Methadone Treatment Absent in Many Jails

BY KEVIN FISCELLA, MD, MPH

Enrollment in community methadone maintenance programs is a major step on the hard road to recovery from opiate dependence. But of the 140,000 to 170,000 individuals who participate in such programs across the country, about 10% are arrested and jailed each year. What happens to them? How often is methadone continued? How is methadone stopped, and how is their opiate dependency managed during their incarceration? 

Since there are no reliable data to address these important questions, several colleagues and I conducted a national survey of U.S. jails to find out. (See a summary of study methods on page 14.)

We found that very few jails provided continuous treatment to inmates on methadone, except in the case of pregnancy. Few jails contacted programs to determine dose. Most stopped methadone abruptly rather than tapering it over time. Roughly half of jails provided clonidine for withdrawal symptoms, 30% used only ibuprofen or acetaminophen and 20% reported providing no symptomatic treatment!

These findings are troubling. Forced interruption of methadone maintenance often is associated with painful withdrawal symptoms and significant health risks, including lethal overdose. It also is associated with a very high relapse rate and risk for rearrest. National standards for management of these arrestees would help to stop this costly and dangerous revolving door of arrest, detox, relapse, rearrest.

Three Key Findings

1. Inmates enrolled in methadone maintenance programs are likely to experience discontinuity in their methadone maintenance.

2. Coordination of care between jails and methadone programs is lacking.

3. Nearly half of jails failed to use recommended detoxification protocols for methadone clients.

Opiate Dependency Among Jail Inmates (N=246)

Survey respondents estimated the percentage of their jail’s inmates who were dependent on opiates. Their responses conform with Arrestee Drug Abuse Monitoring Program estimates of opiate dependence in 2000, as reported by the National Institute of Justice in 2003.

<table>
<thead>
<tr>
<th>Percentage</th>
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<tr>
<td>0% - 1%</td>
<td>32</td>
<td>27</td>
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<tr>
<td>2% - 5%</td>
<td>82</td>
<td>37</td>
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<td>6% - 10%</td>
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<td>22</td>
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* Results were weighted to account for oversampling of larger jails.

The study’s objective was to assess how jails manage individuals who are enrolled in community methadone maintenance programs at the time they are admitted to jail. In addition to inquiring whether a methadone program existed in the local community, the self-completed questionnaire asked whether the jail routinely:

- Assessed opiate dependence of incoming inmates
- Used a specific standardized treatment protocol to detoxify inmates on methadone
- Contacted the community methadone program to determine the inmate’s methadone dose
- Continued methadone during incarceration
- Used clonidine to treat withdrawal
- Used methadone to treat withdrawal
- Used any other opiates to treat withdrawal

The survey also asked for the percentage of inmates dependent on methadone, the jail’s daily census and the respondent’s job title.

Reported Practices

The table on page 14 summarizes key findings about the practices taking place in the jails that responded to the survey. The results reported here are weighted to account for oversampling of larger jails as measured by daily inmate census.

In brief, 62% of the respondents said there was a methadone maintenance program in the community; only 56% routinely asked inmates whether they are opiate dependent.

However, most (85%) of the jails did not continue methadone for these inmates, nor did most (77%) use a specific standardized treatment protocol for opiate detoxification. Only 27% of jails routinely contacted the community program about the inmates now under their care.

Closer examination of the data reveals disparities in the findings, though the reasons often are unclear. Not surprisingly, compared to jails that reported no local methadone maintenance program, those jails that did report such a program were more likely to seek information about program enrollees. Yet these jails were not significantly more likely to continue methadone maintenance.

Continued on page 14

New Commission Tackles Health Disparities

The nation’s largest physicians’ organizations are teaming up to eliminate gaps in health care based on race and culture. Formed in January, the Commission to End Health Care Disparities has a who’s who roster of 30 members, with a secretariat comprised of the American Medical Association, the National Hispanic Medical Association and the National Medical Association.

In a prepared statement, AMA president John Nelson, MD, MPH, said, “The causes of health disparities are complex, and raising awareness is an important step toward ending the inequality in care. This is a historic time when medical and public health organizations are coming together to identify and implement strategies for eliminating health care disparities.”

The group cites studies indicating that, despite steady improvements in overall health in the nation, racial and ethnic minorities experience a lower quality of health services, are less likely to receive routine medical procedures and have higher rates of morbidity and mortality than nonminorities. These disparities are found even when controlling for gender, condition, age and socioeconomic status.

Four committees have been established to examine the current health care system. They will work to raise professional awareness, improve data gathering, increase education and training, promote workforce diversity and, ultimately, improve patient care.

Eleven of the commission’s members are supporting organizations of the National Commission.

To learn more about the Commission to End Health Care Disparities, visit the Web at www.ama-assn.org/go/healthdisparities.
Mental Health Educational Conference Enjoy Broad Support

For the second year, NCCHC is developing an intensive, two-day conference to meet correctional health professionals’ growing interest and need for education on mental health care. Major health care organizations are on board: This year’s event marks the first time that the three organizations listed below have cosponsored a conference:

- Academy of Correctional Health Professionals
- American Psychiatric Association
- American Psychological Association

Several other important organizations also are supporting the conference:
- American Academy of Child & Adolescent Psychiatry
- American Academy of Psychiatry & the Law
- American Association for Correctional and Forensic Psychology
- American College of Neuropsychiatrists
- American Counseling Association
- American Society of Addiction Medicine

More of a Good Thing

In 2004, NCCHC’s first-ever seminar on mental health care received extraordinary attendance and garnered tremendous reviews. Clearly, professionals in this field know a good thing when they see it. This year’s program will build on the same, and then some. It incorporates the latest findings in research and practice, new approaches to care and treatment, and best practices. Presented by an invited faculty selected for the speakers’ knowledge and first-hand experience in correctional mental health care, the two-track program includes the following subjects:

- Behavioral aspects of pain management
- Building relationships with acute medical centers
- Cost-effective psychotropic medication programs
- Designing and managing effective mental health care programs
- Differentiating genuine needs from manipulative behaviors
- Evaluation and treatment of ADHD for juveniles and adults
- Implementing an effective opioid treatment program
- Interventions for the mentally ill sex offender
- Legal and ethical issues of disciplinary proceedings
- National standards and guidelines for mental health care treatments
- Principles of care for co-occurring disorders
- Suicide prevention: Can the numbers be reduced?
- Treating trauma among victims of physical and sexual abuse
- Women’s mental health care needs

2004 Juvenile Standards Now in Effect

The transition phase is coming to a close: Accredited juvenile facilities must be in full compliance with the 2004 Standards for Health Services in Juvenile Detention and Confinement Facilities by June 30. Facilities seeking accreditation for the first time will be surveyed on the 2004 Standards.

To help facilities better understand what is expected, we have posted a standard-by-standard “Summary Guide to the Revisions” at our Web site, www.ncchc.org. If you don’t have Web access, contact the Accreditation Department and we’ll send a hard copy. As always, if you have questions about any of the Standards for Health Services, please contact us.

You Have Questions, We Have Answers

Below is a list of key contacts by department for the next time you need help from NCCHC. To reach us, call (773) 880-1460, or e-mail info@ncchc.org.

Administration
- President
- Vice President
- Controller
- Office Manager

Accreditation
- Director of Accreditation
- Assistant to the Director
- Operations Coordinator

Professional Services
- Director of Professional Services
- Certification and Membership
- Director of Meetings
- Publications Editor
- Meetings and Sales

Board Member Update

William J. Rold, JD, CCHP-A, was selected by the Institute of Medicine to serve on the Committee on Ethical Considerations for Revisions to DHHS Regulations for Protection of Prisoners Involved in Research on NCCHC’s board, representing the American Bar Association.

Also on the IOM committee is NCCHC surveyor and consultant Jeffrey L. Metzner, MD. Former NCCHC board member Nancy Dubier, LLB, serves as liaison to the Health Sciences Policy Board.

Robert E. Morris, MD, has been appointed as the new medical director for the California Youth Authority. Morris also presents the Society for Adolescent Medicine on the NCCHC board.

Robert E. Morris, MD, has been appointed as the new medical director for the California Youth Authority. Morris also contributes an article on health care for juveniles in confinement to Virtual Mentor, a free, Web-based publication of the American Medical Association that focuses on ethical issues in medicine. Published in the March issue, the article is available at www.virtualmentor.org.

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Mentally Ill Offender Law Brings Help...and Hope

BY CARL C. BELL, MD, CCHP

Let’s say you’re a community physician and a child comes into your office with a rat bite. If you dress the wound and give the child antibiotics and a tetanus shot, you are a good doctor.

But what if 50 children show up with rat bites? If you provide the same treatment but do nothing more, your license should be revoked. That’s because you did not take the next step: Go out and get rid of the rats.

As a core element of public health, that’s what correctional health care should be about: getting rid of rats.

