Clearing the Air on Tobacco Use in Corrections

BY JANET PORTER

Tobacco use is the most preventable cause of death in the United States, responsible for one out of every five deaths. But use of this deadly agent is skewed, with high prevalence seen among individuals of low socioeconomic status. This trait is common among the incarcerated, of course, for whom smoking rates are estimated to be as high as 70%, well above the 23% rate for all U.S. adults. Unfortunately, many correctional facilities lack—or fail to enforce—policies that prohibit tobacco use. This is true even in states with progressive tobacco-control policies. It was only last year that California, a longtime leader in this area, passed legislation to ban the possession of tobacco products by inmates in state prisons and youth facilities.

Even for those in tobacco-free facilities, tobacco use often is only interrupted while they are in custody; it is quickly resumed after release. Clearly, prohibition alone is not enough to change long-term behavior.

To help people of low socioeconomic status eliminate tobacco use altogether, the Centers for Disease Control and Prevention provided the Health Education Council with funding to create the National Network on Tobacco Prevention and Poverty. From its inception in 2000, NTTPP recognized correctional populations as an important target and enlisted the National Commission on Correctional Health Care as a charter stakeholder organization. Together, NCCHC and NTTPP are working to promote tobacco-use policy as well as educational and cessation programming in correctional facilities. This article describes our efforts to date.

Conflicting Trends

Secondhand smoke is one of the most talked about topics in tobacco control. Helping protect the health of non-smokers has become the business of many private sector employers and public organizations. State and local governments continue to pass laws to limit or prohibit tobacco use in their buildings.

Along with this trend, a growing number of correctional facilities have had to adopt tobacco-free policies to comply with federal, state or local mandates. This presents a dual challenge since such policies impact both staff and inmates.

When asked, correctional facility staff members often point to the stressful nature of their work as a prime reason for use of tobacco, particularly at work. As a result, it is not uncommon for a significant portion of staff to smoke. As for inmates, cigarettes have traditionally been one of the few “privileges” they could look forward to, one of the few pleasures they could still control.

Given the prevalence of tobacco use among inmates and staff, it is a challenge to keep tobacco products out of correctional facilities, even at those where it is prohibited.

Studying the Problem

In 2002, NCCHC convened a forum to discuss tobacco use and the needs for education and prevention among inmates and correctional staff. Forum participants included correctional health care providers and administrators representing a variety of disciplines and settings in seven states.

The participants shared their facilities’ experiences with going tobacco-free and the effectiveness of their policies. They also identified challenges—many of them unique to correctional settings—they encountered along the way.

Among the challenges noted were dealing with difficult patients, fitting tobacco control in when other health concerns and addictions seemed more pressing, enforcing policies with insufficient staff to monitor inmates and guards, and recruiting and retaining staff (many would-be candidates are smokers).

The rise in tobacco as contraband is another big problem. One participant said, “Once we went tobacco-free, what had been viewed as a privilege and reward became valuable contraband. I’m actually glad, because it has replaced heroin in the top spot.” This loser-of-two-evil-tests view was a common theme during the discussion.

Forum participants suggested ways to overcome these challenges and enhance tobacco control efforts in prisons and jails. These included providing cessation education materials to staff, inmates and families; toll-free quit lines for inmates and staff; and offering and promoting cessation support and education after release.

Perhaps the most profound message from the discussion was its simplest: “Correctional health care practitioners want to change behavior, change beliefs.”
Commission Receives SAMHSA Grant to Aid Opioid Treatment Education, Programming

BY R. SCOTT CHAVEZ, PHD, PA-C, CCHP-A

As for legal issues, many correctional institutions operate under the “shadow of the law.” For example, methadone patients could be considered disabled under the Americans with Disabilities Act, so failure to provide methadone maintenance may be interpreted as a violation of this law. Also, due to concerns about keeping methadone on site, some jails allow it to be dispensed but only by external agencies, whose staff bring in the methadone, administer it and leave. This approach, however, does not meet federal opioid treatment standards found in 42 CFR Part 8.12.

Getting Past the Hurdles

The federal Substance Abuse and Mental Health Services Administration recognizes that correctional methadone maintenance programs are within the law and are practical. That’s why two years ago SAMHSA asked NCCHC to develop standards for opioid treatment programs in correctional facilities. Along with the publication of the OTP Standards in 2004, SAMHSA authorized the Commission as an accrediting body. Accreditation by NCCHC allows the OTP to seek the federal certification required for its legal operations. NCCHC is the only approved accrediting body focusing on the correctional health care field. Now, SAMHSA has awarded NCCHC a three-year grant to make clinically sound opioid treatment services more available in correctional facilities, with the ultimate goal of improving patient outcomes. Our “Project to Improve Opioid Treatment Services in U.S. Correctional Institutions” has two major goals: conduct corrections and health administrators on the importance and advantages of proper opioid treatment, and to fund activities that will help correctional facilities establish accredited OTP programs.

Policy & Standards Committee Invites Your Input

NCCHC’s Standards for Health Services for adult facilities are due for revision (see article on page 24), and an important part of that process is reviewing input from correctional health professionals who use the Standards. To share your comments, please write to us at the following address: Judith A. Stanley, MS, CCHP-A NCCHC Accreditation Department 114 W. Diversey Pky. Chicago, IL 60614 judithstanley@ncchc.org

This project addresses these needs in a cost-efficient and realistic manner. First we will conduct an analysis to identify gaps in understanding of opioid treatment and programs. We will provide information and education through means such as national mailings and conference presentations. This will build awareness of alternative addiction therapies, as well as an appreciation of the federal rules and regulations governing methadone administration.

The grant also provides two forms of financial assistance to facilities seeking to establish and accredit OTPs. First, it can pay for on-site technical assistance to help facilities prepare for accreditation. It also can pay for the initial and annual accreditation fees for at least the three-year duration of the grant. This assistance permits facilities to concentrate on the clinical issues in setting up an opioid treatment program.

While jails are expected to be the primary target for this assistance, prisons also may be interested, especially those that take parole violators and those that specialize in substance abuse programming.

R. Scott Chavez, PhD, PA-C, CCHP-A, is NCCHC’s vice president and director of the OTP education project. To learn more about the project or OTP accreditation, contact us at (773) 880-1460 or OTPinfo@ncchc.org.

Calendar

July 16
CCHP exam, multiple sites nationwide

July 17-18
Mental Health in Corrections conference, Chicago

August 26
Call for Proposals deadline for the 2006 Updates conference, April 8-11, Las Vegas

September 1
Application deadline for October 9 CCHP exam

October 8-12
National Conference on Correctional Health Care, Denver

October 9
CCHP and CCHP-A proctored examinations, Denver

October 28
Accreditation Committee meetings: Health Services and Opioid Treatment Program

Odds & Ends

• Correctional health experts are invited to submit a proposal to present at the 2006 Updates in Correctional Health Care conference, April 8-11 in Las Vegas. This growing meeting is a forum for cutting-edge information and instruction from leaders in this specialty. Submission guidelines are posted at the Education section of our Web site, www.ncchc.org. The deadline is August 26.

• NCCHC’s Clinical Guidelines committee recently updated the guideline for high blood cholesterol; it is posted in the Resources section of our Web site, www.ncchc.org. Also in the works: the Juvenile Health committee is developing a clinical guideline on juvenile HIV, and will modify other NCCHC guidelines to make them suitable for practitioners who treat incarcerated youth.

• The American Diabetes Association has issued Diabetes Guidelines for Correctional Institutions. They were developed by a task force that was headed by Daniel Lorber, MD, who represents the ADA on the NCCHC board of directors, and included board members Ronald Shansky, MD (Society of Correctional Physicians) and Barbara Wakeen, MD (American Diabetic Association), as well as NCCHC vice president Scott Chavez, PhD, PA-C, CCHP-A. The ADA guidelines were featured in the April edition of American Jails, published by the American Jail Association, also a supporting organization of NCCHC.

Copyright 2005 National Commission on Correctional Health Care. Statements of facts and opinion are the responsibility of the authors alone and do not necessarily reflect the opinions of this publication. NCCHC, a not-for-profit organization, is devoted to improving health care in our nation’s jails, prisons and juvenile confinement facilities. NCCHC is supported by 37 leading national organizations representing the fields of health, law and corrections.
Defining the Goals of Correctional Medicine

BY RICHARD GARDEN, MD, CCHP

At the Utah Department of Corrections (UDOC), medical providers meet weekly in a utilization committee. The forum gives providers an opportunity to justify their referrals and to share any helpful details.

Occasionally the meeting gets a bit rowdy, but a few months ago it was a downright knockdown, two-fisted brawl. The point of contention was whether to treat onychomycosis [fungus infection of the nails], with one provider arguing that treatment was the standard of care. The group was quickly polarized into a “treat” camp and a “do not treat” camp.

Out of the growing bedlam, I heard the question, “Is it our goal to practice mediocre medicine?” I instantly became fixated on the question. Was it true? Do we in correctional medicine strive for mediocrity?

The excitement faded as the group pondered the question. Soon others revealed that they, too, felt that we were going too far. Everyone agreed that we do not provide the very best care as it would be provided in the community. Other comments were that our level of care was on par with the military or a free clinic. Still others expressed a capitalistic view that perhaps incarcerated populations are not entitled to the same extent of care available to those who can pay for it.

Ultimately, the issue boiled down to this: Do inmates deserve health care par with the community? My initial reaction to the situation was a moment of doubt. Could this be true? Could so much effort, good intention and determination seek anything short of excellence?

A Unique Discipline

Reality broke through this moment of self-doubt and I prepared to argue that correctional medicine is different, set apart from community medicine. It has unique qualities by which it should be judged and measured. This is how I responded to the doubters in my midst.

The federal courts and security needs have defined the parameters in which we work. These, along with budget restraints, allow only a little wiggle room that we can use to our patients’ best interests. Developing more efficient and effective approaches to care delivery is an area in which most correctional providers excel.

We in correctional medicine are at the cutting edge of managed care as we seek to clarify necessary from unnecessary. Not treating grade II acne in prison is not evidence of poor care; rather it serves as an example of our commitment to focusing on serious medical and mental health needs. We do what is right for our patients. Our patients have unique needs and circumstances that may justify delaying a stable longstanding hernia, for example, from being repaired until release.

Correctional institutions are not intended to provide for every need or want an inmate may have. We focus on serious needs. We dedicate ourselves to provide for medical care that limits pain and suffering, maintains health and preserves life and limb. We rely upon the inmates’ own resources, be they public or private, to address issues that can reasonably wait or undergo a period of watchful waiting until release.

Not treating acne, long-standing stable hernias, gynecomastia, etc., is no reflection upon the quality of medical care in correctional medicine. These limits do not conflict with the ethical standards of medicine. Medical care is a continuum, with an acute coronary syndrome on one end and male pattern baldness on the other. Admittedly, we occupy the location just before the elective or desired care begins along the continuum. This is appropriate and meets our moral and professional obligation to our patients.

Noble Work

Correctional medicine is a noble endeavor. We serve those who are for the most part a segment of society that is disowned and downtrodden. We lend hard-earned knowledge and skills to serve humanity for lower wages in austere work settings at personal risk. There is no mediocrity in that. In fact, our lofty career choice rings with professional and personal pride that Hippocrates himself would endorse.

Richard Garden, MD, CCHP, is the clinical director for the Utah Department of Corrections, Draper.


From the Meth Epicenter

I read with interest the article “Meth Mouth” Plagues Many State Prisoners [Winter 2005]. Oregon is the national epicenter for methamphetamine use, and the Oregonian newspaper recently ran an excellent series on meth, printing mug shots at various intervals showing accelerated aging and general devastation with meth use.

Meth mouth implies a catastrophic oral situation, usually with numerous abscesses and hopelessly decayed teeth. But it’s not just the meth that causes the damage. The rapid dental destruction is due to a combination of extreme dry mouth the drug causes, high sugar intake (one woman told me she had subsisted on chocolate milk and Pepsi) and poor oral hygiene. In fact, one inmate-patient of mine was a dental assistant and another was the daughter of a dental hygienist. In fact, one inmate-patient of mine was a dental assistant and another was the daughter of a dental hygienist. In fact, one inmate-patient of mine was a dental assistant and another was the daughter of a dental hygienist.

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From the Meth Epicenter

I was catching up on some articles and came across “Teamwork Vital to Meeting the Medical Autonomy Standard” [Spotlight on the Standards, Fall 2004], it is excellent. We need more “crossing of the lines” of this nature to help all our facility staff to understand that we aren’t against each other, we just view things differently, but want the same outcome.

