Pop! Pop! Fizz! Fizz!

For Chronic Pain Relief, Look Past the Pills

By Kelly J. Egan, PhD, MHA

This is the second of a two-part article. Part One (Vol. 19, Issue 3) introduced the concept of chronic pain and issues common in correctional settings.

It only takes an evening of watching television to pick up the powerful message of the drug companies. “You shouldn’t have to suffer pain. Our drug will stop it. Ask your doctor!” The message is followed by appallingly graphic symptoms you might get as a replacement for your pain.

The message that gets through, though, is that you deserve a pain-free existence through chemicals—swallowed, rubbed in or inhaled. No one is completely immune to this message. The concept of entitlement particularly appeals to me. At the University of Washington Pain Center, an outraged patient once told me, “I came into this world with no pain, and by damn, I’m going out with no pain!”

A Patient Right

The Joint Commission on Accreditation of Healthcare Organizations has established pain management standards for hospitals stating that “pain management is a right for all patients.” The standards also call for providing patients with “pain reduction education” and “continuity of care for pain management.” Similar standards don’t exist for nonhospitalized patients.

We don’t want our inmates to suffer needlessly, however, so prisons can, and should, meet these standards. But correctional physicians need not be concerned if their states do not allow the prescribing of opioids to inmates. Nothing in JCAHO standards says that the pain management has to involve opioids. There are many other strategies and interventions besides medications.

This is a confusing concept to doctors, not to mention the patient who is hurting. Entire medical careers have been built on diagnostic investigations that may, perhaps, lead to a diagnosis and interventions besides medications. The difference between people is how they react to the experience. Culture, family influences and personal experiences cause some people to see the doctor for virtually any symptom, while others avoid seeking professional care under any circumstances. These and all responses in between occur in inmates.

Pain education and self-management techniques for chronic pain should be part of our treatment plans. “Continuity of care for pain management” means follow-up with inmates who report pain problems. Pain management may or may not include medications, but merely prescribing drugs—whether NSAIDS or opioids—is a disservice to our patients. I’ve yet to hear one of our physicians express alarm that we are not providing pain reduction education for inmates.

Providers have had little training in pain management. Medical training teaches elaborate methods, procedures and tests for tracking down the “cause” of the pain. But with chronic pain (longer than three months), the original cause is not what is maintaining the present pain. Tissue damage, strains and sprains have resolved. Even if the original cause is found, it is seldom something that can be “fixed” far out from the onset.

Minimize the Impact

Chronic pain is part of the human condition. Eventually, everybody has one or more chronic pain problems. The difference between people is how they react to the experience. Culture, family influences and personal experiences cause some people to see the doctor for virtually any symptom, while others avoid seeking professional care under any circumstances. These and all responses in between occur in inmates.

It is tempting to attribute an inmate complaint of pain at sick call to manipulation or to drug seeking. That may make it easy for the provider to decide how to deal with the complaint. But you don’t want to ignore a legitimate pain problem that deserves your efforts to help minimize its impact on the individual’s life, functioning and mood. Patients, whether inmates or in the community, deserve your help. They also are entitled to you acting in their best interests in the long term.

Armed with more than a prescription pad, you can help inmates in an invaluable way, far beyond the immediate problem. You can begin to model for them a different way to interact with their doctors and nurses, to teach them about self-management of pain and other health matters. Real cognitive changes in an inmate’s perspective can occur.

This is an outcome with far greater impact than further “medicalizing” the pain by handing out a pill.

Continued on page 16
Introducing NCCHC’s 2006 Board Chair

One-on-One With Nancy White

She dreamt of a career in music, but it was not to be. Just as well: Nancy B. White, MA, LPC, has made her mark on the world, but not by giving audiences the fleeting pleasures of vocal recitals. Instead, she has given countless troubled souls relief from their demons and real hope for a better future.

A highly accomplished professional counselor, White has devoted most of her career to helping mentally ill and substance abusing individuals involved in the criminal justice system. Now, nearly 30 years after starting out as a practicum student at the Municipal Correctional Institution in Kansas City, MO, she is back at that same city jail managing a project that provides a continuum of care for inmates with mental health needs.

The project is under the auspices of White’s employer, Truman Medical Center, where she also manages other corrections-related projects.

A highly important element of the MCI project is the case manager who links clients with needed services in the community upon release. “We hope these individuals will be able to avoid the criminal justice system in the future,” White says.

In fact, she would prefer that many mentally ill clients never be jailed in the first place. She notes that the national goal of “assimilation,” coupled with widespread closures of state and local mental health facilities, had unintended consequences.

“Some people have done a miraculous job in living productive lives, but others needed the supervision and structure of the hospital or habilitation center, and some of them have not done so well. They have become homeless, stopped taking their medications and committed crimes. They may be locked up for very minor offenses because the system does not know what to do with them. She also decries a lack of funds and programs for substance abuse prevention and education.