Mental Health Epidemic

From an epidemiological viewpoint, mental illness is unacceptably rampant in U.S. correctional facilities. There are three times more mentally ill people in prisons than in mental health hospitals, and rates of mental illness among prisoners (about 16%, overall) are two to four times greater than rates among the general public.

A major factor behind this phenomenon is the co-occurrence of substance abuse. About 70% of people who are mentally ill also abuse drugs, and this combination often results in behaviors that lead to their arrest. We also see high incidence of trauma, depression and other disorders among women and juveniles in the justice system.

Adding insult to injury, observers such as Human Rights Watch report that seriously ill inmates and detainees too often receive little or no meaningful treatment.

On the positive side, we know corrections is dealing with this problem better than ever before. For instance, 75% to 85% of state prisons now provide screening, assessment, medication, medication monitoring and access to inpatient care.

Ideally that number would be 100%, but even if it were, we’d still need to ask why our society accepts a system that locks up so many mentally ill individuals, especially those who commit nonviolent offenses.

Fortunately (and finally!), the government is getting serious about improving the status quo.

Help on the Way

Last October President Bush signed into law the Mentally Ill Offender Treatment and Crime Reduction Act of 2004. Public Law 108-414 authorizes $80 million a year for five years for mental health programs for adults and juveniles in correctional and community-based facilities.

While this sounds like a lot of money, one of the bill’s selling points was that diagnosing and treating mentally ill offenders will save money in the long run, given that their per-inmate cost for security alone is twice that of the rest of the prison and jail population.

The law’s language targets nonviolent offenders and is designed to identify offenders who could respond to treatment and evaluate different mental health interventions. It supports collaboration between mental health and criminal justice agencies to come together to provide “individualized, needs-based assessments to determine, plan, and contribute the most appropriate services.

The bill includes proposals that specifically address developmental and learning disabilities, as well as problems arising from a documented history of physical or sexual abuse.

The law authorizes a grants program administered by the Department of Justice in consultation with the Department of Health and Human Services. Grants will be provided to help communities establish diversion programs (pre-booking, jail diversion and mental health courts), treatment programs for mentally ill offenders who are incarcerated, and transitional and discharge programs for mentally ill offenders who have completed their sentences.

The grants will target programs that specify plans to make “mental health, or mental health and substance abuse, treatment services available and accessible to mentally ill offenders at the time of their release and to ensure access to effective and appropriate community-based mental health services.”

The law also will fund programs that facilitate reintegration into the community through housing, education, job placement, mentoring and health care benefits.

Up to 3% of the allocated funds can be used for programs that develop, facilitate or research alternatives to traditional prosecution and sentencing. Naturally, funded programs will be required to assess outcomes.

Successful programs will receive 80% federal funding for the first two years of the grant, with state or local funding increasing from the initial 20% to 40% in year three, and 75% in years four and five.

So what are you waiting for? Develop a grant request and help get rid of those rats!

Carl C. Bell, MD, CCHP, is president and CEO of the Community Mental Health Council and Foundation in Chicago. He also is director of public and community psychiatry and a clinical professor of psychiatry and public health at the University of Illinois. Bell is a founding member and past chair of the NCCHC board, representing the National Medical Association. He wrote the chapter on correctional psychiatry for the newly released Comprehensive Textbook of Psychiatry (8th Edition), Kaplan & Sadock, editors, published by Lippincott Williams & Wilkins.

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www.ncchc.org
Jail Moonlighter Turns Correctional Go-getter

BY KRISTIN PRINS, MA

During his residency in orthopedic surgery at the University of Utah nine years ago, Todd R. Wilcox, MD, MBA, CCHP, found himself “moonlighting at a local jail and enjoying it so much I ended up staying.” But this new member of the CCHP board of trustees has done more than merely stick around in the correctional health care field: He is helping to lead it.

You may know Wilcox from one of the many presentations he has given at NCCHC conferences. Or from his work as chairman of the Electronic Medical Records Task Force for NCCHC in 2002. Or from the celebrated NCCHC Accredited Facility of the Year Award, presented in 2001 to the Salt Lake County Jail for its turnaround from probation to excellence, in which Wilcox was one of the main actors.

Today he is the medical director for the Salt Lake County (UT) and Maricopa County (AZ) jail systems, as well as president of Velcon LLC, which was created to serve as the contract medical provider for the Salt Lake County Jail. He’s also a senior consultant with Phase 2 Consulting, which focuses on health care.

CCHP Board Seeks a Few Good Candidates

CCHPs in good standing are encouraged to nominate a fellow CCHP to serve on the Certified Correctional Health Professional board of trustees. Elections are held every year to fill a three-year term on the board. Comprised of 10 correctional health professionals, the board is charged with guiding the CCHP program and improving it as necessary to make it more responsive to the needs of the correctional health community. Trustees also are responsible for developing, scoring and evaluating the CCHP examination.

To make a nomination, please complete the form below, or provide the same information via e-mail (cchp@ncchc.org) to the CCHP board of trustees by Monday, May 16. Self-nominations are welcome.

Upon acceptance of nomination, the candidates will be asked to submit a short statement describing their ideas regarding the direction of the CCHP program. Elections will be conducted online in August. The new trustees will begin their term immediately following the annual board meeting in October.

CCHP Board of Trustees Nomination

I nominate the following CCHP to serve a three-year term on the CCHP Board of Trustees.

Nominee ____________________________
Place of employment ____________________________
City, state ____________________________
Daytime phone ____________________________

Nominator ____________________________
Daytime phone ____________________________
Signature ____________________________

Please fax this form to (773) 880-2424.
Or submit information by e-mail to cchp@ncchc.org.
Deadline: May 16, 2005

For more information, call (773) 880-1460.

Wilcox was elected to the CCHP board, where, he says, he brings a “voice from the front lines.” In his various professional roles, he sees firsthand the relationship between the NCCHC standards and their practical use in a wide array of correctional health care settings. This experience forms the basis for his vision of what the CCHP program can do to maximize health care delivery in corrections.

Optimistic about the future of the field, Wilcox envisions a day when more facilities and practitioners will use technology to their advantage. He hopes for more recognition for those who toil in the facilities, and for more educational and professional opportunities, including further development of the CCHP program.

Such healthy enthusiasm is not limited to Wilcox’s professional goals. In his own words, he is “an avid skier and an aspiring wakeboard star.” Let’s hope he doesn’t go pro: Correctional health care needs him!

Kristin Prins, MA, is the professional services assistant at NCCHC.
Congrats to the 35 Newest CCHPs!

While throngs of correctional health professionals attended the 2004 National Conference on Correctional Health Care for continuing education and networking (and certainly to enjoy New Orleans), a select group had a more ambitious goal: Attain professional certification! The CCHP board of trustees congratulates those individuals who passed the proctored examination administered Nov. 14.

Abhay K. Agarwal, MD, CCHP
North Carolina Department of Correction
Raleigh, NC

Pauline Alonzo, LVN, CCHP
Brazos County Sheriff’s Department
Bedias, TX

Hattie J. Armstrong, MBA, CCHP
Health Assurance LLC
Jackson, MS

Robert M.S. Bell, LPN, CCHP
Wexford Health Sources
Hollywood, FL

Jane M. Breeggemann, BSN, MS, CCHP
Minnesota Department of Corrections
Belle Plaine, MN

Jason L. Burns, MS, CCHP
Forcht-Wade Correctional Center
Keithville, LA

David W. Drosche, BS, CCHP
Brazos County Sheriff’s Office
Bryan, TX

Suzanne Friddell-Flores, RN, CCHP
Physicians Network Association
Lubbock, TX

Martha J. Hayes, RN, CCHP
Prison Health Services Inc.
Montgomery, AL

Virginia M. Henkel, RN, MS, JD, CCHP
Law Offices of the Public Defender
San Diego, CA

Judith A. Royer, BSN, MD, CCHP
Madison Correctional Institution
Troytown, OH

James E. Santelli Jr., DDS, CCHP
Nassau County Correctional Center
Oyster Bay, NY

Sir Scott Savage, DO, FACEP, RPh, CCHP
London Correctional Institution
London, OH

Cynthia J. Schupp, RN, CCHP
Tipton Correctional Center
Tipton, MO

Diana Severson-Tomak, RN, CCHP
Nebraska State Penitentiary
Lincoln, NE

Terah Smith, BS, CCHP
NaphCare Inc.
Birmingham, AL

Debora S. Steinman, RN, CCHP
Corrections Medical Services
Lohman, MO

Colleen M. Sullivan-Lee, BSN, CCHP
Sutter County Health Department
Yuba City, CA

Tara M. Taylor, RN, CCHP
Corrections Medical Services
Jefferson City, MO

Sandra K. Tilton, LPN, CCHP
Quest Medical LLC
Marietta, GA

Catherine Todehushich, BSN, CCHP
Corrections Medical Services
St. Louis, MO

Sean-David A. Waterman, BSN, CCHP
BGCE SPC Aguadilla
Aguadilla, PR

Katrina S. Whaley, RN, CCHP
Mayfield Youth Development Center
Mayfield, KY

Kamzner R. Wills, MSN, CCHP
Forsyth County Detention Center
Winston-Salem, NC

Michelle R. Ziegelmann, LVN, CCHP
Brazos County Sheriff’s Office
Bryan, TX

Future Exam Dates and Locations
• April 10: Las Vegas, NV, during the Updates in Correctional Health Care conference

Exam sites are being sought for July 16, 2005, and Feb. 4, 2006. If you are interested in hosting a CCHP examination at your facility or volunteering to proctor an exam, contact Paula Hancock at cchp@ncchc.org.

