documentation, the Compliance Indicator section provides guidance as to what is required.

For example, in J-A-04 Administrative Meetings and Reports, administrative meeting minutes need to be kept to document discussion of all the topics listed in the standard, while the documentation of monthly health staff meetings need include only attendees and topics or agenda. However, for QCI meetings (J-A-06 Continuous Quality Improvement Program), the minutes need to record topics or problems discussed, assigned responsibilities, action plans, findings, evaluation, subsequent actions, etc.

Meds for Off-Site Inmates

I have been given the task of developing a statewide policy for our prison system on providing prescribed medications to inmates who are not available to take them due to court trips, appointments outside the facility, transfers to other institutions, administrative leaves such as funerals, etc. Can you help?

A

The guidance you need is based on one principle: If the medication is clinically necessary, provisions must be made to supply that medication. When it is the judgment of the treating physician, psychiatrist, or other primary care provider that the medication needs to be continued when the inmate is temporarily out of the facility, provision must be made either for the inmate to self-medicate or for transporting agents or health staff at the “temporary” facility to provide the medications.

On the other hand, the physician may determine that a one-day “drug holiday” or other length of time without the medication will not interfere with treatment. Skipping a dose may not make a difference in the case of some medications.

However, some medications need to be taken daily and on time so that the therapeutic levels remain within the proper range. This is especially true of psychotropic medications, including those for depression, seizure medications, HIV medications, and others as determined by the physician.

Your policy should include consulting with the designated health services staff in the situation at hand and then making appropriate arrangements. Policy should include such issues as whether the medication is to be sent with the inmate to cover him or her for the duration of the absence, or whether a prescription is sufficient. This is important when the medication may not be readily available at the receiving institution.

As well, there should be provision for steps to take when an inmate on medication is moved out without notification of the medical staff. Training for transporting staff who may need to give the medication must be addressed. When the physician determines that the medication is not needed during the temporary absence, be sure the policy includes informing the inmate of this so the inmate does not worry when the medication is not available.

Peer Review in Jails

This question concerns the new standard for peer review. We are a small jail, average daily population about 200, in a rural area. We understand that our consulting psychiatrist now needs an annual review of her performance at the jail, but she is the only psychiatrist who works at the jail in our area. Can our licensed psychiatric social worker do her review?

A

You are referring to important standard C-02 Clinical Performance Enhancement, which is new to the 2003 jail and prison Standards and included in the 2004 juvenile Standards. To quote from the discussion section: “The intent of this standard is to enhance patient care through peer review of the clinicians’ practice. The clinical performance enhancement review process is neither an annual performance review nor a clinical case conference process. It is a professional practice review focused on the practitioner’s clinical skills; its purpose is to enhance competence and address areas in need of improvement.”

Facilities in which the practitioner (in your case, the psychiatrist) is the sole representative of a profession is actually one of the situations the standards revision committee wanted to address. The standard’s intent is to promote the professional exchange of ideas and practice that can occur only with another professional of equal or more advanced training and experience in the same discipline. So, while medical physicians can review other medical physicians and midlevel practitioners, only psychiatrists should be reviewing psychiatrists.

So, what are you to do? Is there a community psychiatrist in private practice willing to do such a review? Will a state medical school provide such services? Ideally, the performance review is a face-to-face meeting, but telephone reviews following sample record reviews might be an option. Exchange of written materials may not be best, but it could work. Yet another possibility is the use of a university telemedicine program, if one is available.

Failing all of the above, you should note that NCCHC has designated this standard as “important” (as opposed to “essential”) so noncompliance should not affect your accreditation status.

For more details about compliance with this standard, see Spotlight on the Standards on the facing page.

B. Jaye Anno, PhD, CCHP-A, is a cofounder of the National Commission on Correctional Health Care. Now an independent consultant, she chaired the task force that developed the 2003 revisions of the adult standards for health services. Judith A. Stanley, MS, CCHP-A, is NCCHC’s director of accreditation and assists in the development and revision of standards.

Do you have a question about the NCCHC standards for health services? We’re here to help. Write to Standards Q&A at info@ncchc.org.
Reach the Decision Makers

U.S. correctional institutions house more than 2 million people, many of whom represent medically underserved populations. They receive a broad spectrum of health services ranging from treatment for infectious diseases (e.g., hepatitis, HIV/AIDS, tuberculosis) to management of chronic illnesses (e.g., asthma, diabetes, hypertension) to general health care. They also receive dental care, mental health care, substance abuse treatment and health education. To meet this heavy demand for government-mandated care, correctional facilities spend nearly $6 billion dollar annually on health care, substance abuse treatment and health education. To reach the key decision-makers and help them make informed choices. A great way to do that is to exhibit at Updates in Correctional Health Care, which attracts highly qualified attendees with buying power and authority. In addition to the extensive commercial exhibit, this well-attended meeting offers over 30 educational and numerous networking opportunities.

Exhibitor Benefits

• Exhibit hall breaks and networking opportunities, with six hours of exclusive exhibit time
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Registration Information

The rental fee for each 10’ x 10’ booth is $1,000, which includes one full and two exhibit-only registrations. Additional representatives may register at discounted rates. Advance and on-site promotions of the exhibit include mailings, scheduled breaks, exhibitor prize drawings, and a reception and lunch in the exhibit hall. To learn more, contact director of meetings Deborah Ross at (773) 880-1460, ext. 286, or deborahross@ncchc.org.

