NCCHC CORRECT CARE

A Publication of the National Commission on Correctional Health Care

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Study Notes Risk of Relapse, Rearrest

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

Areas of Inquiry

The study's objective was to assess how jails manage individuals who are enrolled in community methadone 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

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.

	N	Percentage*
0% - 1%	32	27
2% - 5%	82	37
6% - 10%	47	14
>10%	72	22
Missing	13	

* Results were weighted to account for oversampling of larger jails.

Meth Mouth

State inmates—and budgets—suffer in Minnesota, page 7.

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 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.

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Inside This Issue

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Mental Health Educational Conference Enjoys 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, too: 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 bring more of 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 academic 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

Where and When

Mental Health Care in Corrections: Transforming Care, Transforming Lives
July 17-18 • Hyatt Regency Chicago
Find more information and a registration form online at www.ncchc.org.

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. Rold serves 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 Dubler, 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 represents the Society for Adolescent Medicine on the NCCHC board.

Morris also contributed 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.

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 under 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.

Calendar

April 9-12
Updates in Correctional Health Care, Las Vegas

April 10
CCHP and CCHP-A proctored examinations, Las Vegas

June 1
Application deadline for July 16 CCHP exam

June 17
Accreditation Committee meetings: Health Services and Opioid Treatment Program

July 17-18
Mental Health in Corrections conference, Chicago

September 1
Application deadline for October 9 CCHP exam

October 9
CCHP and CCHP-A proctored examinations, Denver

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	Edward Harrison
Vice President	Scott Chavez
Controller	Dwain Grunke
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Director of Accreditation	Judith Stanley
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Send correspondence to Jaime Shimkus, publications editor, NCCHC, 1145 W. Diversey Parkway, Chicago, IL 60614.
Phone: (773) 880-1460. Fax: (773) 880-2424.
E-mail: info@ncchc.org. Web: www.ncchc.org.

Guest Editorial

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 $50 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 applicants to come together to provide "individualized, needs-based assessments to determine, plan, and contribute the most appropriate services."

The bill elicits 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.*

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 Wellcon LLC, which was created to serve as the contracted medical provider for the Salt Lake County Jail. He's also a senior consultant with Phase 2 Consulting, which focuses on health care.

Building a Better Model

Ask Wilcox for a description of his job and you'll get a fairly standard "medical director" reply: "design and oversee the care delivery models for medical, mental health, dental, nursing and pharmaceutical services in facilities in order to ensure quality, consistency and optimal use of resources."

But ask him about the best ways to do achieve those objectives and you're in for an exciting and detailed conversation about health care management, resources and technology. Wilcox is passionate about the opportunities he sees to improve institutional models for health care delivery in correctional systems.

Nevertheless, he also is aware of the many challenges that hinder progress in correctional health care, including expanding obligations to provide care that meets community standards, an increased need for baseline statistics and performance data (much like what hospitals are now required to generate) and, always, financial pressure: "You never have enough resources."

This is where Wilcox's master's degree in business administration has been invaluable. "Almost universally, programs in trouble are inefficient," he says. "Maximizing use of resources is the trick to managing a good correctional health program—understanding money, finances and the management perspective."

Wilcox also notes that corrections will continue to fulfill more of the public health mission. "Correctional health is the new public health. We will see more expanded public health screenings in jails."

Optimistic Outlook

While monetary and physical resources may always be in short supply, Wilcox has found in his six years as a CCHP that the credential is a helpful way to maximize human resources.

"Certification is the most recognized mechanism for communicating that you have interest and proficiency in this unique medical field," he notes. "Not only does it convey your medical expertise, but it also enables you to have access to a very experienced group of individuals who can greatly assist you in the challenges you will encounter in your corrections career."

With such a positive view of certification, it's not surprising that 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.

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-declarations 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 _____

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.

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. Haynes, RN, CCHP
Prison Health Services Inc.
Montgomery, AL

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

Ann M. Herman, RN, CCHP
Campbell County Detention
Gillette, WY

Juanita P. Homer, RN, CCHP
PhyAmerica Correctional Healthcare
Salisbury, MD

Michelle D. Horton, RN, CCHP
Michigan Department of Corrections
Pickford, MI

Miles D. Kramer, LCSW, CCHP
Contra Costa County Jails & Juvenile Hall
Martinez, CA

Charles D. Lee, MD, JD, MBA, CCHP
Salinas Valley State Prison
Soledad, CA

Kathryn L. Leiser, RN, CCHP
Correctional Medical Services
Conyers, GA

B. Sue Medley-Lane, RN, CCHP
Cobb County Adult Detention Facility
Woodstock, GA

David B. Meeker, MA, CCHP
Correctional Medical Services
Ewing, NJ

Cristi D. Moore, RN, CCHP
Physicians Network Association
Lubbock, TX

Jerilyn W. Riddick, MSN, CCHP
State of Maryland
Salisbury, MD

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

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

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

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

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

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

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

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

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

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

Catherine Toedebusch, BSN, CCHP
Correctional Medical Services
St. Louis, MO

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

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

Kanzenner R. Wilks, 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
- April 21: Wilsonville, OR, in conjunction with the Oregon Chapter of the American Correctional Health Services Association
- July 16: Regional exams: Chicago, IL; Charleston, ME; Ypsilanti, MI; Harrisburg, PA; Guaynabo, PR; Houston, TX; Lubbock, TX; Yakima, WA; others TBA
- October 9: Denver, CO, during the National Conference on Correctional Health Care

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.

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 dyamics 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 different in the course of someone's career.

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.