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Risk Management...
Reduced Liability

Accountability...
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We are ready to provide you with a customized, corrections-based health care solution.
Make A Difference: Participate!

2006 Board of Directors
The Board of Directors establishes the vision and strategic direction for the Academy, and it assures adherence to the Academy’s mission, bylaws, policies, procedures and values. As the Nominating Committee begins the process of selecting a slate of individuals to serve on the Board of Directors, its first appeal is to you the member. You are encouraged to become involved by seeking election or by identifying those members who will provide strong leadership in the years ahead.

The Nominating Committee seeks candidates committed to advancing the Academy and its values.

Board Composition
The Academy Board of Directors comprises 13 persons who are members of the Academy; seven of the directors are selected by the membership through a national election, and six are appointed from the field. Terms of office are for two years. This year there are two open elected positions on the Board.

2005/2006 Committees
Participating on a committee of the Academy of Correctional Health Professionals is one of the best opportunities for you to become more involved in your profession. As a committee member you will not only help the growth of the organization, but also will enhance your leadership skills and abilities; strengthen your professional network; and establish new personal friendships that will last a lifetime.

Committees provide member oversight of the programs and activities of the Academy. Although each committee has its own charges and responsibilities, each acts as a strategic entity of the full board. Members are expected to participate fully in the work of the committee; provide thoughtful input to its deliberations; focus on the best interests of the Academy and the committee; and work toward fulfilling the committee’s goals.

Committees conduct business throughout the year by e-mail and conference calls, as well as at Academy-sponsored conferences.

Mentor Program
The Academy is committed to building the strongest mentor network possible. If you share our commitment to improve the lives of other correctional health professionals, we encourage you to become a mentor. This is your opportunity to offer the positive support that you received—or would like to have received—during your career. Your experience and knowledge will be invaluable to the many professionals struggling to find their place.

The Mentoring Relationship
The mentoring relationship is viewed primarily as an educational experience. Mentors may offer career guidance, resume writing and interviewing tips, and, above all, the opportunity to start developing a professional network. Ultimately, the mentoring experience is designed to help Academy members gain a better understanding of the dynamics of the correctional health care field.

Easier Than You Think!
Things that may seem easy or straightforward to you often are mysterious to people who are new to corrections or who have been recently promoted or given new responsibilities. That’s why it may be easier than you think to make a difference in the course of someone’s career.

Volunteer Today
If you would like to be considered for any of these volunteer opportunities, please complete and submit the form below to Academy headquarters by fax at (773) 880-2424. You also may access an online volunteer form at www.correctionalhealth.org.

Questions? Contact us toll-free at (877) 549-2247.

Academy Volunteer Form

Name ____________________________ Member ID __________________

City/State __________________________ Day Phone __________________

E-mail ____________________________

Academy Board of Directors

I nominate myself for a seat on the Board of Directors.

I nominate the following individual for a seat on the Board of Directors: ____________________________

Committees

Please indicate on which committee(s) you would like to serve. If you are interested in more than one, please rank your preference, with 1 being most interested and 4 being least interested.

Education

Membership and Recruitment

Mentoring

Shared Interest Group

Committee Chair(s): ____________________________

Mentor

I would like to become a mentor. Please send me additional information.

Please return this form by April 1 to:
Academy of Correctional Health Professionals
773-880-2424

fax: 773-880-2424

online: www.correctionalhealth.org

Now on the Web!

Full-text archives of the Journal of Correctional Health Care are now available at the members-only section of the Academy Web site. Issues date back to Volume 9, Issue 1.

Also online is the Journal self-study program. This educational activity is approved for continuing education credit for CCHPs, nurses and psychologists.

Join the Academy of Correctional Health Professionals today!

Complete the form below, and fax or mail with payment to:
Academy of Correctional Health Professionals
PO Box 1117, Chicago, IL 60611
Fax: 773-880-2424

Name ____________________________ Member ID __________________

Occupation ____________________________ Member Degree ____________________________

Mailing Address ____________________________ Phone ____________________________

Other ____________________________ E-mail ____________________________

Please indicate your training:

Physician  Nurse  Psychologist

Pharmacists  Social Worker  Dietician

Administrative  Accountant

Other ____________________________ Indicate your area(s) of certification:

Pharmacist  Educator  Criminal Justice

Mental Health  Juvenile Treatment

Public Health  Medical Examiner

Quality Improvement  Research

Legal Issues

Mentor Program

For more information, please call our national headquarters office toll-free at 877-549-ACHP (877-549-2247) or e-mail us at academy@correctionalhealth.org.
‘Meth Mouth’ Plagues Many State Prisoners

BY MARK BRUNSWICK, STAR TRIBUNE

After more than a decade of drug abuse, Darren Zigas is one of the 10 dentists across the state’s prison system.

Meth Mouth Causes

Authorities say they believe several factors contribute to meth mouth. The drug often produces anxiety levels and paranoia that can contribute to teeth grinding and gnashing. Many abusers also have a dry mouth, and the absence of saliva can exacerbate the acidic nature of methamphetamine if it is smoked or snorted. “When I was smoking it I could feel the slime on my teeth,” Zigas recalled.

One offshoot of methamphetamine abuse also appears to be insatiable appetite for high-coffee, high-sugar sodas, particularly Mountain Dew. That can combine with the frenetic nature of the drug, letting users go for long periods without good hygiene.

“When abusers are ‘doing the Dew,’ they’ll go for days without brushing their teeth or washing or sleeping,” said Dr. Mark Legan, a dentist who treats patients at Lino Lakes.

While Gov. Tim Pawlenty’s budget has yet to be unveiled, corrections officials say they have been in contact with the governor’s office about the need to increase funding for prison health care, including dental programs for methamphetamine users.

Why provide false teeth and dental care to offenders who brought on their problems themselves? Officials say prison systems have constitutional obligations to provide a basic level of health care, including dental care, or face the possibility of litigation. For instance, the family of an inmate who died last year from an infection caused by an abscessed tooth filed a federal suit in October against the state of California.

Level of Care

While there are no fancy crown and bridge restorations, there is a debate about what level of dental care to provide offenders, particularly in a period of increased prison populations and budget demands, said Nanette Schroeder, director of health services for the Corrections Department.

“Should we be providing them with dentures so that when they go to apply for a job they at least have a decent smile? Even as a team, we couldn’t come to an agreement as to whether or not that was something the state should be doing,” she said. “For every denture we provide for this population, it means we don’t buy another piece of equipment or we have fewer supplies.”

Study Links Gum Disease, Atherosclerosis

Evidence of a “direct relationship” between periodontal microbiology and hardening of the arteries was reported in the Feb. 8 issue of Circulation. Conducted by a team of researchers from Columbia University Medical Center, this was the first study to count and categorize specific populations of oral bacteria, then compare that data to ultrasound measurements of arterial thickness, lead researcher Moise Desvarieux explained to HealthDay, a Web-based news service. Study subjects with the highest bacteria levels also had the highest levels of atherosclerosis, but this association was only found with the bacteria known to cause gum disease. This tended to rule out poor overall health as a factor in the atherosclerosis. The HealthDay article explained that the oral bacteria trigger a physical response that cause artery walls to thicken over time. To counteract this problem, individuals should seek professional treatment and practice good oral care on their own.
Dedicated Health Education Sets Youth Center Apart

BY JAIME SHIMKUS

Surprise and bewilderm went the initial reactions registered by Katrina Whaley, RN, CCHP, when she learned that Mayfield Youth Development Center was to receive NCCHC’s 2004 Program of the Year Award. “This is not special,” she recalls thinking at the time. “Doesn’t everybody do it?”

“It” refers to formal classroom education, delivered every Friday at 2 p.m., dedicated to health care subjects. This program has been in place for 17 years, initiated at Whaley’s suggestion.

At last year’s National Conference on Correctional Health Care awards ceremony, Patrick Sheridan, MD, MPA, CCHP, spoke on behalf of the Kentucky Department of Juvenile Justice, he knows well the work they do.

“[Good nurses] are our eyes and our ears and our hands,” he observed. “Without good nurses we are nothing. With good nurses it is relatively easy. Katrina is such a nurse, the very best.”