Two Trends

In the 13 years since White joined the NCCHC board, she has seen this trend mushroom and says jails have become “a revolving door” for people who instead should receive treatment in the community. That insight underlies one of her goals as board chair: to raise awareness that jails and prisons are “the new mental hospitals.”

White also is a strong advocate for another trend: the use of mental health courts to divert certain offenders from incarceration. “It is a productive solution to the mentally ill consumer who has committed a nuisance crime,” she says, adding that some mentally ill offenders do require incarceration.

Regardless of circumstances, many such individuals do end up behind bars, and that’s why NCCHC’s health services standards and accreditation remain so vital, White says. She also strongly supports NCCHC’s accreditation of opioid treatment programs in jails and prisons.

On a personal note, White comes from a very close-knit family and is a fervent aunt to her adolescent niece and nephew. She herself had good parents who instead should receive treatment in the community. That’s why NCCHC’s health services standards and accreditation remain so vital, White says. She also strongly supports NCCHC’s accreditation of opioid treatment programs in jails and prisons.

Curriculum Vitae

Nancy B. White, MA, LPC

Formative Years

• Born, raised and continues to live in Kansas City, MO
• BA degree, music education and vocal performance, Avila College, Kansas City, 1976
• MA degree, counseling and guidance, University of Missouri, 1978

Professional Career

• Nearly 30 years experience in the criminal justice field working with adults and juveniles with substance abuse and mental health issues
• Municipal Correctional Institution: manage grant-funded mental health program to provide inmates with evaluation, care, counseling, case management and linkages to community supports
• Truman Medical Center Behavioral Health: team leader of program to treat homeless, dually diagnosed substance abusers
• Numerous positions creating, administering and facilitating counseling programs

Professional Record

• Licensed Professional Counselor, National Certified Counselor, Master Addictions Counselor
• Involved with the American Counseling Association and state affiliates in Missouri and Kansas, as well as International Association of Addiction and Offender Counselors
• Served in various board roles and received numerous honors from the ACA’s Missouri affiliate
• Appointed by two governors for two terms to the state’s licensing body for professional counselors

Board Update

We are pleased to welcome three new board members, one of whom represents a group that has just become a supporting organization of NCCHC.

• At its annual meeting in November, the NCCHC board approved the National Association of Social Workers as our 38th supporting organization. Established in 1955, NASW is the world’s largest membership organization of social workers, with over 152,000 members and 56 chapters. With social workers’ widespread involvement in correctional health care, the association’s support will be an asset to the Commission. The NASW representative on the board is Judith Robbins, LCSW, JD, CCHP. Robbins directs the juvenile detention mental health program in Connecticut, where services are provided by Yale Behavioral Health Department of Psychiatry.

• Renee Kanan, MD, MPH, has become the representative of the American College of Physicians. Kanan has worked in prison health care for 10 years, and held director-level positions for the state departments of corrections in Washington and California, where she currently works.

• Kevin Fiscella, MD, MPH, now represents the American Society of Addiction Medicine. Among his many professional activities, Fiscella is a tenured associate professor of family medicine and community and preventive medicine at the University of Rochester (NY) School of Medicine and Dentistry.
Award Winners Wow the Crowd at National Conference

The recipients of NCCHC’s 2005 awards are an inspiring group, illustrating both the high level of commitment to quality in correctional health care and the challenges that this field continues to face. The awards were presented in October at the National Conference in Denver.

Bernard P. Harrison Award of Merit
NCCHC’s highest honor, this award is presented to an individual or group that has demonstrated excellence and service to the correctional health care field, either through an individual project or a history of service.

Betty J. Hron, RN, CCHP-A
Betty Hron has a 25-year record of dedication to the correctional health care field that is truly impressive. A loyal friend of the Commission, she has volunteered at NCCHC educational conferences for years, conducting seminars, moderating sessions, registering attendees, you name it.

Hron is a consummate professional who sought not only to advance her own career by becoming certified in 1992 (reaching “advanced” status just three years later) but also to help advance the field by becoming an accreditation surveyor. She is a member of NCCHC’s survey advisory committee and for many years served on the CCHP board of trustees.

Hron’s professional experience is extensive. She was the health services administrator at Jefferson Community Correctional Center in Louisiana for 23 years. She also was a member of the medical expert team for the federal magistrate in the Eastern District of Louisiana for about 10 years.

She’s now officially retired, but that word doesn’t mean much for a tireless worker like Hron. A lead surveyor since 1993, she conducts about 25 accreditation surveys per year and relishes her time in the field. “It gives me an opportunity to share much of the knowledge I have gained over the last 25 years.” She also shares her knowledge with other

letters...letters...letters...