I’m using your article as an orientation for new staff and will recommend it to our site training director for corrections new staff. Thank you!

Nadine K. Belk
Health Services Administrator
Lansing (RS) Correctional Facility

Defining the Goals of Correctional Medicine

BY RICHARD GARDEN, MD, CCHP

At the Utah Department of Corrections (UDOC), medical providers meet weekly in a utilization committee. The forum gives providers an opportunity to justify their referrals and to share any helpful details.

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Former Naval Officer Relishes Challenges of Corrections

Until three years ago, correctional health care wasn’t even on Frank Komykoski’s radar. Now sporting MBA and CCHP credentials, in 1979 he was a Penn State undergrad ready for a dynamic and exciting career. Komykoski recalls seeing a Time magazine ad that read, “Navy officers get responsibility fast.” Exhilarating possibility met innate patriotism, and Komykoski soon began a 23-year career as a naval officer. By the time he retired from service in July 2002, he had completed five tours of duty, including his final post as a commanding officer of the Naval Reserves in Fort Dix, NJ.

For a leader like Komykoski, however, “retirement” simply meant the start of his search for a second career. “I had been looking into various medical services fields,” he says. “It’s a growing field and I could enter it, but would require a bit of retraining.” He interviewed for various positions but says that “nothing looked challenging and rewarding.”

Finally, longtime friend Carl Hoffmann, Jr., DO, CCHP, suggested that Komykoski join PrimeCare Medical, Inc. Hoffmann founded PCM in 1985 and serves as its president and corporate medical director. Komykoski recalls seeing a Time magazine ad that read, “Correctional health care provides innate patriotism, and Komykoski realized that there was “more to correctional health care than locking people up in jail.” He found that it was the right field for him. “Correctional health care provides medical service and support to many of society’s indigent citizens,” he says. “Without correctional health care, many of our patients would never have an opportunity to be provided health care by a nurse or physician. I was looking for a dynamic and gratifying second career that would challenge my management and leadership experiences; correctional health care was the answer to all my challenges.”

Three years into his new career, Komykoski is vice president of operations, directing policy and procedures and NCCHC accreditation. His duties include oversight of NCCHC accreditation efforts at all of PCM’s contracted sites in the northeastern United States. Shortly after starting at PCM, Komykoski began an MBA program with an emphasis in health care administration. Knowing the degree alone wouldn’t be enough to fulfill his need to excel in the correctional health care field, he attained CCHP certification in October 2004. “It’s a one-two punch with the MBA and the CCHP,” Komykoski says. “What I learned earning the MBA is invaluable for the business aspects of my job. But being a CCHP identifies you as an expert who understands and is able to implement the standards set forth by NCCHC. I have gained recognition and respect from the wardens/superintendents of [our] 46 contracted facilities.”

NCCHC standards are taken seriously at every level at the company, he adds. “Institutionally, we recommend that every contracted facility seek accreditation. Accreditation is so much easier when your administrator is a CCHP—the survey goes so much smoother so much quicker.” Regardless of their accreditation status, all PCM facilities are audited based on NCCHC standards, says Komykoski. “It’s the standard PCM uses. It allows a standard and equitable health care delivery system to patients.”

Spreading the Word
Komykoski is more than happy to help spread the good news of certification. When he took the CCHP exam in Harrisburg in August 2004, it was one of the largest exam sites to date. And now that Komykoski is reaping the personal and professional benefits of CCHP, he has been a great help in establishing Harrisburg as one of the largest sites for the July 16, 2005, exam. He also is helping to establish new sites for future CCHP exams and drumming up candidates to take those exams.

Komykoski is proud that the voice of one CCHP carries a lot of weight. “I recently attended health services administrators’ training in West Virginia, where PCM has 12 HSAs in adult facilities. Four of them are CCHPs and all of the others are planning to apply for the exam next year. Most of the state’s senior management staff are CCHPs as well.”

Gone Fishin’
When he’s not busy conducting pre-survey inspections or touting the value of certification for all correctional health staff, Komykoski is an avid trout fisherman, and he recently returned from a family-favorite spot in Pennsylvania. Komykoski and his four sons have been going to Clarks Creek for about six years, and on their latest trip, two of them caught their limit in just one day. “It’s something we all enjoy, mostly because it gives us a chance just to be together.”

Komykoski also admits to another hobby: motorcycling. “PrimeCare is a motorcycle kind of place. Sometimes you can find six of us riding down the road on Harleys at 45 mph. We’re headed out to get burgers.” He writes it off as a “midlife crisis thing,” but it also sounds suspiciously like yet another facet of an outgoing man who lives life to the fullest.

Kristin Prins, MA, is the professional services assistant at NCCHC.

Isn’t It Time You Considered Advanced Certification?
Mary Muse, MSN, of Germak Health Services in Chicago, IL, thought so. She earned Advanced Certification after sitting for the CCHP-A exam last October in New Orleans. You can do it too! All CCHPs are eligible to apply after three years of basic certification. Learn more online at www.ncchc.org/CCHP.

Future Exam Dates and Sites
• July 16: Regional sites: Rancho Cucamonga, CA; Chicago, IL; Charleston, ME; Ypsilanti, MI; Billings, MT; Trenton, NJ; Harrisburg, PA; Guaynabo, PR; Houston, TX; Lubbock, TX; Yakima, WA; and others to be determined
• October 9: Denver, at the National Conference on Correctional Health Care
• February 4: Regional sites: Daytona, FL; Atlanta, GA; Chicago, IL; Shelby, MT; Richmond, VA; Charleston, WV; Salt Lake City, UT; and others to be determined
• April 9: Las Vegas, at the Updates in Correctional Health Care conference

Application deadlines are the first day of the month preceding the test month. Exam sites are being sought for Feb. 4. If you are interested in hosting an exam at your facility or proctoring an exam, contact us at cchp@ncchc.org.

CCHP News

The next step in your professional advancement
The CCHP program, sponsored by the National Commission on Correctional Health Care, is the only national program to recognize the special knowledge and skills required to provide health care in a prison, jail or juvenile confinement facility.

The exams are given four times a year in a proctored setting. To receive an application, complete and return this form.

For more information, call NCCHC at (773) 880-1460. To apply online, visit www.ncchc.org.

Mail to: CCHP Board of Trustees
1145 W. Diversey Parkway • Chicago, IL 60614
Fax to: (773) 880-2424
THE VALUE OF OPEN ACCESS TO ATYPICAL ANTIPSYCHOTIC MEDICATIONS

Clinical Differences Among Atypical Antipsychotic Medications

WHAT IS OPEN ACCESS?

Open access is a health care policy that provides physicians and their patients with unrestricted access to all available atypical antipsychotic medications for the treatment of mental illnesses. Today, some private and public health care systems are considering limiting access to atypical antipsychotic medications to reduce drug costs. Yet, studies have shown that restrictive policies actually increase costs, such as partial hospitalizations, emergency mental health services, and nursing home use, as well as potentially contributing to an increase in patients' pain and suffering.

WHY IS OPEN ACCESS TO ATYPICAL ANTIPSYCHOTIC DRUGS IMPORTANT?

1. Open access allows clinicians to select the most appropriate drugs for their patients. Patients often try different atypical antipsychotic medications before finding one that is suitable for them. Studies have shown that atypical antipsychotics offer patients effective symptom control and a more favorable side effect profile, which can reduce the need for therapy changes and improve patient outcomes and compliance.

2. Drug costs represent only a small portion of the total costs of treating schizophrenia and most other mental health conditions.

3. Open access to atypical antipsychotic medications helps reduce overall direct costs. Results of clinical trials have demonstrated that atypical antipsychotics contribute to fewer relapses and hospitalizations and reduce the need for concomitant antidepressants and mood stabilizers.

4. It is important to weigh the risks and benefits of each atypical antipsychotic in relationship to its clinical profile.

   1. Adverse effect profiles
      - Weight gain, diabetes, extrapyramidal symptoms (EPS), activation, and withdrawals due to adverse effects

   2. Special populations
      - Factors such as gender, age, ethnicity, comorbid conditions, and illness severity can also impact a patient's response to therapy

   3. Metabolism and potential for drug-drug interactions
      - Metabolized by different cytochrome P450 enzymes, therefore, having varying potentials for interactions with other drugs

   4. Approved indications
      - Approved for the treatment of schizophrenia and bipolar mania

   5. Chemical structure and class

   6. Unique receptor interaction profile

Each atypical antipsychotic has a unique receptor interaction profile that contributes to its overall efficacy and adverse effect profile.

ENSURE THAT PROVIDERS MAINTAIN THE ABILITY TO CHOOSE THE ATYPICAL ANTIPSYCHOTIC MEDICATION THAT IS MOST APPROPRIATE FOR THEIR INDIVIDUAL PATIENTS.

References:
Kudos to Volunteers

Members of the Academy of Correctional Health Professionals have benefited from many new products and services that were introduced during the past year. Much of the credit for these advancements goes to the hard-working volunteer committees that guide the Academy’s development.

To ensure that this good work continues, the Academy board of directors adopted formal committee charges at its semiannual meeting in April. These charges will help the committees to prioritize their efforts, as well as providing the board with a tool to measure the committees’ effectiveness at the end of the year. (Committee charges are posted on our Web site at the “About the Academy” section.)

Steve Helfand, PsyD, chair of the Academy board, recently issued the 2005-2006 committee appointments. These individuals, listed below, have volunteered their time and talent, demonstrating their commitment to the association and to the advancement of the correctional health care field as a whole.

‘Welcome’ to New Committee

A new addition to this year’s roster is the National Conference on Correctional Health Care welcome committee. This committee consists of Academy members from the Denver area who have offered to assist in making this year’s conference a memorable one. They will provide advice and pointers on everything from how to get from the airport to the hotel, to favorite restaurants, to the best sightseeing experiences, to tourist traps to avoid. These insights will be featured on the Academy Web site, as well as the conference section of the NCCHC Web site. And, of course, these folks will be on hand in Denver to welcome you to the National Conference.

Over the summer months, committee members will be hard at work developing programs and services to assist you in your work and your professional development. If you have any ideas or suggestions for them, please contact our office and we will share your thoughts with the committees. E-mail us at academy@correctionalhealth.org.

Education Committee
Margaret Collatt, RN, BSN, CCHP-A (chair)
Patricia Daugherty, RN, BSN, CCHP
Eva Leake, RN, CEN
John Miles, MPA
Mary Neureuther, RN, CCHP
Ellyn Presley, RN, CCHP
Joyce Rackauskas-Anderson, MSN, ARNP
Dale Welch, PhD
Gail Williams, MD, MS, CCHP

Membership Committee
Gale Steinhauser, MD, CCHP (chair)
Michael Adu-Tutu, DDS, MBA, CCHP-A
John Miles, MPA
Sue Moul, RN, CCHP-A
Joseph Penn, MD, CCHP
Alan Peterson, DMD

Mentor Committee
Deborah Franzoso, LPN, CCHP (co-chair)
Sue Moul, RN, CCHP-A
Allan Goldberg, DPM, CCHP
Eva Leake, RN, CEN
Sue Moul, RN, CCHP-A
Mary Neureuther, RN, CCHP
Jayne Russell, Med, CCHP-A

Shared Interest Groups Committee
Royanne Schissel, RN, CCHP (chair)
John Carmody, RN, CCHP
John Chapman, PsyD, CCHP
Mark Doherty, DMD, MPH, CCHP
Mary Neureuther, RN, CCHP
Alan Peterson, DMD
Ellyn Presley, RN, CCHP

Welcome Committee
Judy Fender, MSN, MBA, CCHP
Terry Masatik, LPN, CCHP
Jeffrey Metzner, MD, CCHP-A
Christine Mott, BS, RN
Lynn Philpott, RN, BS, CCHP
Glenda Reimer, DNSc, CCHP
Lynn Sanders, MD, CCHP
Jere Sutton, DO, CCHP

Academy of Correctional Health Professionals
Board of Directors Nomination Form

Nominee’s Name
Title
Employer
Address
City/State/Zip
Telephone
Fax
E-mail

Name of Nominator
Member ID Number
Address
City/State/Zip
Telephone
Fax
E-mail

Name of Nominator
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IN DOC Opens Meth Treatment Units
The Indiana Department of Correction is tackling methamphetamine head-on: It is opening nine units dedicated to treatment of meth addiction, which is alarmingly prevalent among state prisoners. Two units are already operating: The Miami facility in Bunker Hill opened a 204-bed unit in April, and the Wabash Valley facility in Carlisle opened a 204-bed unit in June. The units require no additional funding, DOC officials say.