Sheridan also commended the work of Terry Wood, RN, the other nurse on staff, as well as the collaborative environment fostered by former superintendent Angelahe Row.

Comprehensive Curriculum

A few months after joining the Mayfield staff nearly 18 years ago, Whaley spoke with the superintendent about the need for some “preventative maintenance” for the teenage males under her care, in particular to address their pervasive drug and alcohol problems. The superintendent fully supported the idea and provided a one-hour time slot (it runs longer if needed) in the educational program.

Whaley developed the health class from the ground up. Armed with pamphlets, she began teaching the boys about the hazards of substance abuse. The subject matter soon expanded. Apart from dental problems, most of the youth are physically healthy, with little incidence of chronic illness. But Whaley saw that they often lacked the general health education that would help them make sound lifestyle choices and maintain their good health.

Today, the “nurse’s class,” as it is called, covers prevention and self-care in a broad range of subjects, including sexually transmitted disease, birth control, smoking, asthma, oral health, personal hygiene, exercise, violence (including guns), depression, self-esteem and values.

Depending on its overall relevance, Whaley aims to present on each subject two or three times a year to introduce and reinforce different aspects before a resident is released. Substance abuse remains a pressing concern for this population, so it is addressed even more frequently.

Capturing Interest

Whaley conducts most of the classes herself, but she knows that the boys would lose interest if she lectured for field trips that tie in with the educational and rehabilitative mission. Through the Youth Awareness Program, every few months a group of boys visits the state’s maximum security penitentiary for some face time with select prisoners.

Just as for the regular educational curriculum, it is mandatory for the residents to attend nurse’s class, and they do receive assignments. Not that any of them are complaisant. According to NCCHC surveyors who toured the facility and spoke with the boys, the class is very popular.

Solid Services

Health education isn’t the only way in which Mayfield excels, however. As a whole, the health services delivery system is as tight as a drum.

Policies and procedures, patient care administration, medical records, infection control, healthy environment, staff education, interdisciplinary communication, quality improvement and more—all of the fundamentals of a solid department are well-managed.

That’s not to say that problems don’t arise, but in such a small facility, they usually are addressed quickly with a few discussions. To make sure they don’t lose sight of the big picture, staff members also hold formal meetings regularly to review reports and plan future activities.

Since Whaley and Wood are on-site weekdays only, the youth workers are, by necessity, an integral part of the health care team. The preparation they undertake is thorough.

All youth workers who have direct responsibility for juvenile detention are trained in the following areas: medication administration; types of action to take in potential emergency situations; signs and symptoms of an emergency; first aid administration; how to obtain emergency care; procedures for transferring patients to medical facilities or health care providers; signs and symptoms of mental illness, mental retardation, emotional disturbance, potential suicide and chemical dependency; and signs and symptoms of suspected child abuse (including sexual abuse). All staff also are trained in CPR.

Clearly the youth at Mayfield are in good hands, and thanks to Whaley they have the tools to make positive changes to nurture their health and well-being. But do these lessons and interventions have any lasting impact?

Impossible to know, Whaley says. However, a few of her guest speakers have been former Mayfield residents, and she is heartened to see that they have become productive members of society.

“You just do the best you can do and hope that you get through to them. But they have to desire to turn their lives around.”

Mayfield Youth Development Center

Facility: Situated on eight acres near Mayfield, in rural western Kentucky, this is one of 11 Youth Development Centers operated by the state Department of Juvenile Justice. By design, the YDCs are small and treatment-oriented. The main, one-story building has offices, clinic, kitchen and dormitories; the complex also has a large, state-of-the-art gymnasium.

Correctional Population: This 36-bed medium security facility houses males of ages 13 to 18, though most are at the higher end of this range. Average daily population is 31, with 2 to 3 new intakes monthly. Most are transferred from other juvenile detention facilities. Typical length of stay is 6 to 9 months. At release, some are discharged to their homes, while others are transferred to a step-down setting.

Programs and Services: Like all Kentucky YDCs, Mayfield has a six-hour school day, and offers educational alternatives such as vocational training. Community-based education, service learning and community service options are key elements. Off-site activities such as participating in sporting events are common.

Health Care Services: Staff members are employed by the state. Health services are provided by two RNs (one of whom serves as health services administrator), with coverage from 7 a.m. to 10 p.m. on weekdays. Twelve youth workers coordinate care on nights and weekends. Also on staff are a psychologist and drug abuse counselor. Physician, psychiatry (via telemedicine) and dental services are provided off-site through local contracts.

Accreditation: First accredited in 2000, Mayfield was last surveyed in August 2003.

Quoteworthy: “Truthfully, we had no choice [in whether to seek NCCHC accreditation]. But it has only made us stronger and better.” —Katrina Whaley, RN, CCHP, health services administrator
Dr. Scott’s Case File: A Questionable Complaint of Back Pain

BY SIR SCOTT SAVAGE, DO, FACEP, KB, CCHP

The Case
Thursday, 5:30 p.m.
Inmate Health Services, State Prison Exam Room 3
Case 200 - 401
Mr. Paxton entered the room with a right-sided limp and sat in the exam chair slowly and with a short wince. Without prompting, he said, “Doc, my back is killing me.”

He then went on to relate a history of a gradual onset of constant dull low back pain, radiating occasionally to the right buttocks. He had no history of incontinence, fever, weight loss, constipation or urinary problems. The pain was worse when bending forward, and he complained of having difficulty getting in and out of his top bunk.

Physical Exam
On examination, the vital signs were normal. The patient sat stiffly upright. On his right sitting straight leg-raising test, he complained of low back pain radiating to the right buttocks, but not elsewhere. He kept his leg extended for seven seconds after the physician released the leg. The left sitting straight leg-raising test was normal, and the patient kept his leg extended two seconds after this leg was released. On the supine straight leg-raising test, the patient had low back pain radiating to the knees bilaterally at 10 degrees of elevation.

His sensory exam was normal to light touch, and his motor exam was normal. Deep tendon reflexes were equal on both sides. Examination of the back showed no fascioulation, skin changes or atrophy. He had no pain to palpation or rotation of the hips bilaterally. Axial loading of approximately 10 pounds of pressure increased the patient’s low back pain. Passive shoulder and pelvis rotation both increased his pain. The concern for most referred diseases. Even in the absence of neurological findings, care should always be taken to consider emergent conditions such as abdominal aortic aneurysm, retroperitoneal appendicitis and, in females, ectopic pregnancy.

Early in the interview, it is useful to try to classify the disease process into one of four major categories: referred, radicular, mechanical or psychogenic. Commonly, patients will have a mixture of categories, but usually one predominates.

Referred Pain
Referred pain usually has evidence of a remote organ system involvement, commonly from the genitourinary system or gastrointestinal system, but any system can be involved. A rapid review of systems can be useful. Specific red flags for serious disease include:
1. Age > 50 years
2. Fever
3. Night sweats
4. Unexplained weight loss
5. Incontinence
6. Chronic constipation

Reviewing vital signs also is paramount. If any red flags are present, then further history and examination are indicated. Labs may include a complete blood count, erythrocyte sedimentation rate and serum creatinine. Plain film radiographs also may be indicated. Rarely, bone scans, computerized tomography, electroencephalography with nerve conduction studies or magnetic resonance imaging may be indicated.

This patient did not have symptoms of serious underlying disease. Radicular Pain
Radicular (nerve root) pain is usually sharp, burning and radiates below the knee. Neurological findings are sometimes present, and herald more serious disease. Saddle anesthesia and incontinence are particularly worrisome.

A common misconception concerns the straight leg-raising test, which is used to confirm radicular pain. Actually, the test is positive only if there is pain below the knee with greater than 60 degrees of elevation. Patients with short hamstring syndrome will have discomfort limited to the length of this muscle when it is stretched, and elevation below 60 degrees does not stretch the nerve root. Thus, only pain below the knee and angle with more than 60 degrees of stretching is considered positive.

The patient in this case did not have a positive straight leg-raising test. Mechanical Pain
Mechanical pain is common, and keys to diagnosing it include a dull, achinging pain that is localized to the back or radiates only to the buttocks. It is usually worse with movement. There is often, but not always, a history of recent trauma or exertion. This patient had a mechanical component to his pain.

Psychogenic Pain
Psychogenic pain is difficult to diagnose. Findings often include recurrent psychological stressors, desire for special privileges, inconsistent exam findings or non-anatomic findings. This patient had interesting findings. First, he entered the office with a limp, but left without one. Second, on the sitting leg-raising test, he left his leg extended several seconds on both sides. This maneuver causes a great deal of stress on the back muscles, and patients with mechanical pain will drop their legs or at least complain of pain when the leg is released. The fact that this patient was able to voluntarily keep his leg extended was not consistent with severe back pain. Note that this does not mean he had no pain at all, but it does indicate milder disease.