Refusal of Care
I have a comment on the article “When an Inmate Refuses Medical Care” by attorney Robert Vogt [Vol. 19, Issue 3]. While informative and well-written, the article made a crucial omission. Nowhere does it mention that one of the first orders of business for a refusal of key medical care is the correctional practitioner’s obligation to establish, and to document, the competency of the inmate to refuse. Legally, only refusals executed by competent inmates would stand. This is a fascinating area of correctional medicine-law that dovetails with common issues among incarcerated people such as living wills, advance directives, hunger strikes and the like.

Joseph Paris, MD
Medical Director
Georgia Department of Corrections

The Author Replies
The premise of the article, perhaps too subtle, was the Supreme Court’s Cruzen decision, which is quoted in the article as stating, “A competent person has a constitutional right to refuse unwanted medical treatment.”

Robert P. Vogt, JD
Chicago, Illinois

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New Trustee Brings Administrative Chops to CCHP Board

BY MATISSA SAMMONS

The latest CCHP to earn the distinction of serving as trustee on the CCHP board of directors is Joseph R. Marocco, MPA, CCHP. Although he’s fairly new to certification, Marocco is no newcomer to health care. He has been an administrator in this industry for the past 33 years, starting his career in 1973 in the Rhode Island health care system.

He has held his current position as associate director of health care services at the Rhode Island Department of Corrections since 1990. Why transition from the hospital system to the correctional health care field? A federal court case was filed against the state of Rhode Island Department of Corrections since 1990. Rhode Island, which prompted DOC officials to enlist Marocco’s help in raising health care systems in state prisons to an acceptable level. He accepted the job and hasn’t looked back.

“Today I am proud to say that we comply with NCCHC standards in Rhode Island,” Marocco adds.

High-level Leader

In his role as associate director, Marocco is responsible for all administrative functions in the health care services unit of the Rhode Island DOC. This includes budgeting, contracting and auditing of contracts. He also oversees staff in all health services departments: medical, nursing, mental health, pharmacy, dental, x-ray, medical records and clerical support.

That’s enough to fill anyone’s day planner, but Marocco recently received another assignment, and it’s one that he relishes. He is the DOC’s representative on a statewide task force to address emergency management. Recent natural disasters and terrorism threats around the globe have prompted the state to more carefully evaluate and improve its emergency management systems.

Marocco has attended programs sponsored by FEMA as well as other state and federal agencies to help the Rhode Island DOC better prepare in the event of a catastrophic emergency.

The Value of Certification

For such a dedicated professional, seeking certification was practically inevitable. Marocco, who became a CCHP in 2003, says the credential has brought him a “level of recognition” that is an advantage when working with people outside of corrections as well as peers in this field.

Marocco views the immense network of opportunities as one of the greatest benefits of certification. To that end, he takes every opportunity to talk with colleagues and use them as sounding boards for ideas about addressing the specific challenges of working in this unique field.

Personally, he’s picked up a few friends along the way.

Reflecting on his start in correctional health care, Marocco feels it imperative that professionals in this field earn certification to better defend themselves and their facilities should their practices be called into question. “In today’s litigious world, it only works to a person’s benefit, especially when testifying in court.”

With such a pragmatic mindset, Marocco surely will be an asset to the CCHP program. When asked what he aims to accomplish during his term on the board of trustees, he said that he hopes to increase recruitment into the CCHP ranks by “spreading the word about NCCHC and its ability to help professionals deal with problems they experience on a daily basis in a professional manner.”

Matissa Sammons is the professional services assistant at NCCHC.

CCHP Program Celebrates 15 Years

At the 2005 National Conference in Denver, special honors were given to CCHPs who were among the first to become certified. This year, 50 of the original class of CCHPs celebrate with us. Way to go! To learn about the history of the program, visit our Web site at www.ncchc.org/cchp.