Named Clean Lifestyle Is Freedom Forever (CLIFF), the program is described as the first of its kind in the nation. The self-contained units have treatment and counseling programming that runs 15 hours a day, seven days a week. Inmates must meet several criteria to take part in the nine-month voluntary program, and those who complete it are eligible for six-month sentence reductions.

About 900 DOC inmates are serving sentences for methamphetamine abuse, and an additional 3,000 were incarcerated for crimes related to meth abuse, according to an article in the Indianapolis Star.

Death Trends of Juvenile Delinquents
Youth who were involved in the juvenile justice system are four times more likely to die an early, violent death than those in the general population. That is one conclusion of a longitudinal study of 1,829 youth (ages 10-18) selected randomly from the Cook County (IL) Juvenile Temporary Detention Center from 1995 to 1999. The researchers, led by Linda Teplin, PhD, director of psychological studies at Northwestern University, monitored the youth for up to eight years.

Analysis of mortality data showed that 65 of the delinquent youth died in the follow-up period, 90% from homicide; of these, 93% were from gunshot wounds. Females and African American males experienced particularly high death rates. The report calls for treating early violent death as a health disparity, e.g., by identifying modifiable risk factors and preventive interventions.

The article was published in the June issue of Pastoral Psychology and can be accessed on the Web at http://pediatrics.aappublications.org/cgi/content/abstract/115/6/1586.

PREA Update
Stop Prisoner Rape, a national human rights organization, in May issued an analysis of the Prison Rape Elimination Act, examining its impact to date and noting areas of concern. PREA Update describes activities of the various federal agencies involved with carrying out the law’s mandates, including formation of a National Prison Rape Elimination Commission, data collection and research, training for corrections professionals and education for inmates. The report is available from the National Institute of Corrections at www.nicic.org/Library/020478.

Substance Abuse Treatment Locator
The Substance Abuse and Mental Health Services Administration has updated its National Directory of Drug and Alcohol Abuse Treatment Programs as well as its Web-based Treatment Facility Locator database. For a copy of the free directory, call (800) 729-6686. The locator is at http://findtreatment.samhsa.gov.

Informed Consent?
Are inmates truly informed when they sign research consent forms? Maybe not, according to a study described by HealthDay News. “Typically, informed consent documents for research are written above the recommended 8th grade reading level, so they may be difficult for the average person to understand,” said lead researcher Alan Tait, PhD, a clinical research fellow at the University of Michigan Health System. The study subjects were the parents of pediatric patients, but the conclusions certainly apply to corrections: Consent forms that conform with federal guidelines for readability and processability can improve understanding. The study was published in the April issue of the Archives of Pediatrics and Adolescent Medicine.

Lose the Paper
Information technology is the key to improving health care quality and containing costs, according to a survey of more than 1,100 health care executives of various stripes including providers, payers, policymakers, suppliers, academicians and others. A combination of IT, practice guidelines and patient safety measures is an effective way to contain health care costs, 40% of respondents said. Disease-management programs are the second most effective way, according to 27%. The study was conducted by Harris Interactive and reported in the journal Drug Benefit Trends, Vol. 17, No. 3.

NMHA Weighs in on Mental Health Care in Corrections
Noting that “America’s prisons and jails have become de facto mental institutions,” the National Mental Health Association has adopted a position statement that addresses the treatment of incarcerated people with mental illnesses.

These individuals often are “especially vulnerable” to the difficult conditions of correctional confinement, which “imposes special obligations on society,” NMHA said in a news release.

“Our responsibilities to treat and protect incarcerated people with mental illnesses far outweigh the rights currently enforced by U.S. courts,” said Michael Faenza, MSW, president and CEO of NMHA, adding that medical services—including mental health care—and safety are basic human rights.

Issued in May, “Mental Health Treatment in Correctional Facilities” states nine core principles to observe when an inmate needs mental health treatment. These principles address issues such as screening and assessment, treatment of acute disorders, access to care, quality of care, special needs, medical research and more.

The document also cites 11 specific rights that are most often abridged, such as informed consent to treatment, refusal of treatment, confidentiality and freedom from corporal punishment.

The National Mental Health Association is a large nonprofit organization that aims to improve the mental health of Americans by means of advocacy, education, research and service. The position statement and other resources are posted online at www.nmha.org/position/ps55.cfm.

In Sync With NCCHC
The NMHA principles are in sync with NCCHC standards that deal with mental health concerns. NCCHC also offers clinical guidelines, position statements, educational conferences and other resources that address mental health care. An excellent tool for administrators and clinicians alike is the 2003 edition of Correctional Mental Health Care: Standards and Guidelines for Delivering Services. To order, contact NCCHC.

Another valuable learning opportunity is NCCHC’s second mental health conference, being held July 17-18 in Chicago with the support of the American Psychiatric Association, the American Psychological Association and several other major national groups. See page 13 for details.
Every correctional facility is unique, yet all share commonalities. As in jails and prisons nationwide, drug addiction is rife, among the people being admitted to Connecticut’s York Correctional Institution.

Like some of those facilities, York CI has an extensive menu of addiction services. Unlike most other facilities, however, York operates an on-site opioid detoxification program.

Further, it was the first in the nation to earn NCCHC accreditation for its opioid treatment program.

York CI has plenty of other qualities that set it apart. It is a hybrid prison-jail, the state’s only facility for females (see details at right). The grounds are so large that inmates on the “other side” must be bussed to the health unit, an arrangement that creates its own challenges.

At the helm of the vast health services enterprise is Eileen Borowski, PhD, CCHP, a trained psychologist who has been York’s health services administrator for close to four years. She identifies the facility as a “jail-prison,” but opts to comply with NCCHC’s Standards for Health Services in Prisons because those care are “more than medical—there’s the social component.”

You’d think her job was tough enough. Despite a sizeable population of long-term inmates, the heavy volume of daily intakes and releases makes the facility a ringer for a jail, as does the corresponding demand on health services.

And these inmates are women, who utilize health services at rates far higher than do men. To meet their short-term and long-term needs, York offers a broad spectrum of services, including multifaceted mental health care. It also was the first female facility in the nation with a palliative care program and hospice.

Most of the addiction programs, such as education and counseling, are run from the DOC’s addiction services unit, with some assistance from community-based volunteers.

However, detoxification is a medical concern, says principal psychologist Monica Farinella, DO, CCHP. Thus, all women are tested for drugs during the intake health screening. They all receive methadone or simple close monitoring. Typically about 20 inmates are on methadone at any given time, and of those, 16 were in community programs.

Sulllivan then creates a detox treatment plan, with tapering dosages for those who are receiving methadone. (Pregnant inmates receive maintenance doses throughout pregnancy.) Typically methadone is given until 30 days postpartum. Sullivan and other providers all of them throughout the process to help control withdrawal symptoms, even in the case of benzodiazepine.

As a result, it was like being one of the first correctional facilities surveyed for compliance with NCCHC’s Standards for Opioid Treatment Programs: “We had our act together,” Sullivan says. “We were confident we were up to snuff.”

Meeting Heavy Demand

Typical of a female inmate population, rates of mental illness are high: Borowski estimates that 85% of the inmates have a co-morbid diagnosis. Most prominent are trauma-related diagnoses, post-traumatic stress disorder, depression and anxiety.

Women with mental disorders are identified at intake via interviews with their prior health care providers, says supervising psychologist Bill Chalmsa, PhD. They are triaged based on need. The most extreme intervention is admission to the mental health inpatient unit. Most, however, are sent to psychiatric outpatient clinics for assessment and, if indicated, are prescribed medication. About half of the inmates are on psych meds.

“That’s a reflection of the high level of need these women come in with,” observes Chalmsa, who notes that many of them are “more victim than victimizer.”

The inmates at York CI also manifest the full array of medical conditions—chronic and acute—seen in correctional settings. Asthma and hepatitis C are particularly prevalent.

The infrastructure to deal with these needs is “huge,” says LaPalme. One indicator: the health unit receives over 2,000 sick calls requests per month, and the staff usually meets its goal of seeing each request within 24 hours. Similarly, all new intakes receive health assessments and physicals within 24 hours. As a result of this work, over 70% are transferred from the inpatient mental health to general population.

The Stands 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 certifications 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. In the standards, NCCHC used federal regulations and community standards as a guide and modified them to take into account the issues unique to providing opioid treatment 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.
To Change Health Behavior, Change Health Beliefs

By Susan Rustvold, DMD, MS

Correctional health providers are being called to radically change the system of helping patients manage chronic diseases such as hypertension and diabetes.

U.S. Surgeon General Richard Carmona, MD, MPH, CCHP, has said that the “entrenched episodic treatment approach” leads to higher morbidity, mortality and costs. Speaking at the 2003 National Conference on Correctional Health Care, he advocated a total disease management approach that includes adequate counseling about self-care responsibilities. He also exhorted the audience to focus on improving health literacy among the incarcerated, and called for an emphasis on prevention.

A barrier to changing health behaviors, however, lies in patients’ health beliefs.

Beliefs and Behavior

Many of us in the healing professions in the 21st century have beliefs that include the importance of self-care and of attention to nutrition, exercise, stress management and adherence to specific health care guidelines and recommendations when we do develop chronic diseases. We’re likely to agree to some degree with these statements from the Health Beliefs scale. (The scale measures the degree to which individuals believe their health is controlled by internal or external factors.)

- If I take care of myself, I can avoid illness.
- When I feel ill, it’s often because I have not been getting the proper exercise or eating right.
- I am directly responsible for my health.

A person with these beliefs will take an interest in nutrition, in oral hygiene, in simply washing hands. However, many of the patients in correctional facilities have not paid attention to health promotion behaviors, and are perhaps more likely to have beliefs similar to these statements, also from the Health Beliefs scale:

- Good health is largely a matter of good fortune: people who never get sick are just plain lucky.
- Most people do not realize the extent to which their illnesses are controlled by accidental happenings; no matter what I do, if I am going to get sick I will get sick.
- I am directly responsible for my health.

There are so many strange diseases around that you can never know how or when you might pick one up.

People with these beliefs may not even be aware of health promotion behaviors, or may consider them to be too much trouble or futile. Information is not sufficient to bring about significant change in health beliefs and behaviors. It is essential to make patients aware of their tacit beliefs so that they can examine them and then change them.

The Health Belief Model is helpful in explaining individuals’ health behaviors. Developed in the 1950s by public health psychologists with the U.S. Public Health Service, the model is based on the understanding that a person will take a health-related action if (1) he feels that a negative health condition can be avoided; (2) he has an expectation that by taking a recommended action, he will avoid a negative health condition; and (3) he believes that he can successfully take a recommended health action.

This ties in to the concept of self-efficacy, necessary for an individual to tackle the challenge of changing habitual unhealthy behaviors, such as being sedentary, smoking or overeating.

Education Is Key

All well and good, the frontline correctional health care provider may think, but how am I supposed to challenge and change health beliefs and all the while still take care of urgent needs?

It begins with education. NCCHC standard F-01 Health Education and Promotion requires that “health education is offered to all inmates; all patients are provided individual health instruction.” At minimum, brochures on a variety of health topics should be available; resources such as audio- and videotapes and classes also are useful.

But what if patients’ health beliefs or literacy skills do not move them to study brochures, play tapes or attend classes?

One solution is the use of small group medical appointments. Kaiser Permanente has done extensive research on small group appointments in the past 15 years and has found that they increase compliance with health care recommendations, improve patient satisfaction and reduce health care expenses.

The single patient medical appointment system developed over a century ago, when most physician visits were for acute injuries and infections. Over time, as life expectancy has increased, the majority of medical interactions have come to deal with chronic illnesses and syndromes, issues that require lifestyle changes rather than immediate intervention.

But it’s rare to be able to adequately discuss management of complicated medical situations in a 15-minute appointment or while simultaneously providing treatment.

In the community, group-visit programs, also known as shared medical appointments and cluster visits, have emerged to provide a level of patient education and follow-up that office visit schedules seldom allow. Group visits are appointments with a physician that take place in a supportive group setting. While the physician sees as many as 15 patients in the 60- to 90-minute visit, each patient spends the entire visit with the doctor. It’s a positive experience on both sides.