Likewise, although the patient complained of pain with even mild passive straight leg-raising, he had no pain when he had the same test done when he was sitting at a 90 degree angle.

‘Nonorganic’ Physical Signs
The rest of the exam lists Waddell’s signs. If four or more of these signs are present, then the patient can be considered to have a significant psychological component of disease.
1. Pain to very light touch
2. Low back pain to mild axial loading of the head
3. Pain with passive rotation of the pelvis
4. Pain with passive rotation of the shoulder
5. Non-anatomical pain distribution
6. Inconsistent response to lying and standing straight leg-raising tests
7. Non-anatomical sensory deficit
8. Give-way or cogwheel motor weakness

This patient was positive for four signs. Having Waddell’s signs does not mean the patient is feigning his symptoms. Diagnosing a psychological component of back pain also can mean unconscious conversion of stress into physical symptoms, fear by the patient that he will be inadequately treated or even an attempt to please an authority figure. There is no clear and reliable method of differentiating these processes on a single exam. Likewise, the presence of a psychological component of disease does not in any way rule out the possibility of any of the other types of back pain.

To sum up the remainder of the patient encounter…

Diagnostic tests: none
Final diagnosis: mechanical and psychological back pain
Treatment: ibuprofen 600 mg po tid for seven days, light duty restriction with no sports for three days, reexamination in three days, McKinsey exercise instructions given
Follow-up: The patient filed a grievance for not receiving a permanent bottom bunk restriction. Independent review found that this was not indicated for this patient.

* The name of the composite patient discussed in this article is fictitious.

Sir Scott Savage, DO, FACEP, KB, CCHP, is assistant medical director for the Ohio Department of Rehabilitation and Corrections. To contact him, send an e-mail to ssavage@ohiocont.com.

Savage presented on this subject as part of a broader discussion of malingering at the 2004 National Conference on Correctional Health Care. To obtain a recording of that session (no. 123), call “Malingering: Recognition and Coping With Inmates,” please see the order form on the back page.
Georgia a Model for Juvenile Hepatitis B Vaccination

In about ten years, youths entering detention facilities will be part of the cohort that should have been vaccinated for hepatitis B as infants. However, many juvenile detention entrants who are not infants either need to initiate or complete the vaccine series. The greatest barrier to universal vaccination is cost. To overcome this obstacle, juvenile programs can take advantage of the Federal Vaccine for Children program.

The vaccine provides free HB vaccine to youths who have yet to reach their 19th birthday. Juvenile facilities can access this vaccine, as well as a bundled array of other vaccines, at no cost via their local public health departments.

At the Georgia Department of Juvenile Justice, medical director Michele Stapko-Horne, MD, MPH, has collaborated with state and local health departments to maximize the number of detained youth who receive HB vaccine through the GDJJ.

Georgia provides universal HB vaccination for all infants and, for the past few years, catch-up vaccination for entrants to the 6th grade. Still, many youth entering the juvenile justice program have not been vaccinated. The GDJJ has 31 facilities spread out across the state. It administers vaccine materials, at no cost via their local public health departments.

The initial goals of the GDJJ program were to:
- Enroll 31 facilities in the VFC program.
- Create a centralized tracking system, piggybacking on the institutional computer system.
- Select and provide educational materials.
- Obstacles: Two major obstacles to complete the vaccine series were to get facilities to deliver vaccines and ensure the vaccine storage.
- Options: The GDJJ worked with a statewide registry to track vaccine administration. The facility staff responsible for vaccine administration received training to improve compliance with the state's immunization requirements. The GDJJ now works with a local public health department to ensure that all facilities enroll in the VFC program.

Goals and Obstacles

The initial goals of the GDJJ program were to:
- Enroll 31 facilities in the VFC program.
- Create a centralized tracking system, piggybacking on the institutional computer system.
- Select and provide educational materials.

The report describes the GDJJ's efforts to achieve these goals and the obstacles encountered in the process. The GDJJ now works with a local public health department to ensure that all facilities enroll in the VFC program.

This article was reprinted with permission from the Winter 2005 issue of CorrDocs, the newsletter of the Society of Correctional Physicians. It has been edited slightly from the original. To learn about VFC or to obtain the newsletter online, visit the Web at www.soccor.org/corrdocs.

State Health Agencies Urged to Partner With Corrections on Routine HIV Testing

In 2004, two staff members at two Florida state prisons were found to have tuberculosis. Outbreak investigation discovered three more cases (two among staff at the same two facilities dating to 2001).

The report notes that these populations not only have disproportionately high rates of HIV and AIDS, but also “present a risk to institutional health care providers.” The report describes demonstration projects in Louisiana and elsewhere to implement HIV rapid testing in a variety of correctional settings. The challenge, however, is what happens after a positive test result. According to ASTHO: “[I]f an inmate is known to be HIV infected, the state is required to provide treatment. With state budgets already stretched thin, some correctional facilities may be reluctant to provide HIV testing because they cannot afford to treat inmates who test positive.”

Unfortunately, the report is silent on how to overcome that hurdle. The report is on the Web at www.astho.org; go to the Activities & Programs menu, click on Infectious Disease, and then on HIV/AIDS. For more information, contact ASTHO at (202) 371-9090 or publications@astho.org.
Updates in Correctional Health Care
Las Vegas • April 9-12

Your Ticket to Professional Development

Whether this is first Updates conference or your fifth, you’ll benefit from access to experts, resources and tools that can help you address complex professional and clinical issues. Seeking updates on the latest issues and trends? Need creative solutions for perennial problems? Chances are that one of the 45 educational sessions will offer ideas you can implement right away.

NCCHC and the Academy, the nation’s leaders in correctional health care education, have developed a superior program that meets your needs, conducted in a high quality environment, to maximize your opportunities to learn, network and grow professionally.

Program Highlights
The meeting offers two full days with 45 concurrent sessions in seven educational tracks—administration, infectious diseases, legal issues, medical issues, mental health care, nursing issues, professional development—along with several general sessions and two days of preconference seminars. You’ll also have plenty of opportunities to network.

Conference Objectives
• Demonstrate an understanding of skills necessary to better manage common medical, dental and psychological problems found in correctional settings
• List major health care and policy issues facing incarcerated individuals, including HIV infection, mental illness and substance abuse
• Describe legal, ethical and administrative issues and ways to prevent potential problems that arise in correctional settings
• Demonstrate increased understanding of common correctional health care issues by exchanging ideas with colleagues about new developments in specialty areas.

Entertainment Capital of the World!
Even though the Flamingo offers all you could want (and then some!), there is much more to Vegas than the Strip. The entire valley offers fun and excitement, as well as the natural beauty of the desert. And its popularity is booming: In 2004, the city welcomed a record 37.4 million visitors.

Shows Las Vegas presents performances by some of the most famous singers and comics in show business, as well as lavish productions featuring statusque showgirls, stunning sets and incredible special effects. Tickets for most shows and headlining entertainers can be purchased by phone, at showroom box offices or online at vegas.com. Hotel lounges also offer some of the best and most economical entertainment around. Some require a small cover charge or minimum drink purchase, but there are many with no charge at all.

Tours For a great diversion from the casinos, consider a tour. Tour companies offer helicopter views of the city, trips to see celebrities’ homes, rides out to Lake Mead, and most economical entertainment around. Some require a small cover charge or minimum drink purchase, but there are many with no charge at all.

Only in Las Vegas
The Flamingo is the conference headquarters hotel. Bugay Siegel’s desert dream, the Flamingo has anchored the Las Vegas Strip since they started rolling dice in 1946. This self-contained casino and resort offers everything you could want—including a wildlife habitat and a 15-acre Caribbean-style water playground. The hotel combines heart-pounding excitement with unmatched hospitality and service.

Restaurants Where to begin in a city that has exquisite cuisine for every taste and budget? Las Vegas is renowned for buffets, so maybe the Pharaoh’s Feast Buffet at Luxor, with a wide variety of international foods and chef’s stations that prepare entrees to order. Sushi lovers should head to Todai at the Aladdin, where a 160-foot buffet serves up 30 kinds of sushi and other seafood. For casual, group-friendly dining, AJ’s at the Hard Rock Hotel encourages sharing with its large portions, and enlivens patrons with drink specials. Or indulge your senses at the Rainforest Cafe at MGM Grand, with its huge aquarium, lush vegetation and waterfalls (and great steaks!).

Trolley Tired of hoofing it? Hop on the Trolley, a convenient way to travel the length of the Strip from 9:30 a.m. to 1:30 a.m. Exact fare of $1.75 is required.

Las Vegas information comes from What’s On: The Las Vegas Guide magazine.

Essential Exhibits: The Lineup
From the opening reception Sunday evening to the final break and raffle drawing late Tuesday morning, the Exhibit Hall will be your place to relax. You’ll have plenty of time to talk with representatives from leading companies whose products and services can assist you in your job.