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. The chairs of this committee are looking for a leader or liaison for each SIG. The SIG leader automatically becomes a member of the SIG committee. Please indicate which SIG you would like to lead:
- ___ Administration
- ___ Dental
- ___ Infection Control
- ___ Juveniles
- ___ Legal Issues
- ___ Mental Health
- ___ Nursing
- ___ Public Health
- ___ Quality Improvement
- ___ Research

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
fax: 773-880-2424
online: www.correctionalhealth.org

‘Meth Mouth’ Plagues Many State Prisoners

BY MARK BRUNSWICK, STAR TRIBUNE

After more than a decade of drug abuse, Darren Zigas is now facing what could be seen as the expected consequences of his methamphetamine addiction: prison time, alienation from friends and family, and a rap sheet filled with convictions for assault, terroristic threats and burglary.

But, at 32 years old, he’s also facing another consequence: a lifetime without a tooth in his mouth.

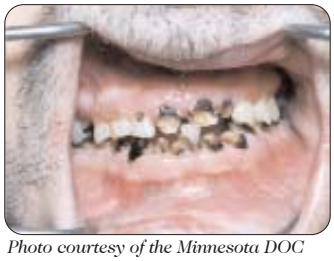


Photo courtesy of the Minnesota DOC

As the number of regular users of the illegal drug methamphetamine has increased, so has a peculiar set of dental problems linked to the drug, a phenomenon appropriately named “meth mouth.” Symptoms include gum disease, broken and cracked teeth, and tooth decay.

Zigas’ condition was so bad that he once bit into a peanut butter sandwich and teeth were left in the bread. In June 2002, malnourished and down to 150 pounds, he had the rest of his remaining teeth pulled.

His dental problem is not only his own now, but the state of Minnesota’s as well. In the Lino Lakes prison for a 2002 conviction for manufacturing methamphetamine, Zigas had dentures made for him four months ago by a state dentist.

Zigas’ Department of Corrections’ intake photos show the concave appearance of a man with no teeth, his chin curving upward almost cartoonlike toward his nose. With his new dentures, he now has the appearance of a man 10 years younger.

With the burgeoning use of methamphetamine, a ripple effect has flooded the state’s court systems and now its prison population. A quarter of all state inmates now are drug offenders, half of them for methamphetamine, a drug that wasn’t represented at all on the prison rolls as recently as 2000.

Incarcerating drug offenders brings with it traditional costs, including rehabilitation and health expenses from years of abuse. But one of the unexpected results of the methamphetamine explosion is the demand for dental care from those behind bars.

The state has not broken down the costs of the increased occurrence of meth mouth in its prisons, but it is believed to be a significant driver in the nearly doubling of dental health care costs in the state’s corrections system since 2000—from $1.19 million to $2.01 million in 2004.

Because of the demand for emergency and urgent care from the methamphetamine users, it can now be up to a year’s wait for other inmates to get routine dental care from 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-caffeine, 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.”

‘Thorn in Paw’ Thing

There also may be an element of security concern about inmates who might be in chronic pain.

“It’s kind of the bear with the thorn in his paw kind of thing,” said Dr. James Macfarlane, a part-time dentist at Lino Lakes.

Duane Nyquist, who is serving time in Lino Lakes for possession of methamphetamine, has broken teeth and diseased gums. He began using methamphetamine while in federal prison for bank robbery in 1994 and used it daily intravenously after being released until he was rearrested in 2002.

Nyquist’s long-term abuse has resulted in joint problems from injuries, and he said he still has bouts of paranoia. His mother-in-law, who also is a long-term methamphetamine user, is dying of cancer.

At 37, he has yet to bring himself to get his teeth worked on, even though he has trouble drinking hot or cold liquids. “I know I’m going to have to do something. I don’t know why I’m holding out,” he said. “Maybe it’s because I don’t like dentists.”

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 bewilderment were 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 Mayfield. As medical director 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 Angelique Rowe.

Comprehensive Curriculum

A few months after joining the Mayfield staff nearly 18 years ago, Whaley spoke with the superintendent about the need for some "preventive 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 an hour. Instead, she uses a variety of other media, especially videos and DVDs from her library of 140-and-growing titles. All, of course, have been evaluated to make sure they are appropriate for this age group.

Educating impressionable minds. *The Program of the Year Award was accepted on behalf of the Mayfield team by Patrick Sheridan, MD, MPA, CCHP. Also pictured (L-R): NCCHC board chairman Eugene Migliaccio, DrPH; Katrina Whaley, RN, CCHP; former Mayfield superintendent Angelique Rowe; and NCCHC board representative Joseph Penn, MD, CCHP.*

These are not dull educational films, however. If there is some lesson to be learned, Whaley will use Hollywood releases, knowing that they are more likely to capture and hold attention. She recently showed the 1995 movie "Outbreak" (tagline: "This animal carries a deadly virus... and the greatest medical crisis in the world is about to happen") to teach infectious disease concepts.

Other Mayfield staff members teach classes occasionally, as do guest speakers from the community. When the local sheriff talks to the boys about the effects of alcohol, he brings a pair of glasses that simulate the blurred vision caused by intoxication. "They all think they can handle alcohol," Whaley says. "This is a reality check for them."

A striking lesson on methamphetamine was delivered by a man who asked permission to share with the youth his own story: A former user, his face was horribly disfigured when he tried to kill himself while under the drug's influence.