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Group Visit Models
The group visit concept translates well to the correctional setting, especially because the “appointment” need not always be with a physician. Indeed, it often may be appropriate for nurses—the front-line providers in many cases—to lead such groups. Many types of medical problems lend themselves to the group-visit format, particularly those that are common, costly and responsive to lifestyle changes. Among the conditions that can be addressed effectively using group visits are asthma, congestive heart failure, coronary artery disease, depression, diabetes, GERD, irritable bowel syndrome and obesity. The format also is useful to improve patients’ oral health self-care.

Three general models for the shared medical appointment exist. Depending on the patient population profile, any or all would be appropriate in a correctional setting.

First is the cooperative health care clinic (CHCC), created for older patients who require frequent, broad-spectrum care. Second is the disease-specific CHCC, an ongoing, diagnostically exclusive group that helps patients manage chronic disease. The third model is the drop-in group medical appointment. Intended for established patients who need a more comprehensive approach to their follow-up care, DIGMAs usually are effective for patients who might otherwise need a disproportionate amount of visits or time, including patients who:

• need routine follow-up care
• have relatively stable chronic illness but require mind-body care, more time with their physician, periodic surveillance and monitoring, or closer follow-up care
• are noncompliant or come for frequent return visits
• have extensive informational, emotional or psychosocial needs
• are the “worried well”

To challenge health beliefs, to empower patients to take responsibility for their health and to effect change in health behaviors, it is necessary to think beyond what is covered in typical office visits.

Group visits are most effective if they involve dialogue, not lecture. It’s important to establish a respectful group culture and to find out what people know—and what they think they need to know. The concept of constructivism tells us that when we learn, we are building upon what we already know or believe, and that we learn best experientially, by making connections and reaching conclusions ourselves.

As always, audiovisual materials and handouts enhance the effectiveness of presentations and the application of information by patients.

Proven Results
Use of well-structured group appointment models can have many benefits, as numerous studies in the medical literature have shown.

Kaiser Permanente has found that such models reduced emergency room visits, hospital admissions, use of skilled nursing facilities and referrals to specialists. They also saved money: The cost of care per member per month was nearly $15 lower for the group participants than for the controls, despite the extra expense of running the groups. Studies also show that participants were more likely to get flu and pneumonia shots and to practice other health promotion behaviors, and they experienced higher levels of satisfaction.

While correctional populations are unique in many ways, it’s not difficult to envision the positive effects from improving inmates’ awareness of and motivation to practice healthy behaviors. Foremost, it would lead to better health. But it also would lessen the strain on health resources and budgets for medications and urgent care.

Small group appointments may not appear overnight in correctional settings, but the development of formats and content tailored to specific illnesses can be a goal for the future.

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Safe Use of Psychotropic Meds With Confined Youth

BY JOSEPH V. PENN, MD, CCHP

In many juvenile justice settings, a nonpsychiatric physician assumes the responsibility for prescribing psychotropic medications and setting the policies and protocols. To assist in these decisions, the following considerations are presented in NCCHC’s 2004 Standards for Health Services in Juvenile Detention and Confinement Facilities.

General Precautions

Psychotropic medications are potent drugs, often with long-lasting effects. Current literature on the use of these medications in juvenile settings is limited, and the emerging medication studies on treatment of youths with conduct disorder is confined to small outpatient samples. Thus, clinicians should use these drugs with youth only in a safe and clinically appropriate manner, and only as part of a comprehensive treatment plan. When youthful offenders present with insomnia, depression, disruptive behaviors or other symptoms, clinicians often initiate referrals to psychiatrists for further diagnostic evaluation and possible psychotropic medication treatment. Many youth are on multiple medications at the time of initial detention while others have never received medications, so a comprehensive mental health assessment, when clinically indicated, provides an opportunity to reassess their current treatment needs.

If psychotropic medications are used, they should augment a comprehensive, individually developed mental health treatment plan with the youth’s compliance and active participation, including the modalities of individual, group and family therapy (if feasible), and other appropriate interventions.

Clinicians also can recommend behavioral interventions and strategies such as regular exercise and better sleep hygiene, encouragement of family members and other social supports to rally around a youth, additional staff supervision and support, development of supportive relationships with both peers and direct care staff, and through other correctional, clergy and community resources.

Psychotropic medications should be used with great caution and only after reviewing potential risks, benefits, side effects and alternatives with the youth and, if the youth is a minor, the parent or legal guardian. In general, signed informed consent is needed for minors according to state mental health code.

Multiple psychotropic medications should be used judiciously in juveniles, not only because an empirical research base supporting this practice is lacking, but also because of liability issues related to potential risks, medication interactions and side effects. Newly detained youth on one or more psychiatric medications require careful assessment and monitoring, and attempts should be made to serially reevaluate the youth and, if possible, gradually reduce the need for or dosage of medications.

Ideally, a youth’s legal disposition and placement should be clarified or resolved before any psychiatric medication is initiated or reduced to assure that the treatment plan can proceed in a safe, supervised fashion. It is unwarranted to prescribe psychotropic medications in the absence of distinct target symptoms, or when placement and mental health follow-up services are unclear. Particularly relevant with detained youth is the need to weigh the proposed medication’s risk/benefit in terms of overdose, side effects, anticipated youth and family compliance with medication and follow-up treatment, health provider and patient comfort and bearing of the potential for abuse and diversion.

The clinical team should reassess the need for previously prescribed psychotropic medications based on symptoms, level of functioning and treatment needs. Many juvenile justice youth have a history of noncompliance with mental health treatment and may have abused stimulant medications.

Clinicians should assess a youth’s medication compliance and perform ongoing follow-up and monitoring for problematic side effects. It is important to explore the circumstances and rationale for a pattern of medication refusal with the youth, clinician team, other relevant staff and the youth’s family when indicated.

Clinicians and direct care staff also must be aware of the potential abuse of psychiatric medications, as well as trading medication for money, sexual favors or goods. Clinicians should educate other staff and review with them the evaluation and management of medication noncompliance, including surreptitious behaviors such as checking medications.

Emergency Use

Clinicians should know the facility’s policies and procedures regarding forced psychotropic medication. As a rule, without a court order, use of psychotropic medications must be voluntary and not coerced or forced upon a youth, with the exception of psychiatric emergencies. Clinicians must be careful to avoid the use of these medications for staff benefit. Clinicians also should be knowledgeable about facility policies and procedures regarding seclusion and physical restraints. Generally, national standards require written institutional or department policy and defined procedures for the appropriate use of therapeutic restraints for patients under treatment for a mental illness. NCCHC and other organizations that develop health care standards for correctional facilities have created guidelines and standards for the use of psychotropic medications administered by trained direct care staff for immediate control of behavioral dyscontrol) versus therapeutic restraints (for youths under treatment for mental illness) in juvenile correctional facilities. Assessment of the ability of individual youths to tolerate seclusion or restraint requires knowledge of pulmonary and cardiac/cardiovascular risk factors and their interaction with prescribed medications.

The decision to order a chemical restraint (the emergency use of medications for aggression control) must consider the juvenile’s available medical and psychiatric history, including previous medications being used. Chemical restraints must be administered and continuously monitored by trained nursing personnel. In general, oral medication should be offered before parenteral medication is used. Before using any of these agents, it is important to obtain a history of the youth’s current medications and illicit drug abuse because of potential drug interactions (e.g., the combination of phenycyclidine and haloperidol may promote hypotension). Also, youths may be more sensitive to the side effects of older antipsychotic agents (e.g., haloperidol, fluphenazine) such as extrapyramidal symptoms, acute dystonic reactions involving various muscle groups and the rare but very dangerous acute laryngeal dystonia.

Scant literature describes the use of atypical antipsychotics (risperidone, olanzapine, quetiapine) for chemical restraint in juveniles. Short-acting anxietolies such as lorazepam and antihistamines, like hydroxyzine and diphenhydramine, have been used with youths both individually and in combination with antipsychotic medications. It is not clear whether the combination is either more effective or more likely to produce side effects than each agent on its own. With anxietolies and antihistamines, a risk of increase in rage exists, but it is not possible to predict unless it has happened previously with the youth.

Joseph V. Penn, PhD, CCHP, is director of psychiatric services, Rhode Island Training School, Cranston. He represents the American Academy of Child & Adolescent Psychiatry on the NCCHC board of directors. This article is an adaptation of Appendix G of the 2004 Juvenile Standards; references are omitted here.
Mental Health in Corrections
Transforming Care, Transforming Lives

Hyatt Regency Chicago • July 17-18

For the second year, NCCHC and an impressive roster of partners are hosting an intensive, two-day conference to meet correctional health professionals’ growing interest in and need for education on mental health care. Our first seminar on this subject, held in 2004, received extraordinary attendance and garnered tremendous reviews. This year’s program takes the same approach but with some twists. Attendees can expect to learn about recent findings in research and practice, new approaches to care and treatment, and best practices.

Continuing Education

• CCHPs: The Certified Correctional Health Professional Board of Trustees has approved this activity for 13 hours of Category 1 credit.
• Nurses: NCCHC is approved as a provider of continuing nursing education by the Illinois Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. This activity was approved for 15.6 contact hours.
• Psychologists: NCCHC is approved by the American Psychological Association to offer continuing education for psychologists. NCCHC maintains responsibility for the program. Participants can earn up to 13 CE hours.
• Psychiatrists and other physicians: This activity was planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the University of Colorado School of Medicine and NCCHC. The University of Colorado School of Medicine is accredited by ACCME to provide continuing education for physicians, and designates this activity for a maximum of 13 category 1 credits toward the AMA’s Physician’s Recognition Award.

Educational Lineup

The two-track program features timely subjects presented by speakers invited for their knowledge and experience in correctional mental health care.

Sunday, July 17

• Mental Health Roundtable Discussion (sponsored by the Academy of Correctional Health Professionals)
• Mental Illness Behind Bars: Is Belp on the Way? – Thomas J. Fagan, PhD, and Henry Weinstein, MD
• Mental Health and Substance Abuse: Principles of Care for Co-occurring Disorders – Fred Osher, MD
• Designing and Managing Effective Mental Health Care Programs – Judith Robbins, JD, LCSW, CCHP
• Educational Breakfast: Unraveling the Complexity of Schizophrenia – Andrew Angelino, MD (sponsored by Pfizer)
• Women’s Mental Health Care Needs – Joan Gilhee, PhD
• Building Relationships With Academic Medical Centers – Judith Robbins, JD, LCSW, CCHP
• Legal and Ethical Issues of Disciplinary Proceedings – Jeffrey Metzner, MD, CCHP-A
• Interventions for the Mentally Ill Sex Offender – Dean Aufderheide, PhD, MTH, and Chris Carr, PhD
• Evaluation and Treatment of ADHD for Juveniles and Adults – speaker TBD

Monday, July 18

• Educational Breakfast: Unraveling the Complexity of Schizophrenia – Andrew Angelino, MD (sponsored by Pfizer)
• Women’s Mental Health Care Needs – Joan Gilhee, PhD
• Building Relationships With Academic Medical Centers – Judith Robbins, JD, LCSW, CCHP
• Legal and Ethical Issues of Disciplinary Proceedings – Jeffrey Metzner, MD, CCHP-A
• Interventions for the Mentally Ill Sex Offender – Dean Aufderheide, PhD, MTH, and Chris Carr, PhD
• Evaluation and Treatment of ADHD for Juveniles and Adults – speaker TBD

Conference Sponsors

Underscoring the importance of this conference, it has gained the support of major national organizations in the fields of correctional health care and mental health care. In fact, this year’s event marks the first time that the four organizations listed below have together cosponsored a conference:
• National Commission on Correctional Health Care
• 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 and the Law
• American Association for Correctional and Forensic Psychology
• American College of Neuropsychiatrists
• American Counseling Association
• American Society of Addiction Medicine

Housing Information

The program is being held at the Hyatt Regency, ideally located in the heart of downtown Chicago. A special rate of $144 has been arranged for conference participants. To make room reservations, call the hotel toll-free at (800) 233-1234. Be sure to tell the reservations agent that you are attending the NCCHC meeting to receive this discounted rate.

Registration Fees

Regular registration: $195
Academy member: $120
Guest (meal functions only): $40
Continuing education certificate: $10

Registration Methods

For fastest service, please register online at www.neche.org. Or contact us and we will send you a conference brochure and registration form: call (773) 880-1460, or send an e-mail to info@ncchc.org. You also may register on site at the conference.

Registration must include check or credit card payment. Purchase orders are accepted only from governmental agencies and their contractors, and must accompany the registration. A $15 fee will be assessed for processing purchase orders.