Continuing Education
The following are the maximum hours of CE credit that may be earned at this conference. Please see the conference program for details about NCCHC’s approvals to provide this credit. A $10 fee is required to obtain a CE certificate.
• CCHPs: Up to 25 hours of Category 1 credit for recertification
• Physicians: Up to 25 hours of Category 1 credit
• Psychologists: Up to 25 hours of Category 1 credit
• Nurses: Up to 30 contact hours of continuing education credit.

Preconference Seminars
• In-Depth Look at NCCHC’s Standards (Prisons/Jails or Juvenile)
• In-Depth Look at NCCHC’s Mental Health Care Guidelines
• The Correctional Nursing Assessment
• Risk Management in the Correctional Environment
• Assessment & Treatment of the Mentally Ill Offender (Pfizer Inc. is sponsoring this free session, but registration is required)

Exhibitor Booth
Abbott Laboratories 307
Academy of Correctional Health Professionals 506/508
Albany Medical Center 209
AstraZeneca 304
Bristol-Myers Squibb Immunology 405/407
BSI Supply 317
Carstens 408
COMED 318
Contract Pharmacy Services 415
Correct Rx Pharmacy Services 114
CorrectionCare, Inc. 316
CorrecTek 303
Correctional Healthcare Management 410
Diamond Pharmacy Services 104
Eli Lilly 412
Federal Bureau of Prisons 103
Gilead Sciences 404
GlaxoSmithKline 208
Grifols USA 513
Health Professionals Ltd. 215
Henry Schein 418
Internune 418
Language Services Associates 217
Locum Medical Group 416
Medical Staffing Network 502
Medical Wholesale 112
Medline Industries 315
Merk Human Health 203
MHM Correctional Services 305
Moore Medical Corp. 505/507
NaphCare 205
National Partnership for Juvenile Services 107
NCCHC 510/512
OPUS Unit Dose 406
Pfizer 306/308
Pride Enterprises 105
Quick Med 204
Raptd-Scan 504
Roche Laboratories 211/213
Sequest Technologies 517
SHC Services 106
Society of Correctional Physicians 515
Solvay Pharmaceuticals 206
Southpoint Technologies 110
Sycon Justice Systems 414
Tiburon 218
ViroLogic 216
Wexford Health Sources 503
Zerowet 108

Sponsored by the National Commission on Correctional Health Care and the Academy of Correctional Health Professionals
Find conference information and online registration at www.ncchc.org.
To obtain a preliminary program with registration form, download it at our Web site, e-mail info@ncchc.org, or call (773) 880-1460.
SSRI Benefits Outweigh Risks
That’s the conclusion of a review of decades’ worth of data from Europe and the United States. Juvenile use of selective serotonin reuptake inhibitors, a family of antidepressants that includes Paxil, Prozac and Zoloft, has been mired in controversy after reports of suicides and attempts. But the study author, a psychiatry professor at UCLA medical school, found a close correlation between dramatic declines in suicide and the introduction of SSRIs into the marketplace. The findings were published in the February issue of Nature Reviews: Drug Discovery.

African Americans and Asthma
Controlling asthma among African Americans is sometimes difficult, and a new study suggests why: They may need more medication than Caucasians. Researchers found that both asthmatic and nonasthmatic African Americans required higher doses of glucocorticoids to suppress the lymphocytes involved in airway inflammation. This suggests these patients may have “an inherent predisposition that affects their ability to respond to certain medications at recommended doses.” The study was published in the February issue of CHEST, the American College of Chest Physicians’ peer-reviewed journal, online at www.chestjournal.org.

Sleep Apnea Treatment Aids Diabetics
Diabetics are nine times more likely to have sleep apnea than nondiabetics, and now a study shows that they may be able to lower their glucose levels significantly if they treat their breathing disorder. According to a report in the Feb. 28 Archives of Internal Medicine, study subjects with Type 2 diabetes underwent standard sleep apnea treatment, known as continuous positive airway pressure. While sleeping, the nostrils are covered by a mask attached to a machine that blows air through the upper respiratory tract, keeping the back of the throat open. The patients were mostly male, average age of 50, and severely obese (a risk factor for both diabetes and sleep apnea). Their overall hemoglobin levels were reduced by 0.5%, similar to the reduction achieved by medication. By reducing glucose levels, diabetics also can cut their risks for stroke, heart attack and kidney disease.

FDA Hearings on COX-2 Inhibitors
With COX-2 inhibitors under fire for their cardiovascular risks, an FDA advisory committee in February held a series of hearings to determine whether the painkillers should stay on the market. In a word, “yes” was the final recommendation of the 32-member panel, though the vote was split, most notably for Vioxx and Bextra. However, most panel members wanted to see black box warnings about heart risk on the labels of the three drugs in this category (the third is Celebrex). It remains to be seen whether the FDA will follow the panel’s recommendations. For detailed meeting proceedings, go to www.fdaadvisorycommittee.com and click on the “arthritis drugs” option.

Guidelines Update
• Updated guidelines for the use of rifamycins to treat of tuberculosis among HIV-infected patients taking protease inhibitors or nonnucleoside reverse transcriptase inhibitors. www.cdc.gov/nchstp/tb/TB_HIV_Drugs/TOC.htm.
• Antiretroviral postexposure prophylaxis after sexual, injection-drug use or other nonoccupational exposure to HIV. www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm.
• Public Health Service Task Force recommendations for use of antiretroviral drugs in pregnant women infected with HIV-1. www.aidsinfo.nih.gov/guidelines

Lit Review
• Cost-effectiveness of HIV Screening for Incarcerated Pregnant Women; Resch, Altice, Paltiel; Journal of Acquired Immune Deficiency Syndromes, February 2005.
On any given day, more than 100,000 youth are being held in juvenile detention centers or residential facilities across the country. Research suggests that at least one in five of these youth has a serious mental disorder, and that many others have at least one mental disorder less serious in nature. These disorders often are coupled with substance abuse.

In the juvenile justice system, concern has been growing about the need to provide these youth with appropriate treatment and services. However, the first step—effective identification of youth who require mental health services—has been largely absent, according to a publication recently released by the National Center for Mental Health and Juvenile Justice.

Developed to remedy this deficiency, the NCMHJJ publication offers a “comprehensive, user-friendly synthesis” of information to help practitioners screen and assess youth for mental health disorders and substance use problems at various stages of the juvenile justice process.

“Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System: A Resource Guide for Practitioners” was developed through a grant from the U.S. Department of Justice’s Office of Juvenile Justice and Delinquency Prevention.

In a foreword, OJJDP administrator J. Robert Flores writes that “problems related to [mental health- and substance use-related disorders] play a continuing role in delinquency and pose risks to the welfare of youth, juvenile justice staff and others.” With “early, accurate identification” of their disorders, Flores adds, “these youth can receive the services required to improve their lives, reduce recidivism, and promote community safety.”

Chapter by Chapter

In its five chapters, the guide profiles more than 50 instruments, provides guidelines for selection, and makes best practice recommendations for diverse settings and situations.

Chapter One discusses the role of screening and assessment in the juvenile justice system, defining terms and outlining the stages during which these activities generally take place. It describes a range of approaches for screening and assessment, though it notes the lack of evidence-based knowledge and research regarding the various models.

Chapter Two presents information on how to select instruments, with attention to their development, purpose(s) and capacity for meeting these purposes. Instruments selected must be designed specifically for use in the various juvenile justice settings, in addition to meeting psychometric standards. Selection must be based on questions of “what” disorders; “whom,” or youth characteristics; and “what context.” The chapter also describes how to judge psychometric quality.

Chapter Three is a menu of a wide range of available instruments. To help practitioners narrow the choices for a given application, information is summarized in two overview tables, one for screening tools and one for assessment tools. Characteristics to weigh include constructs measured, age range, administration and scoring, administration time, training required and more.

With the caution that real-life circumstances and objectives vary widely, Chapter Four presents “best practice” selections, describing typical circumstances (e.g., intake assessment, juvenile detention, pretrial emergency consultation) and suggestions for selecting instruments that might best meet their specific needs. The guide closes with several comments and recommendations:

• Screening should be performed for all youth at the earliest point of contact with the system.
• Assessments should be performed for youth who require further evaluation.
• Care should be taken to identify the most appropriate instruments.

The 90-page document is available online only. It can be accessed at www.ncmhjj.com/publications. For more information, contact NCMHJJ toll-free at (866) 962-6455, ext. 244.

This article is based on information published in the NCMHJJ Resource Guide.

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METHADONE TREATMENT

(continued from page 1)

Even jails that had a written protocol for methadone management did not necessarily continue the treatment. On the other hand, these respondents were more likely to detoxify inmates using recommended protocols.

In terms of jail size, those with more than 2,000 inmates were most likely to report use of appropriate detoxification protocols, yet continuation of treatment was more common in jails with 1,000 to 2,000 inmates.