The Youth Center also organizes frequent off-site activities, including 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 complaining: 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 and treatment, 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 juveniles 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, emotion 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. Health-trained 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, KtB, CCHP

The Case

Thursday, 5:30 p.m.
Inmate Health Services, State Prison
Exam Room 3
Case 200 - 401

It had already been a full day, and Dr. Scott was looking forward to finishing this last case and going home. He reviewed the information on the manila chart: Andrew Paxton*, 36 years old, had been incarcerated just over one year. He complained of low back pain for three days. There was no known injury or other significant medical history. Flipping back a few pages, Dr. Scott noted Mr. Paxton did have a seven-year history of cocaine abuse but no intravenous drug use. He also was listed as having depression, but without suicide attempt.

History

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."

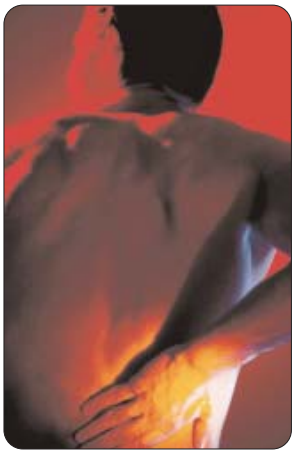
He then went on to relate a history of a gradual onset of constant dull low back pain, radiating occasionally to the right buttocks. He had no history of incontinence, fever, weight loss, constipation or urinary problems. The pain was worse when bending forward, and he complained of having difficulty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

Upon leaving the office, the patient was noted to rise quickly and smoothly, and he had spontaneous twisting without gait abnormalities.



Discussion

This case is actually a composite of two similar patients I recently saw in one day. Back pain is a common problem. In the corrections setting there are added concerns for work avoidance, privilege seeking and drug seeking. A large portion of the inmate population has a history of intravenous drug abuse. In this subsegment of inmates, there is a special concern for transverse myelitis.

Fortunately, this patient did not have a fever, recent drug abuse or focal neurological symptoms. The patient's relatively young age of 36, his normal vital signs and his lack of constitutional symptoms abate the concern for most referred diseases.

In the corrections setting, psychologically mediated pain is frequent. Careful history and examination can help classify organic disease into one of the major pain syndromes, while Waddell's signs can help identify psychological disease and manipulative behavior. It is important to remember that more than one type of low back pain syndrome may be simultaneously present.

Even in the absence of neurological findings, care should always be taken to consider emergent conditions such as abdominal aortic aneurysm, retroceocal 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 are:

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, electromyography 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 pain and 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, aching 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 recent 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-anatomic pain distribution
6. Inconsistent response to lying and standing straight leg-raising tests
7. Non-anatomic 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 clinically 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 low 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, KtB, CCHP, is assistant medical director for the Ohio Department of Rehabilitation and Corrections. To contact him, send an e-mail to ssavage4@columbus.rr.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), titled "Malingering: Recognition and Coping With Inmates," please see the order form on the back page.

In the News

Proposed Change to Psych Exam Law
Sen. Daniel Inouye (D-HI) has introduced a bill that would allow clinical social workers to conduct psychiatric or psychological examinations of offenders with mental disease, as required under chapter 313 of title 18, United States Code. The Psychiatric and Psychological Examinations Act of 2005 (S-88) has been referred to the Judiciary Committee.

Tobacco Cessation Guide for Inmates
The National Network on Tobacco Prevention and Poverty is developing an educational curriculum designed to help inmates quit smoking while incarcerated. The curriculum was pilot tested in several facilities across the United States in 2004. It is divided into two modules; one provides general education to encourage a move toward cessation, and the other is an actual lesson on how to quit. The curriculum will be distributed through NCCHC at the Updates conference in Las Vegas and at our Web site. Learn more about about NNTPP online at www.nntpp.org.

Disparities in Heart Disease, Stroke Risk
No surprise, perhaps, but a CDC study found "considerable" disparities in risk factors for heart disease and stroke based on racial/ethnic and socioeconomic characteristics. On average, 37.2% of respondents reported two or more of the six risk factors examined. But this percentage rose to roughly half for certain groups of adults: African Americans, American Indians, Americans with less than a high school diploma, and those with annual income under $10,000. The study examined six modifiable risk factors: high blood pressure, high cholesterol, diabetes, smoking, obesity and physical activity. The study was published Feb. 11 in *Morbidity and Mortality Weekly Report*, online at www.cdc.gov/mmwr. (See the story on page 1 to learn about a new national commission to end health care disparities.)

Suicide Prevention Standards Examined
The evolution and current state of the various national jail standards that address suicide prevention is the subject of the lead article in the Winter issue of *Jail Suicide/Mental Health Update*. While noting that different organizations' standards show "great variation as to...specificity," the report describes NCCHC's jail standards as providing "the most comprehensive and practical guidelines for suicide prevention." Edited by suicide prevention expert Lindsay M. Hayes of the National Center on Institutions and Alternatives, the quarterly publication is available at no charge. Subscribe online at www.ncianet.org/cjjsl.cfm.

TB Investigation in Florida
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 index case was an HIV-infected staff member who was considered "noninfectious" when first diagnosed with TB in 2001, did not adhere to the anti-TB medication regimen, and had frequent contact with other personnel. Sounds like trouble, and it was. The mystery is recounted—and lessons shared—in the February issue of *Infectious Diseases in Corrections Report* (formerly the HEPP Report), sponsored by Brown Medical School. It is available at www.ideronline.org.

Drug Prices Headed Up?
It seems so, based on an analysis in *American Journal of Health-System Pharmacy*, Jan. 15 issue. While the study authors did not consider correctional settings, they forecast price increases of 6%-9% in hospitals, 10%-12% in outpatient settings, and a whopping 12%-15% in clinics. The rate of increase is expected to outpace the growth in overall health care expenditures as well as growth in the economy.

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 were not vaccinated as 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 VFC program provides free HB vaccine to youths who have yet to reach their 19th birthday. Juvenile facilities can access this vaccine, as well as a broad array of other vaccine materials, at no cost via their local public health departments.