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CCHP Exam Dates and Sites

- February 4: Regional sites: Daytona, FL; Atlanta, GA; Champaign, IL; Shelby, MT; Richmond, VA; Charleston, WV; Salt Lake City, UT; and others
- April 9: Las Vegas, at the Updates in Correctional Health Care conference
- May 11, Durham, NC, at the American Correctional Health Services Association conference (application deadline March 1)
- May 15, Wisconsin Dells, WI, at the Wisconsin Corrections Conference (application deadline March 1)
- August 5: Regional sites to be determined
- October 29: Atlanta, at the National Conference on Correctional Health Care Application deadlines are the first day of the month preceding the test month, except as noted. If you are interested in hosting an exam at your facility or proctoring an exam, contact us at cchp@ncche.org or (773) 880-1460.
Your fellow 1,700-plus CCHPs, welcome, and congratulations!
The Certified Correctional Health Professional board of trustees is pleased to
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Florida Department of Juvenile Justice
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McNeil Island Correctional Center
Steilacoom, WA
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Correctional Health Services Corp.
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State of Maryland / MTA
Sparks, MD
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Lakewood, CO
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McNeil Island Corrections Center
Auburn, WA
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Chicago, IL
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Pinal County Correctional Health
Apache Junction, AZ
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Denver Health and Hospital
Lakewood, CO
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Community Education Centers
Roseland, NJ
Luis J. Rodriguez, PsyD, CCHP
Hospital Psiquiátrico de Salud Corr
San Juan, PR
Esther Rodriguez Guerra, PhD, CCHP
Correctional Health Services Corp.
San Juan, PR
Ruben Roman, OD, CCHP
Río Piedras Correctional Facility
Trujillo Alto, PR
Diane Schissler, RN, CCHP
Adams County Detention Facility
Brighton, CO
Vivian A. Silva, BS, CCHP
Hospital Psiquiátrico Correccional
Guaynabo, PR
Linda Sinchak, RN, BSN, CCHP
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Denver City & County Jail
Denver, CO
Thomas J. Tooman, LPN, CCHP
PrimeCare Medical Inc.
Harrisburg, PA
Kelley E. Trabal Quiles, RHA, CCHP
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Mayaguez, PR
Kathryn L. Villano, MD, CCHP
Correctional Health Services Miami, FL
Erik Von Kiel, DO, CCHP
Lehigh County Prison
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Correctional Healthcare Management/MSC
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Adams County Adult Correctional Complex
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www.ncchec.org
Take Charge of Your Future With Academy CareerCenter

The Academy of Correctional Health Professionals is launching a new and expanded employment resource: the Academy CareerCenter. Available at the Academy Web site, the CareerCenter is the most comprehensive career and recruiting site dedicated to serving the correctional health care field. The site offers many new features for individuals and organizations to facilitate employment connections.

For Job Seekers: Your Key to Career Success

Are you looking for a new job or moving to a new area? Just entering the field or curious about other career opportunities? If you answered “yes,” then the Academy CareerCenter will be invaluable tool for you. Active job seekers can showcase their skills and work experience to prospective employers, while others can take advantage of networking, training and career development services. Utilize this unique resource and take charge of your future.

- Job search control — Quickly and easily find relevant industry job listings and sign up for automatic e-mail notifications of new jobs that match your criteria.
- Easy job application — Apply online and create a password-protected account for managing your search.
- Resume posting — Make your resume available to employers in the industry, confidentially if you choose.
- Saved jobs — Quickly save up to 100 jobs to a folder in your account, then come back to apply when you are ready.
- RSS capability — If you have an RSS reader, you can receive new job notifications by e-mail as soon as they are posted!
- Mentor program — Academy members can participate in this unique opportunity to learn from a mentor.
- Certification and Education Take You Even Further

The Academy are another great way to expand knowledge in a broad array of specialties, such as medical, dental, mental health, administration, infection control, accreditation and staff issues, to name a few. Mentors provide professional guidance along with invaluable networking opportunities.

Mentor Program Promotes Professional Growth

A positive experience can have a profound effect on a person’s perspective of themselves. The Academy of Correctional Health Professionals’ mentor program is definitely a positive experience! Designed especially for health care professionals who are new to the correctional field or those who are new to a specific position, the program pairs Academy members with qualified mentors who can assist with their professional growth and development.

Correctional health care brings unique problems and concerns. A mentor can help to alleviate these. Mentors have experience and expertise in a wide variety of specialties, such as medical, dental, mental health, administration, infection control, accreditation and staff issues, to name a few. Mentors provide professional guidance along with invaluable networking opportunities. Academy members can participate in this unique opportunity to learn from a professional mentor by visiting the Career Services / Mentor Program section of the Academy Web site (www.correctionalhealth.org). Not a member? We encourage you to join the Academy to take advantage of this and other great opportunities and benefits you will receive with membership. Perhaps you would like to become a mentor? The Web site has information on this, as well.

Certification and Education Take You Even Further

Whether or not you use a mentor, one sure way to foster professional growth is to become a Certified Correctional Health Professional. The only such certification in the nation, this NCCHC program also has an advanced component for professionals who have already attained the basic CCHP credential. National and—new in 2006—regional conferences and seminars hosted by NCCHC and the Academy are another great way to expand knowledge in a broad array of topics. Learn more about these offerings online at www.nccchc.org.

For Employers: Hire Smarter

Target your recruiting and reach qualified candidates quickly and easily! The Academy CareerCenter gives employers and recruiters access to the most qualified talent pool with relevant work experience.

- Incredible exposure for job listings — The Academy represents the largest audience of correctional health professionals in the nation.
- Higher quality candidates — Academy members are the top professionals in the industry.
- Easy online job management — Employers can enter and edit job descriptions, check the status of postings, renew or discontinue postings, and even make payments online.
- Resume searching access — With a paid job listing, employers can search the database of resumes and proactively contact candidates; they also can opt to receive notification by e-mail when new resumes match their job criteria.
- Build company awareness — Along with each job posting, employers can provide information about their company and links to their Web site.
- Special introductory pricing — Through March 31, employers will receive 20% off regular posting rates!