Registrants will receive written confirmation. Badges and other meeting materials will be distributed when you check in at the conference.
Relationship Between HPV and HIV

In state prisons, prevalence of HIV infection was higher among women (3%) than among men (2%) at year-end 2002, though in some states the rate for women has reached 10%. Further, women tend to have myriad factors—social, mental and biological—that should be taken into account by health care providers. These factors and special considerations for care are spelled out in the June issue of the Infectious Diseases in Corrections Report, published by the Brown Medical School.

For example, the authors note the importance of testing for and treating coinfection with hepatitis B and C viruses. Further, they recommend a “network of interconnected services” such as clinical medical care, mental health services, physical and sexual abuse recovery programs, drug treatment, discharge planning and even vocational training and skills building to enable the women to manage their own health care and prevent HIV transmission after release. Regular monthly IDCR is available free online at http://jncicancerspectrum.oxfordjournals.org/cgi/content/full/jnci;89/7/577.

Noncardiac QTc-prolonging Drug Risk

Certain gastrointestinal and antipsychotic drugs that interfere with the heart’s electrical activity increased the risk of sudden cardiac death threefold in a study published May 11 at the European Heart Journal Web site. Risk of death was highest in women and those new to the drugs, which included domeridone, chlorpromazine, haloperidol and pimozide. The study examined 775 cases of sudden cardiac death and matched them to 6,000 controls. Despite the findings, the authors issued a statement urging caution, noting that these drugs are “vital treatments for serious conditions,” according to a HealthDay News article.

Overexercise and Rhabdomyolysis

Unsupervised overexercise in the prison population can lead to emotional rhabdomyolysis, which in turn can lead to kidney damage and failure, according to an article in the April issue of the Logbook Nursing. The author, who works at the Federal Detention Center in Philadelphia, describes the condition’s causes, pathophysiology, and signs and symptoms, along with implications for nursing and considerations for the correctional setting. The article is available at www.medscape.com/viewarticle/503643_1.

Fiber Supplements Can Help Diabetics

Fiber supplements create a significant “two-sided” positive effect on cholesterol of people with type 2 diabetes, not only reducing LDL cholesterol but also boosting HDL cholesterol, according to a study presented at an American Heart Association conference on arteriosclerosis, thrombosis and vascular biology. The meeting report notes that cardiovascular disease is the leading cause of diabetes-related death, and that most American adults do not consume enough dietary fiber: Average daily intake is 15 g, but 25 g to 30 g is recommended. The report is available at www.americanheart.org/presenter.jhtml?identifier=3030591.

FDA Digest

Recent news from the Food and Drug Administration:


• The FDA Web site now features a section on drug-induced liver toxicity. Noting that it is the nation’s leading cause of acute liver failure, the site addresses liver toxicity caused by prescription and over-the-counter medications, dietary supplements combined with special diets and alcohol consumption, and environmental chemicals. The site sponsor is the Hepatotoxicity Steering Committee, with representatives of the FDA’s Center for Drug Evaluation and Research, the American Association for the Study of Liver Diseases, and the Pharmaceutical Research and Manufacturers of America. www.fda.gov/ceder/liver.tox

Guidelines You Can Use

• Guidelines for the Use of Anti-retroviral Agents in HIV-1-Infected Adults and Adolescents. The April 2005 version of this Department of Health and Human Services document features updated drug information, including hepatotoxicity risks, drug interactions, pregnancy data, contraindications and warnings for use for various drugs. All changes from the previous version are highlighted. www.aidsinfo.nih.gov/guidelines

• Diabetes Guidelines. For the latest edition of the American Diabetes Association’s clinical practice guidelines features separate standards of medical care to address diabetes in specific settings. The guidelines that pertain to correctional institutions were developed by a task force headed by NCCHC board member Daniel Lorber, MD, with involvement of several other NCCHC representatives. http://care.diabetesjournals.org/cgi/content/full/28/suppl_1/A53

New Mexico Approves Funds for Opioid Therapy in Prisons

New Mexico is emerging as a progressive state when it comes to medical and political acceptance of opioid treatment in corrections. Gov. Bill Richardson signed a 2005 appropriations bill that allocates $150,000 to the state Department of Correction for opioid therapy in correctional facilities. A hitch: The language makes the funding “contingent on Senate Bill 426 or similar legislation.” SB 426 Opioid Replacement Treatment Programs did not become law. Nevertheless, advocates of the bill are trying to gain release of the funds by pointing out “similar legislation” related to Department of Corrections performance measures specified in its budget.
Prescribing Antihypertensives: Vanilla or Mocha Deluxe?

BY JEFFREY KELLER, MD

I have a friend who owns an ice cream truck. He would drive around neighborhoods in the summer selling ice cream to kids. He told me that he sold much more ice cream if he offered only three flavors: chocolate, vanilla and strawberry. Surely you would sell more ice cream if he offered a lot of flavors, the kids couldn’t decide which kind of ice cream to buy. They would stand by his ice cream truck for a seemingly endless amount of time, paralyzed by indecision. At the end of the day, he sold less ice cream. This story has an exact analogy for the situation that confronts medical practitioners who treat hypertension. We face too many choices. Should we use a diuretic, a beta-blocker, an ACE inhibitor, a calcium channel blocker, an angiotensin blocker or a peripheral vasodilator? Are any of these categories more effective than the others? Which have the fewest side effects? Angiotensin blockers are 15 times more expensive than ACE inhibitors; are they 15 times more effective? This can quickly become complicated. Like kids buying ice cream, we can become paralyzed by indecision. All too frequently, we defer the decision to whatever good-looking drug rep has most recently bought us pizza and we use their medication.

Head-to-Head Comparison

A comprehensive course in antihypertensive pharmacology would go through all of these categories of medications in detail, but that literally would take weeks. Fortunately, we are spared that exercise because of ALLHAT. Shorthand for the Anti-Hypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial, this was a truly landmark study that should change your practice. (The results were published in the Journal of the American Medical Association, Dec. 18, 2002.) ALLHAT makes hypertensive prescribing easy.

First, let me give some background. As a result of this marketing, practitioners who treat hypertension.

Evidence-based Medicine

Thiazide diuretics are better than other blood pressure medications in preventing heart disease. Diuretics should be the first-line blood pressure medication for almost every patient.

2. For patients currently taking a different antihypertensive, they and their medical provider should consider switching to a diuretic—even if their blood pressure is well-controlled.

3. Most hypertensive patients will require more than one medicine to control their blood pressure. One of those medications should be a diuretic.

Three-Step Approach

1. We educate hypertensive inmates about lifestyle modifications they should make to lower their blood pressure—stuff like losing weight and exercising.

2. The first drug we prescribe for almost everybody is a diuretic. We use hydrochlorothiazide.

3. If a second drug is needed, we choose it based on the patient’s underlying disease process.

We have found this information to provide cost-effective, evidence-based treatment for the initial treatment of hypertension in our jails and prisons. For my jails, it is a simple, three-step process:

1. Educate hypertensive patients using the study diuretic (chlorthalidone) done had better blood pressure control and were much less likely to suffer from cardiovascular disease events than patients taking any of the other drugs.

2. The adrenergic blocker (doxazosin) was the worst—in fact, its use was discontinued midway through the study. The ACE inhibitor (lisinopril) and the calcium channel blocker (amlodipine) were better than doxazocin, but clearly inferior to chlorthalidone.

Who knew? The cheapest and simplest of the available agents is the one that we should be using most. I don’t know about you, but I always tickle me when the cheapest form of therapy turns out also to be the best evidence-based therapy.

Thiazides cost a couple of cents per pill. The less-effective blood pressure medications often cost as much as $1.50 per pill.

The ALLHAT recommendations as follows:

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3. Most hypertensive patients will require more than one medicine to control their blood pressure. One of those medications should be a diuretic.

I have a final recommendation. Once you have used this information to develop new policies and procedures for the treatment of hypertension in your facilities, treat yourself to some ice cream.

Jeffrey Keller, MD, is president of Badger Correctional Medicine, a contract management company based in Idaho Falls, ID. Reach him by e-mail at badgermed@datawco.net.

Evidence-based Medicine

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Jeffrey Keller, MD, is president of Badger Correctional Medicine, a contract management company based in Idaho Falls, ID. Reach him by e-mail at badgermed@datawco.net.
A Managed Care Model for Mental Health Service in Jail

Mental health care utilization and related drug costs were soaring at the Salt Lake County (UT) Metro Jail five years ago. No surprise there: It’s a tale playing out in jails nationwide. But administrators didn’t simply slash budgets and clamp down on services. Instead, they sought “an alternative, systematic approach” to mental health services that would curb costs while maintaining high quality care. They largely succeeded, according to Steven Szykula, PhD, and Dawn Jackson, PhD, writing in the latest issue of the Journal of Correctional Health Care. The article describes the system they developed, along with the results they achieved.

The system incorporates several time-tested managed care strategies: guidelines for assessing medical necessity and level of care, a psychotropic drug formulary, preauthorization for nonformulary prescribing and profiling of provider prescribing patterns.

Assessment Guidelines
With so many patients requesting antidepressants, the jail found that the frequency of prescribing these drugs was inordinately high despite the availability of counseling and psychotherapy. Before implementing the managed care strategies, more than 12% of the 1,800-inmate population was on antidepressants.

To standardize assessment of the level of care and medications that patients may need, mental health practitioners now use the Global Assessment of Functioning scale, based on the American Psychiatric Association’s DSM-IV. The scale, which is reproduced in the Journal article, establishes criteria for referral to a prescribing psychiatrist.

This “psychotherapy first” approach to assessment and referral eliminates prescriptions that are not clinically indicated, and has sharply reduced the number of patients using antidepressants, the study authors report. As with many large jails, the SLCo Metro Jail has an inpatient psychiatric unit for patients who need acute care. Again, however, determining who belongs in that unit was not based on a standard assessment or clinical pathway.

To ensure best use of the unit, and to avoid the problems that arise when patients don’t belong there, practitioners now use established clinical criteria to determine who qualifies for admission. As well, multidisciplinary teams of custody officers, nurses, psychiatrists and other mental health professionals assess these inpatients daily and discuss treatment and discharge plans.

Drug Formulary
Another step was to develop a list of preferred medications to use when prescriptions of SSRI antidepressants and atypical antipsychotics are clinically indicated. This formulary was developed by the pharmacy and therapeutics committee, which selected the medications based on their use in the community, clinical efficacy (as shown in the literature and in practice) and cost. The formulary uses a “cascading” format that indicates a sequence of drugs to try if the top choice is not effective for the patient.

Despite early resistance from some providers, the formulary has been accepted, and it has been healthy for the bottom line. Monthly expenditures for psychotropic drugs dropped from a high of $22,625 to $7,505 two years later, and often the monthly outlay is even less. Further, the study authors say this strategy has resulted in “no notable increases in service requests, referrals, adverse outcomes or self-injury.”

When developing the formulary, health administrators expected a fair amount of nonformulary prescribing from providers who favored other medications or who were concerned about loss of autonomous decision making. Thus, they established a procedure for preauthorization when a provider wished to prescribe a nonformulary psychotropic. This entails the chief psychiatrist’s review of the clinical justification for a nonformulary medication and approval before such an order is fulfilled.

This managed care strategy may have been unnecessary, say the study authors. Within a few months after the formulary was implemented, only a few requests for other drugs were being made, and few (if any) of these requests were denied. The authors also note the trend of managed health care companies loosening or waiving their preauthorization requirements for psychiatric visits.

Provider Profiling
Jail administrators noticed some provider practices that violated policy or were outside the bounds of normal psychiatric practice. For instance, policy prohibited medications with sedating effects, yet prescriptions for drugs to help patients sleep continued to be written.

To more easily detect and remedy such “outlier” behavior, the jail adopted the managed care strategy of provider profiling, but with a sole focus on prescribing practices. The study authors emphasize that the profiling and data analysis is not used “to sanction, punish or coerce, but rather to provide information” to help providers make “appropriate and informed prescription decisions.”

And the outcome? Administrators identified the providers who often prescribed a particular antidepressant for complaints of insomnia and educated them about why this is not desirable and what alternatives are acceptable. This led to a 40% reduction in the number of patients receiving the drug, as well as an increase in referrals for cognitive behavioral interventions for insomnia.

Effective Tools
With the SLCo Metro Jail inmate population now at 2,000, close management of mental health drug and service utilization is more important than ever. Borrowing from the managed care playbook, the study authors contend, can provide effective tools for curbing needless expenses and delivering consistent, high-quality care.

The Complete Lineup: Journal Volume 11, Issue 3
As always, the Journal of Correctional Health Care is 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 (773) 880-1460.