At the Georgia Department of Juvenile Justice, medical director Michele Staples-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 admits about 60,000 youth per year, including both pretrial and sentenced juveniles. Reaching all of its unvaccinated juveniles is challenging.

Funding from the Centers for Disease Control and Prevention two years ago permitted hiring of a hepatitis coordinator who works closely with both the GDJJ and the Georgia Division of Public Health. At the GDPH, the federally funded state VFC program has partnered with the branches that address sexually transmitted diseases, adolescent health and epidemiology.

Prior to the initiation of this program, only two facilities in Georgia routinely vaccinated their charges, even though all incarcerated youth are eligible through the VFC program. Now, cooperative relationships have been set up between the GDJJ and the local health departments in all 159 Georgia counties.

Goals and Obstacles

The initial goals of the GDJJ program were to:

- Enroll all 31 facilities in the VFC program.
- Create a centralized tracking system, piggybacking on the institutional computer system.
- Select and provide educational materials.

Various obstacles stood between the program's planning and its implementation. For example, the requirement for parental consent for vaccinating youth was often cited as a barrier to administering vaccines in juvenile halls. However, HB is a sexually transmitted disease, and youth in Georgia can receive STD services, including HB vaccine, without parental consent. (For your state's policy on minors' access to STD services, see the Alan Guttmacher Institute Web site at www.agi-usa.org/pubs/spib_MASS.pdf.)

The fact that some youth are not detained long enough to complete a three-dose vaccination series should not deter initiation of vaccine. Completion of a three-dose series is optimal and provides greater than 95% protective immunity. However, if patients leave the facility before completion of vaccination, even one or two doses will provide an immunity for a smaller percent of individuals: One dose provides 30% to 50% protective immunity, and 2 doses provide approximately 75% of protective immunity. (See the January 2003 MMWR article on hepatitis in correctional facilities).

Initially, tracking of the vaccine administration was carried out through the facilities' Juvenile Tracking System. However, in order to have access to the data after discharge, GDJJ is now working with public health to integrate its vaccine records with a statewide registry known as GRITS: Georgia Registry of Immunization Transactions and Services.

The numbers already vaccinated are evidence of the program's great success. As of the end of 2003, program personnel had delivered 10,193 doses to 4,127 unique individuals.

How can your state replicate the success of Georgia? To obtain free vaccine for those less than 19 years of age who are incarcerated in juvenile and adult facilities, contact the VFC program in your state's department of health. Your state's immunization coordinator will be able to assist you in procuring the vaccine at no direct cost to your institutions.

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 SCP or to obtain the newsletter online, visit the Web at www.corrdocs.org.*

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

The Association of State and Territorial Health Officials advocates routine HIV testing as a way to reduce rates of undiagnosed infection and, in an Issue Report released in February, says state health agencies can play a vital role in reducing barriers to testing as a routine part of medical care.

Among ASTHO's six recommendations for health agencies: "Partnering with correctional facilities to address the large amounts of undiagnosed HIV infection among incarcerated populations."

The report notes that these populations not only have disproportionately high rates of HIV and AIDS, but also "present a risk to communities" upon release. It 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.

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)

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.

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.

Only in Las Vegas

The Flamingo is the conference headquarters hotel. Bugsy 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.

Shows Las Vegas presents performances by some of the most famous singers and comics in show business, as well as lavish productions featuring statuesque 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 vegasshows.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 Hoover Dam, Lake Mead and other scenic wonders, relaxing rafting down the Colorado River, even shopping excursions. Ask your concierge for advice.

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 Pheast 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. *List current as of March 7.*

Exhibitor	Booth
Abbott Laboratories	307
Academy of Correctional Health Professionals	506/508
Albany Medical Center	209
AstraZeneca	304
Boehringer Ingelheim	101
Bristol-Myers Squibb Immunology	405/407
BSH Supply	317
Carstens	408
CONMED	318
Contract Pharmacy Services	415
Correct Rx Pharmacy Services	114
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To obtain a preliminary program with registration form, download it at our Web site, e-mail info@ncchc.org, or call (773) 880-1460.

Clinical Briefs

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 Celebrox). 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.
• The Spectrum of Chronic Hepatitis C Virus Infection in the Virginia Correctional System: Development of a Strategy for the Evaluation and Treatment of Inmates With HCV; Sterling et al.; *American Journal of Gastroenterology*, February 2005.

Guidance on Tools to Screen, Assess Youth Mental Health

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.
- Need and risk levels should be appropriately balanced.
- There is no one best way to provide mental health screening and assessment for youth in the juvenile justice system.

The 90-page document is available online only. It can be accessed at www.nemhjj.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.

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

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Jail Management of Arrestees/Inmates Enrolled in Community Methadone Maintenance Programs (N=246)

Management Practices	N	Percentage*
Inmates/arrestees are asked about opiate dependence on entry to jail		
Yes	206	56
No	34	44
Missing	6	
Use a specific standardized treatment protocol for opiate detoxification for arrestees/inmates already enrolled in methadone programs		
Yes	96	23
No	140	77
Missing	10	
Routinely contact methadone maintenance programs about dose		
Yes	99	27
No	136	73
Missing	11	
Methadone is continued during incarceration		
Yes	33	12
No	179	85
During pregnancy only	25	3
Missing	9	
Clonidine is routinely used to treat withdrawal**		
Yes	127	50
No	77	50
Methadone is routinely used to treat withdrawal**		
Yes	3	<1
No	201	99
Analgesics are routinely used to treat withdrawal**		
Yes	133	66
No	71	34
Primary drug used to treat withdrawal**		
Methadone	3	<1
Other opiates	13	1
Clonidine	121	50
Analgesics alone	42	30
No treatment	25	18

* Results were weighted to account for oversampling of larger jails.
** Includes only the 204 jails that did not continue methadone maintenance.