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For more information, please call our national headquarters office at 1-800-ACHP (234-7727) or e-mail us at: academy@correctionalhealth.org.
THE VALUE OF OPEN ACCESS TO ATYPICAL ANTI PSYCHOTIC MEDICATIONS

Clinical Differences Among Atypical Antipsychotic Medications

WHAT IS OPEN ACCESS?

Open access is a healthcare 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.1

WHY IS OPEN ACCESS TO ATYPICAL ANTI PSYCHOTIC 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.5

2. Drug costs represent only a small portion of the total costs of treating schizophrenia and most other mental health conditions.5

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 hospitalizations8 and reduce the need for concomitant antidepressants and mood stabilizers.5

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, have 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 ANTI PSYCHOTIC MEDICATION THAT IS MOST APPROPRIATE FOR THEIR INDIVIDUAL PATIENTS.

References

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Whatcom County Jail’s Past Guides Its Future

BY JAIME SHIMKUS

The year was 1977. Jimmy Carter took office as president. “Stars Wars” shattered box-office records. The first viable PCs hit the market. Elvis kicked the bucket.

In Bellingham, WA, brave administrators at the Whatcom County Jail agreed to let outsiders poke around the medical department to see whether it measured up to brand-new standards from the American Medical Association.

That confident act set the stage for what would become an unbroken 29-year (and counting) tradition of accreditation from the National Commission and its AMA precursor.

While that feat is admirable, longevity is not the only reason the jail was honored with NCCHC’s 2005 Facility of the Year Award. According to the committee that selects recipients, Whatcom is “an exemplary small, rural jail that has close ties and cooperative relationships with the community it serves.” (See page 3 to read about all of the award winners.)

Those close community ties reach right into the health service department. When the jail was first accredited, direct health care was provided by the county health department. But 10 years ago the county wanted out of the correctional health care business, and the jail was forced to fill the gap, says Chief of Corrections Lt. Wendy Jones, who has worked at the jail for 24 years.

Jones believes that contracting with health care professionals yields better results than running the service in-house, and already had providers in place for medical, dental and mental health. But the solution to daily nursing coverage required a “big leap”: She engaged Visiting Nurse Personal Services, a well-established, well-respected not-for-profit that offered home health and other services in the community.

From the perspectives of client and contractor alike, it’s been an unqualified success.

Compliance and Quality

Among the things Jones values most from the VNPS crew is the intense focus on quality improvement and on meeting the NCCHC jail standards. In this jail, the two are closely linked: “Each year we do a QI study for every one of the standards,” says health services administrator Jean Beck, RN, who leads the effort. “It’s one of our biggest accomplishments.”

She pores over the compliance indicators and checks written policies and procedures as well as actual practices. In this she works closely with nursing supervisor Shari Holst, RN, OCHP, who follows up to correct any lapses. “I make sure the nurses know what the standards are, why they exist, what we must do to meet them on a daily basis,” says Holst.

Message received: “All health staff are involved in [QI] work and strive toward positive outcomes for inmates and good survey results,” Brock says.

One recent improvement spurred by the QI effort is routine testing for STDs as part of each inmate’s physical exam, rather than testing only based on patient complaints or clinical symptoms. “We’re catching a lot of things in asymptomatic patients that may have ended up back in the community,” says Holst. “Now we treat it and educate the patient. We feel good about that.”

Fully Staffed!

The jail also benefits from the VNPS agency’s staffing expertise. Despite the difficulties of finding and retaining qualified nurses (common to jails everywhere), the plan is to expand the VNPS crew to provide on-site, around-the-clock nursing care, a full-time physician—and a larger staff.

In this jail, the two are closely linked: “Accreditation and to attend NCCHC national meetings or the need to balance the budget. It’s a great check and balance.” — Lt. Wendy Jones, Chief of Corrections

Facility: The medium-security jail was built in 1983 and is part of the downtown county complex. Due to overcrowding a new facility is being built for minimum-security inmates, and plans are being developed to replace the main facility in about eight years.

Correctional Population: The average daily census is 261. The jail houses male and female adult detainees whose average length of stay is 23 days, though stays may last up to one year. Annual admissions exceed 6,000. The jail also houses some federal and Native American tribal prisoners.

Health Care Staffing & Services: Routine medical, mental health and dental services are provided on-site. Acute cases are sent to the local hospital as there is no inpatient. Nursing coverage is provided from 7 am to 9 pm on weekdays and 7 am to 3 pm on weekends and holidays.

Staffing is secured via contract with agencies and professionals in the community. Employed by VNPS are the health services administrator (10 hours/week), medical director (6 hours/month), 8 nurses and 2 medical records clerks. On-site part-time are the clinical physician, psychiatrist and dentist. Pharmacy, radiology and laboratory services also are provided via contract.