• Managed Mental Health Care in Large Jails: Empirical Outcomes on Cost and Quality Steven A. Szykula, PhD; Dorzen F. Jackson, PhD

• Prevalence of Medical and Mental Health Conditions That Warrant Discharge Planning in a Medium-Sized County Jail Mark K. Johnston, MD, MP

• Integration of Telemedicine Practice Into Correctional Medicine: An Evolving Standard Charles R. Doarn, MBA; Debbie Justis, RN, MS/HA; Muhammad S. Chaudhri, MD; Ronald C. Merrell, MD, FACS

• Counseling and Testing Program for Female Inmates: Analysis of Data From the Harris County Jail Randi L. Garzjed, DrPH; Michael W. Ross, PhD, MPH; Theresa Byrd, DrPH; Andrea Sheldton, PhD

• Diabetic Ketoacidosis in Correctional Health Care Kiran Yalamanchili, MD; Sunil Babu, MD; Rishi Sukhija, MD

• Methadone Maintenance in a Men’s Prison in Puerto Rico: A Pilot Program Robert Heimer; PhD; Holly Cattanea, JD; John A. Zombozo; Arlyn Brunet; Arturo Martin Ortiz, PhD; Robert G. Neuman

www.ncchc.org
Lab Data Mining: A New Tool for Quality Improvement

BY JOSEPH E. PARIS, PHD, MD, FSCP, CCXP

The quest for improved correctional health care management has been hotly debated. Many experts in this field believe that, unless monitoring of quality is a priority, clinical visits may take place as planned but patient improvement may not necessarily be the result. Opinion differs on how best to improve quality. Some favor self-assessments and continuous quality improvement. Others feel that only auditing by external reviewers has the potential to ferret out aberrant practice patterns. While the medical literature teems with discussion of outcomes research, quality assessment methodologies vary and no standard has emerged.

Since 1996, I have proposed clinical audit tools to measure quality and certain clinical outcomes in the areas of initial assessment, chronic care, consultation, and emergency care. Broad application of these tools in the Georgia Department of Corrections led to measurable improvements in clinical care quality. However, the laborious, personnel-intensive nature of the review is laborious, personnel-intensive. As information technology has enabled retrieval and analysis. Despite its success at the GDC, standardized medical encounter audit methodology has not seen widespread acceptance. But with the development of computerized health records, scheduling, pharmacy and laboratory data, new avenues are opening. Large volumes of data can be processed expediently and mined to evidence any aberrant patterns of clinical care. The GDC has used automated lab data mining since 2004 with excellent results.

Mining the Database

Although some correctional facilities boast state-of-the-art electronic health records, most would agree that such automation is proceeding at a calculated pace that factors in issues of cost and the myriad details of implementation. Scheduling systems, pharmacy modules and lab data lend themselves to quicker automation than medical encounter/consultation free-text narratives.

Many correctional systems use large commercial clinical laboratories that have automated lab data for many years. Recent cost reductions in information technology have enabled some of these labs to offer access to their databases at minimal expense. In 2003, the GDC entered an agreement with its clinical laboratory vendor for electronic access to data for state prisoners. GDC physicians received one PC each, software, passwords and training.

Now, reviewers from the Office of Health Services or practitioners wishing to review their own patient lab data may access the system, known as Care360. Each practitioner sees about 20 patients a day and orders lab tests for 0 to 4 patients. Therefore, the query usually requests six months of lab data because that interval yields suitable volumes of a variety of tests for the review. Minimal clinical yields are afforded by querying a given practitioner’s or an institution’s lab database for the analyses listed below:

- All hemoglobin A1c above 6%
- Significant ALT abnormalities
- All hemoglobin A1c above 6%
- All subtherapeutic International Normalized Ratio (INR) (coagulation)
- All detectable HIV viral loads (for patients on HAART)
- A sampling of the highest and lowest hemoglobin or hematocrit results
- All abnormal INR levels

Care360 instantaneously produces patient listings for the above, with dates, lab results and names of the attending physicians. A quick match with an updated institutional roster allows the removal of released or transferred inmates. The results are reviewed and acted upon. Some quality issues will be self-evident. In high-quality institutions, earlier abnormal results will be followed by normal values at a later date, the result of the physician noticing the abnormality and taking steps to correct it.

In weaker systems, no additional test results would be found. For these, the reviewer must gather encounter records covering the dates in question. Health record review may validate the conclusion of inadequate care, or verify that the patient did not accept treatment. In the GDC, such records are paper-based today, but electronic, with electronic encounter narratives, centralized review from a distant office would render this system even more efficient.

I developed a six-step methodology for the systematic study of abnormal lab data received. For each abnormal electronic lab report, the patient’s encounter records should show that:

1. The abnormal lab report was filed in the record, initialed and dated by the physician.
2. The physician wrote a note acknowledging the abnormal report.
3. The note describes, and the orders demonstrate, a plan of care, or a rationale for waiting further, repeating the test, etc.
4. The record demonstrates that the care plan was implemented, new tests done, etc.
5. The patient was educated on the report and its clinical significance.
6. For lab data reflecting a new permanent diagnosis, such as diabetes, the diagnosis was entered in the problem list.

A natural way to look at the mined data is to sort them by disease management criteria. For instance, one disease management technique advocated by NCCCH relies on sorting out diabetic patients based on their current hemoglobin A1c. According to the ADA recommendations, diabetic patients with HbA1c below 7% are in good control, those between 7% and 9% are in fair control and those over 9% are in poor control. It follows that those in fair or poor control merit additional ministrations aimed at improving their disease management and, thus, their outcome.

Using these cutoffs to classify the results enables the reviewer to know instantly the proportion of diabetes in good, fair or poor control at a given institution or being treated by a given physician. Thus, institutions or practitioners can be compared in order to educate and improve outliers.

Empowering Tool

Not all physicians reacted enthusiastically to the system, with some voicing concerns about what they perceived as another intrusion into their doctor-patient relationships. However, most accepted it rapidly, and many felt empowered by their ability to analyze their own practices critically.

One physician said, “I have always been scared of the prospect that, no matter how carefully I manage my patients, somehow a new inmate has slipped in with known, serious lab abnormalities that were not communicated to me. If the initial nursing assessment failed to disclose the problem and the inmate did not come to sick call, I would not know about it until serious clinical damage has occurred. Now I can case my flock once a week and detect all outstanding abnormalities.”

After a year of analyzing lab data in this way, care quality has improved notably. Careful practitioners enjoy analyzing their own care and improving their management of diabetes, thyroid disease, HIV infection, anemia and other conditions. One doctor was fascinated by the possibility: “I have a passion for tight diabetic management. At any time, I know whose hemoglobin A1c is sticking out so I can call the inmate to the clinic and refine my approach.”

This system also identified a few physicians who previously did not take the time to fine-tune patients with certain conditions. Once faced with their patient’s persistently abnormal laboratory results, they were educated on improving their care patterns by systematic analysis.

The day of correctional health care data mining has arrived. As the GDC automates other areas of health care, similar approaches will be employed to reduce unwanted patterns in the areas of medication administration, encounter and consultation scheduling, and more. Correctional care will never be the same. And that is a good thing.

Joseph E. Paris, PhD, MD, FSCP, CCXP, is the medical director at the Georgia Department of Corrections.
Moving Forward in Correctional Health Care

Building on 29 years of National Conference tradition, this comprehensive program will cover all of the bases and then some in the most well-attended meeting for professionals specializing in correctional health care. As part of our mission to provide the highest quality education in this complex field, NCCHC and the Academy have recruited knowledgeable leaders to present more than 100 educational sessions on a broad range of subjects and at all skill levels. Whether you’re seeking an overview of the fundamentals, in-depth treatment updates or innovative approaches to leadership challenges, you’ll find it in Denver.

Captivating Keynote: Louis C. Tripoli, MD
At Monday’s opening session, Navy Cdr. Louis C. Tripoli, MD, a prominent correctional and public health professional, will discuss his experiences during a year of active duty in Iraq. A key accomplishment was rebuilding the public health systems in Fallujah during and after intense urban combat. Tripoli’s many interests include forensic medicine, bioterrorism and emerging infectious diseases. As a civilian, he is senior vice president of Correctional Medical Services, chairman of the Correctional Medicine Institute, a professor of medicine in the infectious diseases division of Johns Hopkins University, and a professor at St. Louis University School of Public Health.

Sneak Preview
The National Conference is loaded with learning opportunities. Here’s a sampling of the many intriguing educational sessions in the lineup:
- Chest Pain: How to Assess and Treat This Common Complaint
- Role Development of the Advanced Nurse Practitioner in Corrections
- Dealing With Diabetes: Chronic Complications
- Using an EMR to Facilitate Quality Management
- Chest Pain: How to Assess and Treat This Common Complaint
- Role Development of the Advanced Nurse Practitioner in Corrections
- Dealing With Diabetes: Chronic Complications
- Using an EMR to Facilitate Quality Management

For even more in-depth training, arrive early and attend the preconference seminars on Saturday and Sunday. These interactive half-day and full-day seminars address essential subjects such as NCCHC Standards for Health Services, management of infectious diseases, pain management, risk management and more.

Meet and Mingle
A valuable part of the conference is the chance to mingle with professional colleagues. Be sure to take advantage of these formal networking events:
- Exhibit Hall Opening Reception
- Special Interest Group Discussions
- Educational Poster Display Reception

Window Shopping
You will enjoy strolling through the exhibit hall, the largest in this field, where you can learn about the many goods and services designed to help you improve health care delivery in your facility.

Why You Should Attend This Meeting
- Preconference seminars for in-depth learning!
- Over 100 educational sessions in 9 topical tracks!
- Presentations by top correctional health experts!
- Beginning, intermediate and advanced sessions!
- Oodles of continuing education credit!
- Special interest group discussions!
- Educational posters on display!
- Must-have resources at the NCCHC bookstore!
- First-rate exhibition hall with the latest and greatest!
- Networking with over 1,800 colleagues!
- Denver, a vibrant metropolis with endless attractions!

Continuing Education
- Physicians: NCCHC has applied to be a provider of continuing medical education for Category 1 credit toward physicians’ CMR.
- Psychologists: NCCHC is approved by the American Psychological Association to offer continuing education for psychologists. This activity is approved for up to 30 hours of CE credit.
- Nurses: NCCHC is approved to provide continuing education by the Illinois Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. This activity is approved for 36 contact hours.
- CCHPs: Certified Correctional Health Professionals may earn up to 16 contact hours of Category 1 credit for recertification, plus an additional 14 hours by attending preconference seminars.

Conference Objectives
- Demonstrate an increased understanding of skills necessary to better manage common medical, nursing, dental and psychological problems found in correctional settings
- Identify major health care, research and policy issues facing incarcerated individuals, including infectious diseases, mental illness, substance abuse and special needs, which include women’s issues, juvenile health, geriatrics and the disabled
- Describe legal, ethical and administrative issues and ways to prevent potential problems that arise in correctional settings
- Demonstrate an increased awareness of common correctional health care issues, which include quality of care, access to care, continuity of care and fiscal responsibility

Registration Information
Early Bird Discount: Register by August 26 and save $50 off the full registration fee.

Registration Categories
- Academy Member: $295 after August 26
- Nonmember: $370 after August 26
- One Day: $185 (Monday, Tuesday, Wednesday); this fee covers all events on the day you attend
- Guest: $45; this fee gives access to all exhibit hall events, but not to educational sessions
- Preconference Seminars: full-day seminars, $170; half-day seminars, $95

Preregistration Policy: Preregistration will be accepted through Sept. 30. After that date, please register on site at the conference.

Conference Site
All educational activities will take place at the Colorado Convention Center, 700 14th St., Denver, (303) 228-5000. Parking is available for about $5 per day.

Hotel Accommodations
Special conference room rates are available from the Marriott City Center as well as the Hyatt Regency. These rates are available for reservations made by Sept. 16. They do not include taxes. Rooms are assigned on a first-come, first-served basis. To ensure accommodations, reserve your room early, and be sure to mention the NCCHC conference to receive the special rate.

Denver Marriott City Center (headquarters)
1701 California Street
Direct: (303) 297-1300
Rate: $138 single/double

Hyatt Regency Denver
1750 Walnut Street
Direct: (303) 295-1234
Rate: $109 single/double

All photos courtesy of the Denver Metro Convention & Visitors Bureau.