About the Study

This study was conducted by researchers from the University of Rochester School of Medicine and Dentistry. A mailing of cover letter and questionnaire was directed to health services directors at 500 U.S. jails—the 200 largest plus a random sample of 300 of the remaining jails—with two follow-up mailings sent to nonresponders. Overall 245 jails responded, for a response rate of 49%. Four out of five surveys were completed by a health care provider.

The results reported here were weighted to account for oversampling of larger jails. Even with this oversampling, jails with fewer than 250 inmates were underrepresented among respondents, judging from comparisons with the national distribution of jails by size.

Statistical analysis was used to assess the prevalence of various management strategies, and to identify the factors that predict continuation of methadone during incarceration and the use of recommended detoxification protocols.

Detailed study results (including unweighted results) were published in the New York Academy of Medicine's *Journal of Urban Health,* December 2004 issue. Titled Jail Management of Arrestees/Inmates Enrolled in Community Methadone Maintenance Programs, the article can be obtained online at http://jurban.oupjournals.org.

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 (80%) 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.

The Complete Lineup: *Journal* Volume 11, Issue 2

As always, this issue of the *Journal of Correctional Health Care* carries a self-study exam by which Certified Correctional Health Professionals and others may earn continuing education credits. To obtain this issue or to subscribe to the quarterly periodical, visit the Web at www.ncchc.org (Publications section), or call us at (773) 880-1460.

- Correctional Facilities as Community Health Clinical Placement Sites for RN to BSN Students
  Andrea Kovalesky, RN, CARN, PhD
- Should Female Federal Inmates Be Screened for Chlamydial and Gonococcal Infection?
  Sara B. Newman, MCP, DrPH; Michael B. Nelson, DO; Heidi B. Friedman, PhD; Charlotte A. Gaydos, MS, DrPh
- Caring and Custody: Two Faces of the Same Reality
  Mary Katharine Maroney, PhD, RN
- Sex and Prisoners: Criminal Justice Contributions to a Public Health Issue
  Roberto Hugh Potter, PhD, CCHP; Richard Tewksbury, PhD
- The Potential Use of Directly Observed Therapy (DOT) for the Treatment of HIV+ Individuals Being Released from Prison
  Arlene The; Jennifer A. Mitty, MD, MPH; Helen Loewenthal, MSW; Lauri B. Bazerman, MS; Timothy Flanigan, MD
- Cost of Hepatitis C Treatment in the Correctional Setting
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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:

- Administration: informatics/data systems, medical records management, health care administration, corrections administration, custody/security, staff development and training
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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.

Understanding 'Health Assessment': More Than a Physical

BY JUDITH A. STANLEY, MS, CCHP-A

As 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 involved 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?

A. 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, rectal and testicular 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 this 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 identity 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 insurance, managed care 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 and several other standards. The recommendation is presented as a performance measure in this way:

"100% of the time, when a health problem is identified subsequent to the initial health assessment that 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 each time a new health problem is identified 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 requires 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) 880-1460 or e-mail judithstanley@ncchc.org.

Expert Advice on NCCHC Standards for Health Services


Judith A. Stanley *R. Scott Chavez*

BY JUDITH A. STANLEY, MS, CCHP-A, AND
R. SCOTT CHAVEZ, PHD, MPA, CCHP-A

Fetal Monitors in Juvenile Settings

Q Our county juvenile detention center rarely houses pregnant juveniles, and when we do, it is 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 Y-D-03 Clinic Space, Equipment, and Supplies?

A 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 Y-D-03, the recommendations 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

Q 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.

A 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

Q Please clarify your standards concerning inmate workers. In C-06, Compliance Indicator 3 states, "Inmates do not provide direct patient care," but the Discussion 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?

A 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 how NCCHC distinguishes between these levels to assess compliance with the intent of the relevant standards (C-06 Inmate Workers and G-03 Infirmary Care). When the patient is housed in general population (defined as any noninfirmary 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 infirmary 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 "infirmary 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

Q 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 jails give for diabetics?

A 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.

Do you have a question about the NCCHC standards for health services? Write to Standards Q&A, c/o NCCHC, 1145 W. Diversey Parkway, Chicago, IL 60614. You also may contact us by fax at (773) 880-2424, or by e-mail at info@ncchc.org.

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- 48% are authorized to make purchases

Exhibitor Benefits

NCCHC is committed to creating a sales environment conducive for you as well as our attendees.

- Breaks, lunch and networking opportunities in the exhibit hall, with 9 hours of exhibit time
- Company listing and product description in the Final Program, and a listing in CORRECTCARE (deadlines apply)
- Pre- and final registration lists with attendee addresses
- Special advertising rates for CORRECTCARE, the conference Preliminary Program and the Final Program
- Virtual Exhibit Hall listing at the NCCHC Web site
- New! Lead retrieval system available

Sponsorship Opportunities

Exhibitors can enhance their exposure by sponsoring services, sessions and events that support or complement the conference. Here are a few of the options available.

Premier Educational Programming: Sponsorship of educational programs on hot topics enables companies to support the correctional market and gain great exposure.

Educational Poster Reception: Sponsor the 1 ½ hour poster viewing and you can share in the success of a reception that attracts hundreds of involved attendees.

Fall Gala: This fantastic free event is your opportunity to give attendees a chance to enjoy music, food and drinks, dancing and networking, all the while gaining terrific recognition and visibility for your organization.