Accreditation: The jail has been continuously accredited since 1977; it was last surveyed in 2004.

Quoteworthy: “Accreditation provides oversight that makes sure health care doesn’t get lost in the shuffle of custody requirements or the need to balance the budget. It’s a great check and balance.” — Lt. Wendy Jones, Chief of Corrections

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**Clinical Briefs**

**Asthma Treatment for Juveniles**

Youths with mild-to-moderate persistent asthma have better clinical outcomes with inhaled corticosteroids than with leukotriene receptor antagonists (LTRAs), according to a study by the U.S. National Heart, Lung, and Blood Institute. Children ages 6 to 17 received either an inhaled corticosteroid (fluticasone propionate) twice daily or an LTRA (montelukast) nightly. Both groups had improvements in many measures of asthma control, but results were greater with the corticosteroid after eight weeks of treatment. The study appeared in the January issue of the *Journal of Allergy and Clinical Immunology* and is available at www.jacionline.org/article/PIIS0091674905022670/fulltext.

**Low Back Pain Treatment**

Physical therapy had no edge over cognitive-behavioral therapy in a study of treatment for chronic low back pain. After 10 weeks, patients who received physical therapy, cognitive therapy or both reported improvements in outcome compared to those who received no treatment. Significant reductions were seen in self-reported functional limitations, main complaints and pain intensity. No “clinically relevant differences” between the combined and the single component treatments were found. Published Jan. 20 in *Musculoskeletal Disorders*, the study is available at www.biomedcentral.com/1471-2474/7/5/abstract.

**CPR Simplified**

New guidelines aim to save more lives by simplifying cardiopulmonary resuscitation: they emphasize effective chest compression and simplify ventilation information for single-rescuer CPR. To increase blood flow, 30 compressions for every two rescue breaths is now recommended, vs. 15 compressions for every two breaths in the 2000 guidelines. The rate of compressions—100 per minute—has not changed. The guidelines also include changes in use of automatic external defibrillators. Issued by the American Heart Association in November, the guidelines are meant for medical professionals and first responders, as well as laypersons. The complete guidelines and highlights of the changes can be accessed online at www.americanheart.org; click on the “CPR & ECC” link.

**HIV/AIDS Clinician Toolkit**

The AIDS Education and Training Center is offering a free HIV/AIDS Clinician Toolkit on CD. It contains federal treatment and prevention guidelines and recommendations, training slide sets, reference materials, clinician support tools, a curriculum on incorporating HIV prevention into the medical care of HIV patients and patient education information. To obtain the CD, call the AETC’s National Resource Center at (973) 972-6587 or e-mail nrc@aidsetc.org.

**Beyond a reasonable doubt... Medi-Dose® and TampAlert®**

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**In Memoriam: William J. Byland, DDS**

One of the early leaders in the field of correctional health care, William J. Byland, DDS, passed away on December 24, succumbing to a brain tumor at age 87. Among the many hallmarks of his long and illustrious career, Dr. Byland was the recipient of NCCHC’s Bernard P. Harrison Award of Merit in 2002, the first dental professional to receive that honor. A fellow of the American College of Dentists, Dr. Byland spent 20 years in private practice before giving corrections a try in 1974. He enjoyed working with inmates and spent the rest of his career in this field. He left an indelible mark, says William J. Rold, JD, CCHP-A, a longtime colleague. “Dr. Byland’s career emphasized the importance of dental care as an integral part of the larger correctional health care system. He insisted with his considerable gifts, and sometimes with his wry Midwestern wit, that dental care have a place at the table—and he helped to set that table.”

Dr. Byland was instrumental in establishing NCCHC’s standards and shaping its accreditation program. During his long tenure at the Michigan Department of Corrections, he did pioneering work in developing policies and procedures, quality assurance programs and more. As he neared retirement, he worked extensively as a consultant and expert witness.
When our regular sick-call nurse quit, I thought I’d have to fight hordes of senior RNs clamoring to take on her position. Boy, was I wrong.

Cumberland County Jail in Portland, ME, has a population in the vicinity of 500 inmates on nine pods (two smaller and seven larger ones). Triaging out on the pods and utilizing nursing protocols appeared to me to be the epitome of interest- ing work. I really wanted to go out among the jail population, work with the inmates’ myriad medical, dental and psychiatric problems—and fix these problems wherever I could.

When the dust settled and I had finally experienced the sick-call regimen, however, I found that I had leapt blindly into the chaos of frenzied overwork—alone. I discovered why nobody wanted this job. Sick-call procedures were very disorganized and time-consuming, and everything conspired to make the job more difficult.