Sponsored by the National Commission on Correctional Health Care and the Academy of Correctional Health Professionals
Find conference information and online registration at www.ncchc.org.
To obtain a preliminary program with registration form, download it at our Web site, e-mail info@ncchc.org, or call (773) 880-1460.
"a journey of 1000 miles begins with

a single step"

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When beginning a first-line HIV-combination therapy, look for a pathway paved in evidence.

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INDICATION:
SUSTIVA (efavirenz) in combination with other antiretroviral agents is indicated for the treatment of HIV-1 infection.

*This indication is based on two clinical trials of at least one year duration that demonstrated prolonged suppression of HIV RNA.

IMPORTANT SAFETY INFORMATION:
- Co-administration with azidinidine, cimetidine, midazolam, triazolam, albuterol, or carbamazepine is contraindicated. Concurrent use of SUSTIVA and St. John’s wort (Hypericum perforatum) or St. John’s wort-containing products is not recommended. This list of medications is not complete.
- Serious psychiatric adverse experiences, including severe depression (2.4%), have been reported in patients treated with SUSTIVA. In addition to SUSTIVA, factors identified in a clinical study that were associated with an increase in psychiatric symptoms included history of injection drug use, psychiatric history, and use of psychiatric medication. There have been occasional reports of suicide, delusions, and psychosis-like behavior; but it could not be determined if SUSTIVA was the cause. Patients with serious psychiatric adverse experiences should be evaluated immediately to determine whether the risk of continued therapy outweighs the benefits.
- Fifty-three percent of patients reported nervous system symptoms when taking SUSTIVA compared to 25% of patients receiving control regimens. These symptoms usually begin during Days 1-2 of therapy and generally resolve after the first 2-4 weeks of therapy. Nervous system symptoms are not predictive of less frequent serious psychiatric symptoms.
- SUSTIVA may cause fatal harm when administered to a pregnant woman. Women should not become pregnant or breastfeed while taking SUSTIVA. Barrier contraception must always be used in combination with other methods of contraception (e.g., oral or other hormonal contraceptives). If a woman becomes pregnant while taking SUSTIVA during the first trimester of pregnancy, she should be apprised of the potential harm to the fetus.
- Mild to moderate rash is a common side effect of SUSTIVA. In controlled clinical trials, 26% of patients treated with SUSTIVA experienced new-onset skin rash compared with 17% of patients treated in control groups. SUSTIVA should be discontinued in patients developing severe rash associated with blistering, desquamation, mucosal involvement, or fever. Rash is more common and often more severe in pediatric patients.
- Liver enzymes should be monitored in patients with known or suspected hepatitis B or C and when SUSTIVA is administered with ritonavir.
- Use SUSTIVA with caution in patients with a history of seizures.
- Redistribution and/or accumulation of body fat have been seen in patients receiving antiretroviral therapy. A causal relationship has not been established.
- Immune reconstitution syndrome has been reported in patients treated with combination antiretroviral therapy including SUSTIVA.
- It is recommended that SUSTIVA be taken on an empty stomach, preferably at bedtime. The increased concentrations following administration of SUSTIVA with food may lead to an increase in the frequency of adverse events. Dosing at bedtime may improve the tolerability of nervous system symptoms.

Please see brief summary of Full Prescribing Information for SUSTIVA on adjacent pages.

SUSTIVA and the SUNBURST LOGO are registered trademarks of Bristol-Myers Squibb Pharmaceutical Company.

©2009 Bristol-Myers Squibb Company, Princeton, NJ 08543, U.S.A.
www.sustiva.com
1-888-819-6892

此页面的原始文本内容未显示。
Table 2: Pharmacological Treatments of Adjacent Areas Repeated for 2×50 mg BID in Patients with ShiA1A 2–3

| Trait | Usage | \( \text{mg} \times 
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<tbody>
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<td>Level</td>
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<td>Headache</td>
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<td>Artifact</td>
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Low frequency: 50%.

Internal control: 10.0 mg BID.

External control: 20.0 mg BID.

Table 3: Pharmacological Treatments of Adjacent Areas Repeated for 2×50 mg BID in Patients with ShiA1A 2–3

| Trait | Usage | \( \text{mg} \times 
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<tr>
<td>Artifact</td>
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</tbody>
</table>

Low frequency: 50%.

Internal control: 10.0 mg BID.

External control: 20.0 mg BID.

Table 4: Pharmacological Treatments of Adjacent Areas Repeated for 2×50 mg BID in Patients with ShiA1A 2–3

| Trait | Usage | \( \text{mg} \times 
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</tr>
<tr>
<td>Artifact</td>
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</tbody>
</table>

Low frequency: 50%.

Internal control: 10.0 mg BID.

External control: 20.0 mg BID.

Table 5: Pharmacological Treatments of Adjacent Areas Repeated for 2×50 mg BID in Patients with ShiA1A 2–3

| Trait | Usage | \( \text{mg} \times 
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<td>30</td>
</tr>
<tr>
<td>Artifact</td>
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<td>2</td>
</tr>
</tbody>
</table>

Low frequency: 50%.

Internal control: 10.0 mg BID.

External control: 20.0 mg BID.

Table 6: Pharmacological Treatments of Adjacent Areas Repeated for 2×50 mg BID in Patients with ShiA1A 2–3

| Trait | Usage | \( \text{mg} \times 
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<td>30</td>
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</table>

Low frequency: 50%.

Internal control: 10.0 mg BID.

External control: 20.0 mg BID.

Table 7: Pharmacological Treatments of Adjacent Areas Repeated for 2×50 mg BID in Patients with ShiA1A 2–3

| Trait | Usage | \( \text{mg} \times 
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<td>Artifact</td>
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</tbody>
</table>

Low frequency: 50%.

Internal control: 10.0 mg BID.

External control: 20.0 mg BID.
and others need to see tobacco control as an important, high-profile public health issue with the same sort of status as HIV or tuberculosis. Otherwise, it will continue to get the short end of the attention and health care resources."

NNTPP and NCCHC also conducted a survey to obtain information on tobacco prohibition and availability, policies, cessation programming and resources. "Policy" questions asked whether the facility had a tobacco-free policy, when it was implemented, what it addressed and how strictly it was enforced. "Clinical" questions addressed issues such as how tobacco cessation clinical guidelines were being used and which components were most useful. "Education" questions sought to identify what cessation resources the facility had and what additional resources would be valuable.

After incorporating input from a field test, the survey was sent to the medical directors of 500 facilities accredited by NCCHC.

Surprising Findings

One hundred completed surveys were returned—48 from jails, 28 from prisons and 26 from juvenile facilities. The study results produced many surprises. Some of our assumptions, like how many facilities were truly tobacco-free and how seriously facilities take tobacco control, were off. In many facilities, even the term "tobacco-free" is a misnomer.

Tobacco Prohibition and Availability

Since many states mandate that state-owned properties be tobacco-free, we assumed most correctional facilities would prohibit tobacco use on their grounds, with policies to reinforce the prohibition. While more than 77% of respondents reported having "tobacco-free" policies, this term was interpreted in different ways. For example, 79% of the self-described tobacco-free facilities banned tobacco use by inmates, but only 21% extended the ban to staff. Tobacco use was permitted at 23% of the facilities. Most of these reported that they sell cigarettes, cigars and chewing tobacco, but few allow staff to purchase these products on site.

Tobacco Policies

While 79 facilities reported having a tobacco policy (including 15 that permit tobacco), many of the policies had not been updated for years. This is likely due to the reason for adopting a policy in the first place: Nearly two-thirds of the tobacco-free facilities were mandated by law to adopt their policies.

The estimated compliance rate for staff was higher than that for inmates (81% vs. 71%), but respondents said that the policies are enforced slightly more stringently on inmates than on staff. This supports the view that while facilities must comply with the law, they don't want to lose employees.

Cessation Programming

One clear message from the survey results was that tobacco cessation is not a priority in correctional health care. Providers believe that other diseases, addictions and ailments are more pressing. Consistent with this finding, the survey revealed that very little cessation programming occurs in correctional facilities. In fact, more than 80% of respondents said they offer no cessation programming at all.

Nicotine replacement and other cessation aids were not commonly used, meaning that most inmates must quit tobacco "cold turkey." Interestingly, 63% of the facilities said they assess inmates' tobacco addictions at intake. With few, if any, cessation aids or programming, it is not surprising that the respondents estimated that 76% to 100% of their inmates who are reincarcerated resume tobacco use after their previous release.

This highlights the tremendous need for tobacco control planning upon entry, during incarceration, upon release and during parole or probation. Providing health staff with more advance notification of discharges and resources materials designed for the incarcerated population have been reported as ways to close this gap in potential service.

Resources

A surprisingly large number (44%) of study respondents indicated that no resources would help inmates or correctional staff to reduce tobacco usage. Of the 56% who did think that tobacco prevention and cessation was possible, almost all (96%) of the tobacco-permitting and nearly half (49%) of the "tobacco-free" facilities considered educational materials to be important resources.

The survey also asked about the American Medical Association's standard on tobacco use in correctional institutions. The standard was revised in 2003 to require that smoking be prohibited inside facilities and that there be tobacco prevention and abstinent activities. Few facilities reported using the standard, and most that did used the old version.

One resource that received a positive response was direct patient education, viewed as an important strategy for reaching inmates as well as staff. In fact, 60% said that a tobacco education/cessation curriculum would benefit both audiences.

In response, NNTPP and NCCHC have developed a curriculum for educating inmates about the harmful effects of tobacco use and helping them to quit (see above). We are also working to establish a standard for developing tobacco-free policies in correctional facilities. This may include adopting recommendations to use clinical practice guidelines for treating tobacco use.

Lessons Learned

Get the Caregivers On Board

The correctional health care community is pessimistic about their ability to make a difference in long-term tobacco usage. Thus, providers first must be convinced that tobacco prevention and cessation are important enough to mandate in their facilities and regular work. They are in the best position to influence the cessation programs and other support mechanisms in their facilities. Without the providers and other staff on board, it will be impossible to maximize the effectiveness of any tobacco cessation efforts.

Analyze Policy Language

Knowing that many states mandated that correctional facilities become tobacco- or smoke-free, NCCHC and NNTPP expected that facilities with tobacco-free policies would disallow tobacco use anywhere on the premises. Not so. By asking in detail about tobacco use policies (e.g., what prompted the policy, how long it had been in place, who it applied to), we could identify discrepancies in the definitions of "tobacco-free." Had we assumed that all participants defined the term in the same way, we would have missed important nuances in the policies.

Education Is a Continuous Process

Most respondents were receptive to starting with a tobacco cessation curriculum. Once they are informed about tobacco control, they will be more likely to complement their knowledge with policy adherence and guideline compliance to increase the consistency and the effectiveness of their policies and programs.
Updates and Vegas: A Winning Combination

If conferences were games of chance, you could say that Updates 2005 struck it rich in Vegas: With final attendance figures approaching 900, the fifth installment of this annual Spring meeting enjoyed its largest turnout ever. But, of course, NCCHC and the Academy leave nothing to chance when they develop educational programs. The folks who attended the meeting came expecting top-notch presenters and sessions, productive networking and commercial exhibits of substance—and that’s exactly what they got. The fact that the meeting was held at the fabulous Flamingo Las Vegas hotel was just icing on the cake!

Las Vegas Redux
The “Entertainment Capital of the World” is a popular site for conference-goers, without a doubt. We believe in giving the people what they want, so next year we’re doing it again.

Save the date!
Updates 2006
April 8-11
Flamingo Las Vegas

Updates 2006
April 8-11
Flamingo Las Vegas

Did somebody say “networking”? Spending time with colleagues and friends is one of the many pleasures of attending the Updates conference.

Fashionista! For the ladies: The conference bookstore now carries apparel with a distinctly feminine cut. Modeling the sky-blue Academy t-shirt is NCCHC board representative Pat Reams, MD, MPH, CCHP.

Take-home messages. Popular speaker Thomas White, PhD, share his expertise in a subject important to all correctional settings: suicide prevention.

We mean business. The exhibition hall is always a big draw for attendees. With so many excellent companies offering products and services to aid the task of providing quality health care, why not take advantage of them?

Helping Clients Chart Their Own Course...

to reach their HEALTH CARE goals

The management and clinical professionals at Prison Health Services have spent 27 years understanding correctional facility needs and implementing clinically-effective health care programs.

- Proactive Disease Management...Improved Quality
- Controlled Costs...Predictable Expenses
- Appropriate Settings...Comprehensive Training
- Reliable Pharmacy Services...Cost-Effective Programs
- Risk Management...Reduced Liability
- Accountability...Client Control

We are ready to provide you with a customized, corrections-based health care solution.