Proceedings Manual: The manual provides a lasting record of each concurrent session, including abstracts and handouts. The sponsor is acknowledged in a foreword, and its logo is displayed on the back cover.

Conference Portfolio: The portfolios contain essential conference material distributed to all attendees. The sponsor's logo is displayed on the back cover.

The Internet Lounge: Exhibit hall visitors love to check e-mail and browse the Web at these computer stations, which display the sponsor name, logo and link on-screen.

Other Opportunities: Have other ideas for sponsorship? We'd love to hear them!

Registration Information

Exhibition hours are on Sunday through Tuesday. Booth size is 10' x 10'; rental fees range from $1,350 to $1,950 depending on booth location and include one full and two exhibit-only registrations. Other representatives may register at a discount. For a prospectus, visit www.ncchc.org, e-mail info@ncchc.org, or call (773) 880-1460.

About CorrectCare

Published by the National Commission on Correctional Health Care, this quarterly newspaper provides timely news, articles and commentary on subjects of relevance to professionals in the field of correctional health care.

Subscriptions: CORRECTCARE is free of charge to all Academy of Correctional Health Care members, key personnel at accredited facilities and other recipients at our discretion. To see if you qualify for a subscription, submit a request online at www.ncchc.org or by e-mail to info@ncchc.org. The paper also is posted at the NCCHC Web site.

Change of Address: Send notification four weeks in advance, including both old and new addresses and, if possible, the mailing label from the most recent issue.

Editorial Submissions: We may, at our discretion, publish submitted articles. Manuscripts must be original, unpublished elsewhere and submitted in electronic format. For guidelines, contact the editor at jaimeshimkus@ncchc.org or (773) 880-1460. We also invite letters of support or criticism or correction of facts, which will be printed as space allows.

Advertisers: CorrectCare Provides the Exposure You Need

The leading newspaper dedicated to correctional health care, CORRECTCARE features timely news, articles and commentary on the subjects that our readers care about: clinical care, health services administration, law, ethics, professional development and more. The quarterly paper is free of charge to members of the Academy of Correctional Health Professionals, as well as thousands of key professionals working in the nation's prisons, jails, juvenile facilities, departments of corrections, health departments and other agencies. The paper also is available online at www.ncchc.org.

We now offer special packages for companies that advertise in CORRECTCARE and also exhibit at NCCHC conferences, as well as opportunities to advertise on the NCCHC Web site. Contact us for details.

Production Schedule

Issue	Insertion Order Due	Ad Copy/Art Due	Paper Distributed
Spring 2005 (*Bonus Issue*)	April 18	May 2	May 16
Summer 2005	July 11	July 25	August 15
Fall 2005	October 31	November 14	December 5
Winter 2006	January 23	February 6	February 20

Advertising Rates

Display Ad Size	Width x Height	Black & White Rates 1x	2x	3x	4x
Full page	10 x 14 1/8	$1,595	$1,515	$1,435	$1,355
Junior page	7 1/4 x 10	1,360	1,290	1,225	1,155
1/2 horizontal	10 x 6 1/2	1,200	1,140	1,080	1,020
1/2 vertical	4 3/4 x 13 1/2	1,200	1,140	1,080	1,020
1/3 vertical	4 3/4 x 10	955	905	860	810
1/4 horizontal	7 1/4 x 5	795	755	715	675
1/4 vertical	4 3/4 x 6 3/4	795	755	715	675
1/8 vertical	2 1/4 x 6 3/4	560	530	505	475

Classified Advertising: Ads appear under the following categories: Employment, Meetings, Marketplace. The text-only ads cost $1.25 per word. Box your ad with a solid border for an additional $50. Text for classified ads should be submitted in electronic form (e.g., via e-mail).

For More Information

To learn more about advertising and other marketing opportunities, call Lauren Bauer, meetings and sales representative, at (773) 880-1460, ext. 298, or e-mail laurenbauer@ncchc.org.

To obtain NCCHC's Marketing and Resource Guide, which contains an insertion order form, visit the Web at www.ncchc.org and go to the Supplier Opportunities section.

Notes

1. Ad sizes encompass live area, no bleeds.
2. Color ads cost $250 per color additional per page or fraction.
3. Frequency discounts are based on total number of insertions within the next four issues. Ads need not run consecutively.
4. Recognized advertising agencies receive a 15% discount on gross billing for display ad space and color if paid within 30 days of invoice date.
5. Special opportunities are available for conference exhibitors; please see the Marketing and Resource Guide or contact NCCHC for information.
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.

Classified Advertising

Employment

Western Montana Mental Health Center
Live and work in beautiful mountainous Western Montana. Challenging clinical mental health positions currently available. Work with a multidisciplinary mental health team in a correctional environment providing a variety of services to adult male offenders. Masters level clinician degree required. Montana license or license eligible within 6 months. Contact Joan Hays, Director, Western Montana Mental Health Center @ (406) 723-5489. EEO

Marketplace

Required Reading

To order any of the following books, visit us online at www.ncchc.org or call (773) 880-1460. Don't forget: Members of the Academy of Correctional Health Professionals receive a 10% discount on most NCCHC catalog purchases. Bulk purchases (five or more copies of a single title) also receive a 10% discount. Shipping and handling charges apply to all orders.