The sick-call slips were available to inmates 24/7. This system allowed them enough time to think of trivial complaints. (For example, I had to address issues such as, “I’m allergic to hot dogs and beans.” When I asked the inmate which doctor had diagnosed this allergy, he just chuckled.) Inmates wrote their medical requests on the slips and placed them in boxes that were emptied nightly on all nine pods.

In the morning, I had to wade through hundreds of slips, many of which described multiple problems (“my foot hurts, I have heartburn, I have athlete’s foot and I have to see the psychiatrist”). Triaging the requests in the medical department took hours. By the time I actually got to the pods, I found that I was able to take care of only 15 to 20 medical requests, and that was on a good day.

Naturally grievances ran rampant. In the inmates’ minds, their medical issues were being ignored since it was impossible to process all of their requests in a timely manner.

No one was happy—not the inmates, not me, not the medical administrators. Our director of nursing and our health services administrator decided that enough was enough. We had to fix this.

Seeking a Solution

Thus, our three-member committee for quality improvement was formed, made up of veteran nursing staff members who were familiar with the situation and motivated to improve it. The committee was charged with assessing the problem and suggesting solutions, and was given time and resources during work hours to do so.

Our first task—identifying the problem—was simple. The present system placed too many demands on one person to be handled in a timely fashion. The first few times I did sick call, because of the sheer volume of daily requests and the sheer impossibility of getting to them all, I found myself triaging requests from weeks ago. The committee counted the slips coming into the sick-call boxes, and they averaged around 118 per 24 hours—all to be addressed by one nurse.

We had to find a way to change a system that could not work, and we did. We created a pilot program that we called “open sick call.” Using this model, I would go to a pod with the sick-call slips and call out, “Open sick call! Fill out slips, stand in line and come on in when the other guy comes out!” Then I’d set up shop in the triage room and cringe.

In the first few months it was a feeding frenzy. Following this procedure, I could get through only a few pods in a day while promising the others I’d get to them in the next week or so. The next day, I’d open sick call in the next pods. But by going through the pods in order, I soon found that I could complete all nine in about a week and a half. I could take care of around 56 problems per day instead of the usual 15 or 20.

This had a snowball effect: Because sick call was being done more quickly, the inmates’ medical problems were not compounded and so they had fewer sick-call needs. After a little while, I could get the entire jail done in one day. Medical needs were being met almost immediately, so there was no backlog.

The pilot program worked so well that it quickly became official procedure. With this system, the sick-call nurse was capable of triaging and addressing inmates’ medical problems on all nine pods twice a week.

Fine-tuning the Process

However, even that did not meet the NCCHC standards, which state that all sick-call issues must be addressed within 24 hours on weekdays and 72 hours on weekends (J-E-07).

What a daunting task. Time to tweak the process. When we did, we found that we actually could meet the standards.

We simply divided the work. The regular sick-call nurse continued to handle the seven large pods, while the intake nurse took over the task in the two small pods, where there are usually only a few issues to address. With this system, sick call for the jail initially took two days.

Very soon, however, we were doing on-site sick call for the entire jail on a daily basis five days a week.

Still not quite good enough. To meet the standards, we now do sick call on weekdays and holidays, even though technically no sick-call nurse is on duty those days and it’s handled by the intake nurse.

Our new sick-call procedure works this way. Monday through Friday, the sick-call nurses go to the classroom in each pod throughout the day, announce sick call and leave the slips on tables in the middle of the pod.

The inmates line up for the slips and fill them out on the spot. They then come in to see the nurse, one at a time, first come, first served.

The nurse reads the slip and listens to the inmate describe the problem or problems. This is necessary because not all inmates can write adequate descriptions. If an inmate cannot read or write, I fill out their slip system. I happen to speak Spanish, so I can help Spanish-speaking inmates describe their problem. (I should stress that communication skills are important to this whole procedure.)

So first I read and listen. Second, I assess the inmates while they read the pertinent information about their specific problem from the nursing protocol book. If they cannot do this, I explain it to them, or translate for Spanish-speaking inmates.

Assessment and Triage

The nursing assessment usually takes about five minutes, depending on the problem. Most problems can be dealt with by normal nursing protocols. If it’s a common cold, for example, I give the inmate the normal cold pack.

If the problem is something that

The nursing protocol does not address (for example, someone with hepatitis C complaining of liver pain), the inmate is on a “provider’s list” to see the facility’s physician or physician’s assistant.

If it’s a psychiatric problem, I take the sick-call slip afterward and drop it in the psyche box for triage by our mental health staff. Of course, if the inmate’s need is urgent, then the mental health staff is summoned immediately.

Dental issues are assessed via on-site sick call and addressed appropriately. For example, indications of an abscess would be placed on the medical provider’s list to be seen immediately to determine the need for antibiotics. If the need isn’t urgent, the inmate is placed on the dentist’s list and is given appropriate pain meds as per nursing protocols.