Furthermore, while jails in the South and Midwest were more likely than those in other regions to continue treatment, the Northeast produced significantly more respondents who reported use of appropriate detoxification protocols.

Drawing Conclusions

Halting treatment of individuals who receive methadone maintenance carries many risks, not only for the inmate but also for public health and safety. Thus, jails should consider options that would provide for continuity in opiate treatment and minimize the risks associated with treatment interruption.

Options include:

1. Becoming a satellite of a community-based methadone program.
2. Arranging for the local program to deliver methadone.
3. Substituting buprenorphine, which was approved for office-based use in 2002.
4. A last option, one that has become more feasible now that NCCHC offers accreditation for opioid treatment programs based in correctional facilities, is to become legally certified to operate a methadone maintenance program.

While each of these options presents challenges, they warrant consideration given the risk associated with current practices.

Furthermore, poor or nonexistent coordination between jails and community-based methadone programs exacerbates the problems of managing program enrollees admitted to jail. Without accurate information about current dosing, correctional health care providers cannot make informed decisions about methadone management.

Looking at use of “appropriate detoxification,” most of the respondents who said they used standard protocols reported using clonidine for this purpose. While studies conflict as to clonidine’s efficacy and ability to relieve withdrawal symptoms, it is well-established that methadone is safe and effective, and is known to reduce opiate usage in jails.

Of far greater concern, however, is the widespread use of “detoxification” practices, such as use of non-narcotic analgesics, that do not meet community standards, or allowing inmates to go “cold turkey.” Such practices are inhumane and violate the hypocratic oath taken by physicians: “First do no harm.”

Four Recommendations

The following reforms warrant serious consideration and public debate:

1. Development and implementation of uniform national policies for management of jail arrestees/inmates on methadone;
2. Closer coordination between jails and community-based methadone maintenance programs;
3. Improved education of health care professionals working in jails;
4. Less-restrictive regulations governing the use of methadone in jails.

Kevin Fiscella, MD, MPH, is an associate professor in the Departments of Family Medicine and Community and Preventive Medicine at the University of Rochester School of Medicine and Dentistry, as well as the associate director for the Rochester Center to Improve Communication in Health Care, New York. Reach him by e-mail at Kevin_Fiscella@urmc.rochester.edu.

For more information, call NCCHC’s Director of Accreditation at (773) 880-1460 or send an e-mail to OTPinfo@ncchc.org. To order the Standards for OTPs, call NCCHC or visit the Publications section of our Web site, www.ncchc.org.

NCCHC Accreditation

For Opioid Treatment Programs in Correctional Facilities

NCCHC offers accreditation for opioid treatment programs in correctional facilities. One of only six accrediting bodies so authorized by SAMHSA, and the only one that focuses on corrections, NCCHC has developed standards based on federal regulations and that recognize the special nature of correctional facilities. Health services accreditation by NCCHC is not required to take part in the OTP accreditation program.

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DOT for HAART Shows Promise

Highly active antiretroviral therapy has contributed to significant declines in HIV-related morbidity and mortality over the past nine years, but the success of this therapy depends on strict adherence to medication regimens.

Unfortunately, HIV-positive inmates often have difficulty continuing HAART when they are released from prison, whether due to homelessness, substance abuse or myriad other factors that lead to instability and shift their priorities away from health care.

One way to improve adherence to medication regimens generally is through directly observed therapy, and research on certain populations of patients suggests it can be successful for HIV treatment, as well. But will it work with new releasees?

To test this, researchers from the Miriam Hospital, Providence, RI, conducted a study that assessed the perceived acceptability of DOT among 25 HIV-positive subjects (none of whom had participated in a DOT program) with a history of incarceration. The study methodology used a questionnaire administered by an interviewer during a face-to-face meeting in a private room. Study results were reported in the current issue of the Journal of Correctional Health Care (Vol. 11, Issue 2).

Findings

Two thirds of the study subjects were male, and the mean age was 45 years. Most (50%) had been incarcerated within the past four years. Three-fourths said they had a good attitude about their disease.

However, of the 18 participants currently taking HAART, six had missed doses in the past four days. When asked whether they felt that directly observed therapy would help them in some way, 84% of the study subjects said yes, though a somewhat smaller percentage, 76%, said they would consider taking part in a DOT program for HIV therapy.

Perceived Benefits

What are the perceived benefits to participation? Five were cited:

• Getting information to understand treatment (84%)
• Outreach worker is a link to health care providers (84%)
• Feeling better because of support (80%)
• Outreach workers is a potential source of support (76%)
• Help staying on medications (72%)

Perceived Barriers

Asking about perceived barriers, the researchers found that the primary areas of concern were frequency of visits and acceptable meeting places. Most acceptable, cited by 72%, were the home, followed by medical clinic/hospital (60%) and coffee shop (56%). Only 12% would be comfortable meeting at a methadone clinic. Most (80%) study subjects agreed that excessive visits would be a reason not to take part in a DOT program. They were divided on the preferred frequency of visits, with 40% opting for 2-3 days a week, and 32% opting for 1 day a week.

Conclusions

The Miriam Hospital has a program called Project Bridge that, with collaboration between medical staff and social workers, has a 100% success rate in linking inmates who express a need with HIV care after release. The study authors say that in similar fashion, a well-structured postrelease DOT program could also succeed in providing vital health care and social support to an at-risk population.

Call for Reviewers

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The Journal of Correctional Health Care is the only national, peer-reviewed scientific journal to address correctional health care topics. Published quarterly by NCCHC, the Journal features original research, case studies, best practices, literature review and more to keep correctional health professionals up-to-date on trends and developments important to their field.

To ensure that the manuscripts published meet the highest standards, each manuscript under consideration is sent to at least two qualified reviewers with expertise in the subject. Reviewers assess the article on criteria such as significance to the field, quality of research and quality of writing, and then make one of three recommendations: accept the article, return it to the author(s) for revision or reject. Generally, reviewers are asked to consider no more than two or three articles per year. Among the subjects for which reviewers are sought are the following:

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Those interested in becoming a reviewer should direct an inquiry indicating areas of expertise to editor John R. Miles, 250 Gatsby Place, Alpharetta, GA 30022; fax (770) 650-5789; e-mail thejchc@bellsouth.net.

NCCHC Standards for Health Services In Correctional Settings

The recently revised national Standards for Health Services provide guidance in establishing and maintaining constitutionally acceptable health services systems in jails, prisons and juvenile facilities. Compliance indicators articulate expected outcomes in nine areas: administration, environment, personnel, health services and support, care and treatment, health promotion, special health needs, records and medical-legal areas.

The new editions feature a more user-friendly format; standards on current issues such as chronic care and end-of-life care; clear compliance indicators; guidelines for facilities of various sizes; recommendations for best practice concerns; and appendices on the legal context for correctional health care, quality improvement, extreme conditions of segregation, suicide prevention protocols and more. The Juvenile Standards address these issues taking into account the special health needs of adolescents.

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• The Potential Use of Directly Observed Therapy (DOT) for the Treatment of HIV+ Individuals Being Released from Prison
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Spotlight on the Standards

Understanding ‘Health Assessment’: More Than a Physical

BY JUDITH A. STANLEY, MS, CCHP-A

A s children, or even as adults, we all have played some variation on this word game: I say a word, and you reply with the first word that pops into your mind. That was the idea behind the long-running television game show “Password,” in which pairs of contestants tried to prompt their partners to guess “the word” by using one-word clues. If prompted by the hint “assessment,” many invoked in accreditation likely would blurt out but one response: “physical!” But they would be wrong. Why? This response omits many aspects to assessing the health of an individual.

Simple Questions...

The intent of essential standard E-04 Health Assessment is the same in all three versions of the Standards for Health Services (jail, prison and juvenile): “…that clinicians assess and plan for meeting the health needs of the individual.”

Do you understand how to meet this intent? How would you respond to the following questions? Think about it carefully before you read the answers!

Question 1
What is needed for a health assessment?

If you replied, “a hands-on-physical,” you would be but partially correct. In fact, NCCHC requires seven (adult settings) or eight (youth facilities) components for a health assessment. These include, but are not limited to, review of receiving screening results; collection of data to complete medical, dental and mental health histories; recording of vital signs; physical examination, including breast, recital and rectal exam as indicated (with pelvic and PAP required for women in prison settings); laboratory/diagnostic testing for communicable diseases; immunizations as appropriate; and initiation of therapy.

Question 2
When must the initial health assessment be performed?

A. In all likelihood, those who work in prisons and youth facilities would respond “7 days” and those in jails “14 days.” However, the correct answer must reflect the wording of Compliance Indicator 2: “As soon as possible, but no later than 7 [14 for jails] calendar days” after arrival.

The timing also depends on clinical need as discovered in the receiving screening findings for the individual (E-02).

Question 3
If a facility completes the initial health assessments as required, is it in full compliance?