Published by NCCHC

• *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 *Standards* for prisons and jails, the 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

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

Published by Delmar Learning

• *Health Assessment & Physical Examination, Second Edition, With CD Rom.* This comprehensive book presents assessment as an ongoing process that evaluates the whole person as a physical, psychosocial, functional being. It covers physical assessment skills, clinical examination techniques and patient teaching guidelines in a manner that is easily assimilated. 25 chapters in 5 units address the foundations of assessment, special assessments, physical assessment, special populations and putting it all together. Full-color photos, appendices, references, bibliography, glossary and index. CD-ROM with Flashcard software reviews concepts in each chapter. By Mary Ellen Zator Estes, RN, MSN, CCRN. 2002, 932 pages, hardcover, $75.95

American Psychological Association

• *Treating Adult and Juvenile Offenders With Special Needs* is loaded with practical information that addresses what works in treatment; release planning and aftercare concerns; and the logistics of prison systems and community settings. This groundbreaking book emphasizes offenders' biological, psychological and social needs, and promotes the development of rehabilitative models based on firm scientific information. Edited by Jose B. Ashford, Bruce D. Sales and William H. Reid. 2001, 518 pages, hardcover, $49.95

• *Acting Out: Maladaptive Behavior in Confinement* examines inmates who sabotage their rehabilitation by repeated displays of violence, disruptiveness or other self-defeating behavior. The authors used disciplinary records and mental health exams of chronic offenders to analyze the common threads that precipitate "acting out," and describe a model intervention for disrupting the cycle of maladaptive behaviors. By Hans Toch, Kenneth Adams, 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.* This book presents several treatment methods proven to be effective in reducing crime among chronic juvenile offenders; it features an intervention model for offenders are already placed out of the home, typically incarcerated in residential treatment facilities. By Patricia Chamberlain. 2003, 186 pages, hardcover, $39.95

Meetings

Addiction Medicine. Now in its 50th year, the Annual Meeting & Medical-Science Conference of the American Society of Addiction Medicine will take place April 15-17 at the Hyatt Regency Hotel in Dallas. Call (301) 656-3920, or visit www.asam.org/conf/conf_gf.htm.

Jail Expo. The American Jail Association will host its annual training conference and expo May 15-19 in Kansas City, MO. Learn more at www.corrections.com/aja, or call (301) 790-3930.

APA Annual Meeting. The American Psychiatric Association will convene May 21-26 in Atlanta, GA. Information is online at www.psych.org/edu/ann_mtgs/am, or call (703) 907-7300.

Public Health Law. Atlanta will be the site of The Public's Health and the Law in the 21st Century: 4th Annual Partnership Conference, taking place June 13-15. The meeting is being convened by the CDC Public Health Law Program; the American Society of Law, Medicine & Ethics; the Public Health Law Association; and additional partners. Find information at www.phppo.cdc.gov/od/phlp/conference/annualconf.asp, or call (770) 488-2886.

Sheriffs' Conference. The National Sheriffs Association will convene for its annual meeting June 25-29 in Louisville, KY. Visit www.sheriffs.org for details, or call (703) 836-7827.

Mental Health in Corrections. NCCHC's second two-day intensive meeting on mental health topics will be held July 17 & 18 in downtown Chicago. The preliminary program is posted at www.ncchc.org, or call (773) 880-1460 for details.

Food Service. The American Correctional Food Service Association is hosting its annual international conference August 14-18 in Georgia at the Westin Savannah Harbor Golf Resort. To learn more, visit www.acfsa.com, or call (952) 928-4658.

Forensic Nursing. The International Association of Forensic Nurses' Annual Scientific Assembly will convene Sept. 21-25 at the Hyatt Regency Crystal City in Arlington, VA. Learn more at www.iafn.org, or call (856) 256-2425.

Standards for Opioid Treatment Programs in Correctional Settings

By federal law, opioid treatment programs based in correctional facilities must be certified by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. To become certified, however, OTPs first must be accredited by a federally approved body. In 2004, NCCHC became the only agency specializing in corrections to be authorized by SAMHSA to accredit OTPs.

The *Standards for Opioid Treatment Programs in Correctional Settings* represent the requirements for OTPs seeking accreditation from NCCHC. To develop the standards, NCCHC 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. All of the standards are linked to specific federal regulations.

Conforming with NCCHC's *Standards for Health Services*, the OTP *Standards* are divided into nine areas: governance and administration, environmental safety, personnel and training, health care services and support, juvenile care and treatment, health promotion, special health needs, health records and medical-legal issues. 2004, softcover, $29.95 + s/h

To learn more about OTP accreditation or to order the *Standards*, call NCCHC at (773) 880-1460. The *Standards* also can be ordered via the Publications section of our Web site at www.ncchc.org.

AUDIOTAPE/CD ORDER FORM

National Conference on Correctional Health Care

November 15-17, 2004 • New Orleans, Louisiana

CIRCLE SELECTIONS & SPECIFY CD OR TAPE BELOW

GENERAL SESSIONS

OP1 Opening Ceremony and Keynote Address (Carl Bell, MD, CCHP)
EB1 Educational Breakfast: What's New in HIV and HBV Coinfection
EL1 Educational Luncheon: HIV Care in Corrections: When to Treat and Why
EL2 Educational Luncheon: Treating for Success: HIV Management in Corrections