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• Corrective Mental Health Care: Standards and Guidelines for Delivering Services. Updated to conform with the 2003 NCCHC Standards, the second edition makes explicit what is implicit in the standards regarding mental health issues and coordination of delivery with health services. Appropriate for prison, jail and juvenile facilities of any size, the manual works well as an independent reference or as an annotated companion to the Standards. 2003, softcover, 275 pages, $34.95

• Corrective Mental Health Care: Standards for Delivering Services to Adult and Juvenile Offenders With Special Needs, edited by Jose B. Ashford, Bruce D. Sales, and William H. Reid. 2001, 518 pages, hardcover, $49.95

• Acting Out: Maladaptive Behavior in Confinement, written by Hans Toch and Kenneth Adams, with J. Douglas Grant and Elaine Lord. 2002, 446 pages, softcover, $29.95

• Corrective Mental Health Care: Standards for Health Care Services in Juvenile Detention and Confinement Facilities. The 2004 edition provides guidance in establishing and maintaining constitutionally acceptable health care. As with the 2003 editions of the prison and jail Standards, the new juvenile edition features new standards on clinical performance enhancement and chronic care, clear compliance indicators, and a more user-friendly format and numbering system. 326 pages, softcover, $59.95

The Latest From NCCHC
The following updates of NCCHC standards and guidelines can be obtained via the Publications section of our Web site (www.ncchc.org), or by calling NCCHC headquarters at (773) 880-1460.

• Standards for Health Care Services in Juvenile Detention and Confinement Facilities. The 2004 edition provides guidance in establishing and maintaining constitutionally acceptable health care. As with the 2003 editions of the prison and jail Standards, the new juvenile edition features new standards on clinical performance enhancement and chronic care, clear compliance indicators, and a more user-friendly format and numbering system. 326 pages, softcover, $59.95

• Multidimensional Treatment Foster Care Model. A new approach to the delivery of behavioral health services to children and youth in foster care. 2003, 186 pages, hardcover, $39.95

For more information contact one of the guest editors: htreadwell@msm.edu or joyce_nottingham@msm.edu.

Meetings
Foodservice Meeting. The American Correctional Foodservice Association is hosting its annual international conference August 15-19 in Sacramento, CA. To learn more about “Keys to Correctional Foodservice Management,” visit the Web at www.acfsa.org, or e-mail info@acfsa.org.

Centerforce Summit. The fifth annual Inside/Out Summit will focus on “Models for Change—Delivering Services to Those Affected by Incarceration.” Hosted by Centerforce, the meeting will take place Sept. 11-15 at the San Francisco Airport Marriott. For details, visit www.centerforce.org or call Merjo Roca at (415) 456-9980, ext. 124.

AHIMA Convention. The American Health Information Management Association’s 76th National Convention and Exhibit (being held in conjunction with the Congress of International Federation of Health Records Organizations) will occur Oct. 9-14 in Washington, DC. Learn more at www.ahima.org or call (800) 335-5535.

Opioid Treatment Meeting. The American Association for the Treatment of Opioid Dependence is holding its 20th national conference Oct. 16-20 in Orlando, FL. Find a brochure and registration information online at www.aatod.org.

Youth Psychiatry. The American Academy of Child & Adolescent Psychiatry will convene Oct. 19-24 at the Washington (DC) Hilton for its 51st Annual Meeting. For details, visit the Web at www.aacap.org or e-mail meetings@aacap.org.

Journal of Correctional Health Care
John R. Miles, Editor
The Official Journal of the National Commission on Correctional Health Care

The Journal of Correctional Health Care is the only national, peer-reviewed scientific journal to address correctional health care topics. Published quarterly under the direction of editor John R. Miles, the Journal features original research, case studies, best practices, literature reviews and more to keep correctional health care professionals up-to-date on trends and developments important to their field. Among the topics addressed in past issues: end-of-life care, clinical guidelines, health services administration, personnel and staffing, ethical issues, support services, medical records, quality improvement, risk management and medical legal issues.

www.ncchc.org  SPRING 2004 • CorrectCare  19
We know, we know ... NCCHC and the Academy practically promised perfect late spring weather in our hometown of Chicago. We just forgot to check in with Mother Nature. After thunderstorms in Chicago and many other parts of the nation wreaked havoc with weekend flight schedules and travel plans, many travelers trudged to the conference check-in desk exhausted and sometimes crabby. But exchanging travel horror stories is wonderfully cathartic (it’s also a special form of networking!), and by the time Monday morning rolled around, everybody was back on track and raring to go. Below are pictorial highlights from the meeting.

**A warm Chicago welcome.** The Hon. Richard A. Devine, JD, welcomed attendees to Chicago before Tuesday’s educational luncheon. Devine is the Cook County State’s Attorney and an NCCHC board member.

**Serious business.** Attendees had their evenings free to explore Chicago’s many charms, but the days were packed with education.

**Undivided attention.** Maybe it was the weather or maybe it was just the phenomenal programming, but the presenters enjoyed large crowds of learners in their sessions.

**Refreshing.** As always, the exhibit hall was the place to meet and greet friends new and old while enjoying refreshments between sessions.

**Hands on.** Nothing substitutes for the experience of visiting with exhibitors and getting a hands-on demonstration of their wares.

**Raffle time.** Things quiet down in the exhibit hall when the raffle drawings begin. The folks in this crowd are hoping to walk away with a free future conference registration, gift basket or one of the many other prizes...

**Lucky lady.** ... including, if they’re really lucky, a stylish Academy cap!

**Great to see you again!** One of the best things about NCCHC conferences is the chance to reconnect with friends.

**You’re got mail!** The sleek computer kiosks in the exhibit hall were a big hit with people who wanted to stay in touch with their e-mail...and who doesn’t???