A. Would you say “yes”? The correct answer is “maybe.” Full compliance requires periodic health assessments, as well. Notice that Compliance Indicator 4 does not say “annual” assessments, and that both the timing and extent of this periodic assessment are to be defined by protocols promulgated by nationally recognized professional organizations.

Question 4
Is there way to meet the intent of the standard other than by complying with the indicators?

A. This one is tricky, and again the answer is “maybe.” Depending on the content and extent of the facility’s health screening process at intake, the intent of this standard may be met in other than the usual manner, although this would be rare.

Multilayered Process

In our survey work, we have found that some correctional health professionals have an incomplete grasp of the full intent of the Health Assessment standard. What contributes to this simplistic understanding of what was meant to be a many layered clinical process?

Each field develops its own vocabulary, and health practitioners are no different. We use verbal shortcuts to share information quickly. It then becomes all too easy to forget that there is more to the procedure than the mnemonic used to identify it.

When it comes to evaluating compliance with standards, we may tend to focus on what is perceived to be the most important aspect of a standard. At times “most important” becomes the aspect that is most easily counted, measured or just plain tangible. For example, it is easy to see if jail inmates received a health assessment by Day 14. It takes more effort to see that an inmate identified as an insulin-dependent diabetic at receiving screening, in need of immediate orders for insulin and diet set upon admission, is fully evaluated by a physician or midlevel practitioner as soon as possible.

Other issues may make it difficult to gather all pertinent health assessment data. Such factors may include the volume of intake, problems getting receiving screening forms into the medical record, inability to get the inmate to the clinician on time, delay in obtaining lab results or even unexpected absences of co-workers. But we should not become disheartened. The correctional health care field is not unique in the daily tug between expediency and effectiveness, or between mere adequacy and complete professionalism.

Community-based practitioners face different challenges but still manage to contend with no-shows, health information management and utilization review, to name a few.

Focus on Intent

The best way to keep the whole of this standard in mind is to focus on the intent—that is the reason we are assessing. The standards are not meant to be artificially imposed upon what otherwise would be good clinical practice. Rather, they are meant to supply the parameters within which clinical practice can occur. If something is done solely because the standard requires it, the interpretation and/or implementation of that standard is questionable.

How can we tell if we are meeting our goals? One way is to employ performance measures as part of continuous quality improvement initiatives.

The 2004 Juvenile Standards introduce this concept for the Health Assessment standard. The recommendation is presented as a performance measure in this way:

“100% of the time, when a health problem is identified subsequent to the intake assessment, the individual should have been identified during the initial assessment, but was not, a CQI analysis of the root cause is initiated, and (where indicated) appropriate action is taken to mitigate any negative outcome for the youth involved.”

The expectations for this performance measure are as follows:

“Measure #2 requires the practitioner to check the youth’s initial health assessment time each visit for accuracy and completeness. The time interval at which the practitioner must check and confirm that with good medical practice, should have been picked up during the initial health assessment process.

Evaluation of how well the facility is doing can be accomplished by maintaining a log that records the current treating practitioner to record particulars that allow designated staff to follow up and identify where the process went wrong. This method of identifying problems is ongoing and directly linked to caregiver interactions with the patient.”

Since health care is both science and art, clinical practice and the requirements of basic community care will change over time. As part of the continuum of public health care, correctional health care practice will change accordingly.

Likewise, compliance indicators may and should evolve over time, but there will be little change when it comes to the intent—the reason for assessing the health of inmates entrusted to our care.

Judith A. Stanley, MS, CCHP-A, is NCCHC’s director of accreditation. To contact her, call (773) 580-1460 or e-mail judithstanley@ncchc.org.
Fetal Monitors in Juvenile Settings

Our county juvenile detention center rarely houses pregnant juveniles, and when we do, it is almost always short-term. The community hospital where deliveries would take place is right across the street, and the physician treating these girls has an office nearby. We do not have a fetal heart monitor on site. Given our circumstances, must we have one in order to comply with NCCHC standard V-D-03 Clinical Space, Equipment, and Supplies?

The fetal heart monitor is not required, but it is recommended. To comply with a standard for accreditation purposes, you must understand and meet the requirements of the standard itself and of its compliance indicators. In standard V-D-03, the recommended section lists suggested equipment, including a fetal heart monitor. As its name implies, this section makes recommendations that likely will benefit a facility but that are not mandatory. If your responsible physician is comfortable with your situation and the resources available, then you may follow the physician's protocols. You will be in compliance with the intent of the standard.

Electronic Continuing Education

I am a fairly new health administrator at my correctional facility. Would I be in compliance with the standard concerning health staff training if, for the portions of the training that do not deal with hands-on interventions (such as CPR or first aid), I use a PowerPoint presentation? I could send the training materials through the institutional mail to all health staff, and I have the capability of checking on my computer to see who has opened the training.

The relevant standard is C-03 Continuing Education for Qualified Health Care Professionals. Its intent is the same for jails, prisons and juvenile settings: “the facility’s qualified health care professionals are kept current in clinical knowledge and skills.” The standard allows for a variety of approaches and methods to meet the intent. The use of a few computer-based offerings such as you describe may be appropriate. However (omitting discussion of the hands-on training noted above), if you used the PowerPoint method only with no face-to-face meetings, compliance may be questioned. You want to ensure that the presenter and participants have opportunities to interact, at least some of the time. The exchange of questions and answers and the sharing of experiences often are the most valuable parts of any training. NCCHC’s Accreditation Committee would make the compliance decision based on findings from the on-site survey.

As a side note, staff can earn continuing education credit by providing documentation of external educational activities, including health classes, seminars and conferences such as those sponsored by NCCHC.

Inmates Assisting With ADLs

Please clarify your standards concerning inmate workers. In G-06, Compliance Indicator 3 states, “Inmates do not provide direct patient care,” but the discussion section says they may assist other inmates in activities of daily living, such as ambulation, bathing, dressing, feeding and toileting. In the community, ADLs are direct patient care for certified nursing assistants. How do you define direct patient care?

In general, NCCHC defines direct patient care as health interventions or services that in the free world usually are provided only by appropriate health professionals who have the necessary clinical skills. Inmate workers are not to take the place of health staff. However, ADLs can be provided on different levels and, depending on the patient’s status, may or may not require clinical skills.

In the free world, when assistance in ADLs is part of services provided by family members, volunteers, paraprofessionals, etc., in what are considered non-inpatient settings (home, assisted living situations, hospice care, etc.), it generally falls under the category of nonskilled nursing care. But when a patient is hospitalized, those same ADLs become part of the skilled nursing care provided by nurses of various levels according to the tasks needed. Similarly, different levels of ADL assistance may exist in correctional settings. Here’s where NCCHC distinguishes between these levels to assess compliance with the intent of the relevant standards (G-06 Inmate Workers and G-05 Inmate Care Programs). When the patient is housed in general population (defined as any non-infirmary setting, such as medical housing, sheltered housing, segregation, hospice, etc.), trained inmate workers (known by various names in different facilities) may provide the ADL assistance. However, if the patient is admitted to an infirmary on infirmity status, the ADLs become part of the skilled nursing care required and inmate workers may not provide the assistance.

Some infirmaries may house patients who are not classified as on “infirmity status.” In such cases, it is possible for an inmate worker to assist one patient living in the infirmary who is there on sheltered care status, but not assist another patient who is there to receive infirmary care.

Diabetic Foot Care

My father has been in a county jail for several months and is having trouble with his feet. He is diabetic and used to see a podiatrist regularly. The jail doctor keeps telling him his feet are OK and he does not need to see a podiatrist. The jail has a certificate that indicates it is accredited by NCCHC. Do you have any standards for this? What kind of foot care should the jail give for diabetics?

Relevant issues concerning diabetic foot care are addressed in the jail standards J-G-01 Special Needs Treatment Plans and J-G-02 Management of Chronic Care. NCCHC’s standards are based on the assumption and expectation that health providers will treat a diabetic inmate patient as they would treat a diabetic patient in the community. The responsible jail physician is to follow one of the current national clinical guidelines, such as those of the American Diabetes Association or the NCCHC Clinical Guidelines for Correctional Facilities: Diabetes Chronic Care. Such guidelines recommend regular examination of the feet, as you indicate the jail physician is doing. An annual examination by a podiatrist and as clinically indicated is one of the ADA guidelines.

Judith A. Stanley, MS, CCHP-A, is NCCHC’s director of accreditation and oversees the development and revision of standards. R. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president, liaison to the policy and standards committee, and an accreditation surveyor.
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6. Electronic files (Quark, PageMaker or PDF) preferred; include font files. We also accept camera-ready copy and film (120 line, right reading, emulsion side down). Proofs must accompany all ads.
7. Cancellations must be received in writing before the insertion order deadline.
8. We reserve the right to change rates at any time; however, we will honor the rates in effect when the order was placed.
9. Acceptance of advertising does not imply endorsement by NCCHC.

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