CONCURRENT SESSIONS

101 Developing Specialized Programs in Jails
102 Hepatitis C, Natural History and Treatment of the HCV Mono-infected and HCV/HIV Co-infected Patient
103 Basic Jail Security for Correctional Health Care Professionals
104 Reporting Correctional Staff Violence: Legal and Ethical Considerations for Medical Staff
105 Reducing Cardiovascular Disease Among Diabetics
107 Incarcerated Women: Are Their Medical Needs Really That Different?
108 Oral Cancer: Diagnosis, Treatment and Management
109 Correctional Menus, Nutrition and Medical Diets
111 Sexually Transmitted Disease Prevalence and Treatment in the Georgia Department of Juvenile Justice System
112 Juvenile Suicide in Confinement: Findings From the First National Study
113 Understanding the Importance of the Administrative Process
114 Intensive Medical Management: How to Handle Prisoners Who Self-mutilate, Slime, Starve, Spit and Scratch
115 The Phenomenological Complexities of Providing Mental Health Services to Inmates With Axis I and II Disorders
116 Medication Errors: How Can We Prevent Them?
117 Reproductive Health Issues for Incarcerated Women: Challenges and Solutions
118 Prison Health Care in Developing Countries: The "Health Through Walls" Initiative
119 Release Planning: Developing an Integrated and Comprehensive System
120 Determinants of Pulmonary Tuberculosis in an Incarceration Facility
121 Weight Management Programs in Juvenile Correctional Facilities
122 Preparing for and Working With High Profile Cases
123 Malingering: Recognition and Coping With Inmates
124 Bipolar Disorder in the Criminal Justice System
125 Dental Triage for Nursing
126 Oral Health: Considerations for Chronic Care Patients
127 Feeding the Soul: The Therapeutic Use of Gardening
128 Against All Odds: Cutting Pharmaceutical Costs in Correctional Health Care
129 Complicating Factors and Challenges of Treating HIV in Corrections
130 "Surviving" Juvenile Corrections: Timely Suicide Prevention Strategies
131 The Legal Implications of Direct and Indirect Care Patterns
132 The Painful Patient
133 Improving Correctional Mental Health Care Through Coalition Building
134 Anatomy of the Correctional Health Care Encounter
135 Keep Your Teeth for Life: Oral Health Curriculum
136 Correctional Health Care Preceptorship
138 Hepatitis C in Corrections: Treating the Most Without Breaking the Bank
139 Redefining the Use of Psychotropic Medications for Juveniles in Correctional Settings
140 Relational Ethics in Forensic Settings
141 Managing Intersexuality: The Administrative, Medical and Legal Implications
142 Atypical Antipsychotics: Clinical and Forensic Implications
143 Pain Management of the Correctional Population
144 Quality Management in a Methadone Maintenance Treatment Program for Pregnant Women
145 Guidelines for Antiretroviral Therapy: Considerations for Corrections
146 Renegotiate Your Pharmacy Contract and Save Money!
147 Review of Epidemiology Transmission of Hepatitis B: The Public Health Significance
148 Sports Medicine and Adolescent Orthopedics
149 What Happens When You Are Sued?
150 Toward a More Perfect Understanding of Epilepsy, Seizures, Tremors and Withdrawal
151 Implementation of Evidence-Based Treatment for Schizophrenia in the Correctional Setting
152 Digging Out of Disasters
154 Journal of Correctional Health Care: Get Involved!
155 Optimal Staffing and Scheduling Management
156 Infectious Disease Research Among Correctional Populations: Lessons Learned
157 Development of a Model for Medical & Dental Care Following a Federal Settlement Agreement
158 Clinical Ethics for Correctional Health Professionals – Part 1
159 The Diagnosis of Common Types of Arthritis in Primary Care
160 Mental Health Diagnosis of Incarcerated Females: Labels and Lost Opportunities Related to Gender, Ethnicity and Class
161 End of Life Care: Challenges/Solutions/Techniques for Change
164 Breaking Down the Barriers to Sick Call
167 Clinical Ethics for Correctional Health Professionals – Part 2
168 Increasing Effectiveness of Diabetes Care at the Wayne County Jail
169 Mood Stabilizer Treatment for Institutional Sex Offenders
170 Discharge Planning: When Should It Be Initiated
172 Meditation Behind Bars
173 How a Public-Private Sponsorship Can Reduce Health Care Costs
174 Models of Transitional Health Care Planning for Ex-offenders – Part 1
175 Caring for Incarcerated Youths With Endocrinological Conditions
176 Legal Implications in Correctional Health Care for Deaf & Hard-of-Hearing Offenders – Part 1
177 Methamphetamine and Correctional Health Care Issues
178 Self-Inflicted Violence: Helping Those Who Hurt Themselves
179 Legal Challenges for Nurses in Correctional Practice
182 Public Academic Medical Institutions and Correctional Health Care
184 Creating a Health Care System in Juvenile Corrections: Lessons Learned
185 Legal Implications in Correctional Health Care for Deaf & Hard-of-Hearing Offenders – Part 2
186 Models of Transitional Health Care Planning for Ex-offenders – Part 2
187 Cutting Corners Without Compromising Mental Health Care: Pushing the Limits of Creativity
188 Tobacco Cessation Programming: Results From a National Study
190 WMD Emergency Evaluation Planning for an Adult Detention Center
191 Workload Indicator System: How to Determine Medical and Mental Health Staffing Needs for Youth in Secure Care
192 Collaboration Among Detention Centers for Post-release Patient Access to Palliative Care
194 Harm Reduction: A Comparative Study Between Brazil and USA
195 Do We Help Our Patients When We Put Them in Wheelchairs?
196 Jail-Based Comprehensive Mental Health Services: A Unique Approach to Maximize Funding and Resources
201 The Assessment and Management of Agitation and Aggression in Violent Patients
202 Collaborative Model for Delivering Individualized Services in CT's Juvenile Detention Centers
203 The Impact of "Othering" on Ethical Practice in Correctional Health Care
204 Management of Common Chronic Disease: An Update — Part 1
205 "They Just Don't Get It": Recognizing Underlying Disorders as a Key to Improving Outcomes
206 Opioid Treatment Programs in the Correctional Setting
207 Management of Common Chronic Disease: An Update — Part 2
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