VIPs. Look at all those ribbons! Need we say more? Sharing the bright smiles are Catherine Knox, MSN, CCHP, Jayne Russell, MED, CCHP-A, and Anthea Caruso, MSN, CCHP, CNAA. Their contributions to NCCHC and the Academy are too numerous to list!

Miss the conference? Audiotapes, CDs and CD-ROMs of most sessions are available from Nationwide Recording Service, the official recording company for the 2005 Updates conference. For a list of available sessions and to place your order, visit www.nrstaping.com/ncchc, or call (972) 818-8273, ext. 114.
The National Commission on Correctional Health Care’s mission is to improve the quality of health care provided in correctional facilities. In keeping with this mission, a central activity is the establishment of solid, professional, outcomes-based standards to guide the correctional health care field.

But while the Standards for Health Services are founded on core principles, they are not static. Subject to quality improvement review, the standards evolve to keep pace with contemporary health care, to mirror national clinical guidelines, including those for the mental health and addiction fields, and to align correctional health care with the continuum of public health care.

Thus, revision of standards occurs not on a fixed schedule but rather when it becomes apparent that it’s necessary. With every new edition, our field progresses further. However, a top-to-bottom revision is not always necessary. For the next editions of the prison and jail Standards, scheduled for publication in 2007, the extent of changes may be better characterized as “updates.”

**Continual Change**

The 2003 Standards for Health Services in adult facilities introduced major improvements: several new standards, the combining of some standards and the splitting of others, a new format that includes statements of expected outcomes, compliance indicators and more.

Accredited prisons and jails have now transitioned to compliance with these editions, which took full effect in December 2003. Still, questions may arise that, along with continual progress in the various health care specialties, modifications to national guidelines and community practice, and ever-changing correctional issues, signal a need for updates of specific standards.

It is always a challenge to balance the desire for continuity in accreditation requirements with the need to incorporate changes, and this is especially true after implementation of the 2003 editions. Each stakeholder brings a unique perspective to this discussion. Facility staff who must implement or comply with the standards on a daily basis ask for minimal change so that future surveys can take place under the same set of standards. NCCHC surveyors want clarity in interpretation. Accreditation committee members and staff want to improve wording of standards that cause difficulty for facilities. Users who base policies and practices on the standards but are not involved in accreditation do not want to start over.

Given these various, and sometimes conflicting, perspectives, NCCHC invites feedback as we enter the next cycle of revision. If you have any comments or suggestions about the Standards, please send them to us and we will consider them as part of the review process.

Submit comments to Judith A. Stanley, MS, CCHP-A, Accreditation Department, NCCHC, 1145 W. Diversey Pkwy., Chicago, IL 60614, or e-mail judithstanley@ncchc.org.

Judith A. Stanley, MS, CCHP-A, is NCCHC’s director of accreditation.
Care for Chronic Diseases

Our state prison system has implemented a chronic care clinic (CCC) program. I remember NCCHC having a list of proposed diagnoses for CCC eligibility. What diagnoses should we include in our program?

A

The information you seek is found in standards P-G-01 Special Needs Treatment Plans and P-G-02 Management of Chronic Disease. From NCCHC’s standpoint, any health condition that is considered chronic or that requires multidisciplinary care also requires development of an individual treatment plan for regular, ongoing care. Examples of such conditions are listed in P-G-01.

To sharpen the focus on chronic care, P-G-02, new to the 2003 Standards, specifies seven conditions for which the facility is expected to have identified national clinical guidelines to follow in treating these diseases. To assist facilities, NCCHC has developed correctional clinical guidelines for these conditions (posted online at www.ncchc.org/resources). Alternatively, facilities may choose any of the national clinical guidelines current in community care, such as those from the American Diabetes Association, the American Society of Internal Medicine, etc. (See the National Guideline Clearinghouse at www.guideline.gov.)

The eventual goal is for practitioners to follow specific clinical protocols for all chronic conditions. The current seven are a first step.

Care for Stun Gun Injuries

Community correctional authorities in our area often use Taser/stun gun weapons to subdue individuals who appear out of control. Apparently these weapons can embed particles in the body, which can cause problems if not removed. Our county jail is seeking standards, policies or procedures for dealing with inmates who have been zapped by one of these guns. Do you have any suggestions?

A

The use of weapons such as Tasers and other stun guns appears to be growing in community correctional practice and in facility internal control procedures. These are not health interventions, and the Standards do not address them directly.

However, as with other arrest-related injuries (such as from knives, guns or fists), the receiving screening process must be prepared to deal with stun gun injuries (jail, prison and juvenile standard E-02). And, just as health-related contraindications or inmate accommodations must be considered when the use of segregation, restraint or seclusion is proposed (standards E-09 and I-01), likewise health concerns must be considered with the facility’s use of stun guns, just as is generally done with pepper spray or mace. This issue requires joint planning between correctional and health staffs and complementary policies and procedures.

When you are aware that the correctional authorities in your jurisdiction use stun guns, receiving screening procedures must ask whether such a device was used on the individual being admitted and under what conditions. The facility authority can build this exchange of information into the admission process.

We are not experts in the health effects of these weapons and refer you to manufacturer literature and to health experts who deal with these effects, such as the emergency physicians at your local hospital. It would seem prudent to have such arrests checked at a hospital before your facility accepts them, especially if they are pregnant, young, elderly or infirm. If facility health staff are to assess the individual’s health status after use of the weapon, staff must be appropriately trained.

If a stun gun is to be used in the facility, we would expect joint correctional/health protocols that require review of the inmate’s health history for any contraindications or needed accommodations, as well as evaluation by health staff after the device is used. Your responsible physician would need to establish protocols that outline the steps for evaluating the inmate’s response.

Mental Health Screening

Regarding standard J-E-05 Mental Health Screening and Evaluation: Do we need to screen every admission? For example, if an inmate was seen just 30 days ago and is booked into our county jail again, would the inmate need another screen?

A

The intent of J-E-05 is to identify people with mental health problems, to determine whether there’s a clinical need for further evaluation or treatment, and, if so, to provide it in a timely manner.

To deal with frequently readmitted inmates, the responsible health/mental health authority can establish a protocol that permits modification of the mental health screening interview; but the protocol should not eliminate inquiry into mental health status. Patients well-known to staff and for whom previous incarceration health records are available may simply need a brief interview to ascertain whether anything has changed since the last discharge that would impact mental health treatment. This interview can be combined with the physical review and assessment, provided the staff are trained and the results are documented.

Since mental health problems can and often do change with time or circumstances, this must remain an area of inquiry for all readmissions.

Judith A. Stanley, MS, CHCA-P, is NCCHC’s director of accreditation and oversees the development and revision of standards. R. Scott Chavez, PhD, MPA, CHCA-P, is NCCHC’s vice president, liaison to the policy and standards committee, and an accreditation surveyor.
Exhibitor Opportunity

National Conference on Correctional Health Care
Denver Convention Center • October 8-12

Recognition, Influence and Opportunity Are Yours
As the premier name in correctional health care, NCCHC sets the highest standards of excellence by hosting the best educational events in this field. This event will unite nearly 2,000 professionals who desire to improve health care delivery at their facilities. The extensive exhibit hall will showcase offerings from top companies serving this market, connecting them with highly qualified professionals who want to learn about their products and services. Meeting attendees report being highly influenced by the National Conference expo and being significantly involved in correctional health care purchasing. You'll meet more people prepared to purchase on our exhibit floor than you could contact in a year. Put the purchasing power of billions of dollars to work for you!

At NCCHC’s 2004 National Conference, attendees’ postconference evaluations revealed the following:
• 96% visited the Exhibit Hall at least three times
• 85% visited to learn about new products and services
• 97% found the exhibit hall worthwhile
• 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 some 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 1½ 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 treat attendees to music, food and drinks, dancing and networking, all 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.

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.

Advertisers: Find Your Audience Through CorrectCare
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

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Classified Advertising: Ads appear under the following categories: Employment, Meetings, Marketplace.

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.

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 is also posted at the NCCHC Web site.

26 SPRING 2005 • CorrectCare www.ncchc.org
New to the NCCHC Catalog

**Performing Head-To-Toe Assessment**

This breakthrough video provides complete visual guidance that lets nurses master difficult assessments of the head and neck, thorax, breasts, abdomen, arms, legs, genitalia and rectum. Viewers see illustrated anatomy and physiology; step-by-step inspection, palpation, percussion and auscultation techniques with rationales; and how to interpret and document assessment findings. Includes a 20-page companion booklet with normal and abnormal inspection findings, valuable tips and more, plus a test for earning CE credits. This is the same video used by Scott Chavez, PhD, PA-C, OCHP-A, in his popular educational sessions at NCCHC conferences. Published by LWW/Springhouse. (2000) VHS format, 60 minutes, $49.95

**Tobacco Cessation for Correctional Populations: A Health Education Manual.**

One of the few tobacco education/cessation resources specifically developed for use in correctional facilities, this curriculum contains two modules—one provides education on the health effects of tobacco use, the other is a guide for quitting—as well as instructions for facilitators, reproducible handouts and a section listing additional resources. Developed by the National Network on Tobacco Prevention and Poverty with the assistance of NCCHC and other national organizations, tobacco control experts and administrative and health staff of correctional facilities, with funding from the CDC Office on Smoking and Health. The softcover, spiral-bound manual comes with a CD containing PDF and PowerPoint files of the materials; it is available with color transparencies ($125) or without ($75), 2005

**Published by NCCHC**

- **Standards for Opioid Treatment Programs in Correctional Settings.** These standards represent the requirements for correctional-based opioid treatment programs seeking accreditation from NCCHC. In developing these 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. Conforming with the 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. All of the standards are linked to specific federal regulations. 2004. Softcover, $29.95

**Other New Resources**

- Tobacco Cessation for Correctional Populations: A Health Education Manual. One of the few tobacco education/cessation resources specifically developed for use in correctional facilities, this curriculum contains two modules—one provides education on the health effects of tobacco use, the other is a guide for quitting—as well as instructions for facilitators, reproducible handouts and a section listing additional resources. Developed by the National Network on Tobacco Prevention and Poverty with the assistance of NCCHC and other national organizations, tobacco control experts and administrative and health staff of correctional facilities, with funding from the CDC Office on Smoking and Health. The softcover, spiral-bound manual comes with a CD containing PDF and PowerPoint files of the materials; it is available with color transparencies ($125) or without ($75), 2005

- Performing Head-To-Toe Assessment (part of the Expert Nurse Video Series). This breakthrough video provides complete visual guidance that lets nurses master difficult assessments of the head and neck, thorax, breasts, abdomen, arms, legs, genitalia and rectum. Viewers see illustrated anatomy and physiology; step-by-step inspection, palpation, percussion and auscultation techniques with rationales; and how to interpret and document assessment findings. Includes a 20-page companion booklet with normal findings, valuable tips and more, plus a test for earning CE credits. This is the same video used by Scott Chavez, PhD, PA-C, OCHP-A, in his popular educational sessions at NCCHC conferences. Published by LWW/Springhouse. (2000) VHS format, 60 minutes, $49.95

**For Opioid Treatment Programs in Correctional Facilities**

Is your prison, jail or juvenile facility thinking about providing methadone treatment on-site? By federal law, OTPs based in correctional facilities must obtain certification from the Substance Abuse and Mental Health Services Administration, an agency of the U.S. Department of Health and Human Services. But to become certified, an OTP first must be accredited by a federally approved body.

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

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

**Meetings**

**Sheriffs’ Conference.** The National Sheriffs Association will convene 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 14-19 in Georgia at the Westin Savannah Harbor Golf Resort. To learn more, visit www.acfsa.com, or call (952) 928-4658.

**Psychology Convention.** The American Psychological Association will convene August 18-21 in Washington, DC. Find the details at www.apa.org/convention05, or call (800) 374-2721.

**HIV Treatment.** Several federal health agencies and other groups are hosting a conference titled Treatment and Management of HIV Infection in the United States. The meeting is Sept. 15-18 at the Hyatt Regency in Atlanta. Call (770) 277-6313 or visit www.ushidevconference.org/.

**Addiction & Crime.** The Sixth National Conference on Addiction & Criminal Behavior takes place Sept. 18-21 at the Marriott Hotel in St. Louis, MO. For information, call the meeting host, GWG, at (900) 851-5406 or visit www.gwginc.com.

**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) 286-2425.

**Continuing education credits are available through a self-study exam in each issue.**

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For additional information, please contact:

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