As a rule, the aim is to keep inmates off the provider’s list, thereby reducing the need for more serious problems. By going through this process regularly, inmates become better acquainted with the entire sick-call process and learn to handle it more efficiently. This, too, lowers the number of visits and time per visit.

On weekends and holidays the procedure differs somewhat. As there is no sick-call nurse on schedule, the intake nurse goes to all nine pods and hands out sick-call slips to all who request them. We plead for mercy, though, asking the inmates to save trivial complaints for later.

The slips are taken back to medical and triaged there. Urgent issues are addressed immediately, while routine requests (“Can I have another mattress?”) will be addressed on Monday if it’s a weekend, or the next day if it’s a holiday.

As always, walk-ins are welcome 24/7. And our corrections officers are most diligent and will call the medical department whenever an inmate requests medical care. Thus, all of the inmates’ medical issues are addressed, whether by on-site sick call or by triage, seven days a week.

Sweet Silence

The procedure works. The nurses are not overworked and rushing to keep up with the backlog. In fact, there is no backlog. Health needs are met so quickly that problems don’t escalate and thus the total number of requests is minimized.

Now, rather than being overwhelmed with requests, I find that sick call is sometimes blocked by silent indifference. I go to the pods, throw sick-call slips on the table and yell, “Open sick call! Anything new since...umm...yesterday? Please?” They mostly tell me to go away.

Margo Dowdy, RN, C, is employed by Correctional Medical Services and works at the Cumberland County Jail in Portland, ME.
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Hot Topics
Here are just a few of the outstanding and timely sessions on the lineup:
- Hurricane Rita: The Texas Story
- Self-injurious Behaviors: Assessment and Management
- Leadership Empowerment for Nurse Managers
- Pressure to Treat: A Realistic Approach to Hypertension
- Transgender Clients in the Correctional System
- You Be the Judge: A Mock Trial Involving an Inmate’s Claim
- Creating an In-custody Pain Management Clinic
- Visual Diagnoses: The Eye Doesn’t See What the Mind Doesn’t Know

Preconference Seminars
Begin with one or more of the interactive preconference seminars. Appropriate for both the novice and the experienced professional, the seminars provide a comprehensive look at complex issues. Conference registration is not required to take part in the seminars.

Saturday, April 8
- An In-Depth Look at NCCHC’s Standards for Health Services in Prisons and Jails (full-day)
- The Correctional Nursing Assessment (half-day)

Sunday, April 9 (half-day sessions)
- An In-Depth Look at NCCHC’s Mental Health Guidelines
- Risk Management in the Correctional Environment
- Pain Management in Corrections
- Rethinking Mental Health Care in Corrections (Free! Sponsored by Pfizer Inc.)

Future CCHPs
On Sunday, the CCHP exam will be administered to qualified applicants. Don’t miss this opportunity to add the CCHP designation to your name. Apply for certification no later than March 1 to be eligible to take the exam. Visit www.ncchc.org/cchp for details.

Accommodations and Travel
Conference Hotel
The Flamingo Las Vegas is the headquarters hotel. Set on the famous four corners at Las Vegas Blvd. and Flamingo Road, the hotel has anchored the Las Vegas Strip since they started rolling dice in 1946. Guests are treated to the ultimate self-contained resort experience: 15 acres of exotic foliage; an extravagant wildlife habitat; and four pools, with cascading waterfalls, for swimming and sunbathing. The hotel’s Showroom features major entertainers, and the casinos offer action nonstop.

Reservations made before March 17 will receive a discounted rate of $104 (excluding taxes). Rooms will be assigned on a first-come, first-served basis.

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Known as the Entertainment Capital of the World, Las Vegas is a feast for the senses. The city offers luxurious hotels, unique shopping, dazzling stage shows, first-rate dining and world-class golfing, not to mention the exciting nightlife. Apart from the ubiquitous gaming, visitors give high marks to these popular attractions:
- Cirque du Soleil (O, KA and Mystere)
- Blue Man Group
- Fountains at Bellagio
- Star Trek: The Experience
- Stratosphere Tower
- Elvis-A-Rama Museum

Need a break from the razzle-dazzle? Surrounding the city is a world of natural beauty. The Red Rock Canyon National Conservation Area has unique rock formations that attract climbers and photographers. For water sports, visit beautiful Lake Mead.

To scope out all of your options, visit the Web at www.vegasfreedom.com or call (702) 892-0711.

Registration Information
Early Bird Discount
Register by March 1 and save $50!

Preregistration Policy
To be considered preregistered, your registration with full payment must be received at NCCHC by March 31. After this date, registrations will be processed on site.

Payment
Registration must include check, credit card payment or purchase order (POs accepted only from government agencies and their contractors; a $15 processing fee will be assessed).

Registration Confirmation
You will receive written confirmation of registration. Please allow three weeks. Badges and other meeting materials will be distributed when you check in at the conference registration desk.

Cancellation and Substitution Policy
Notification must be submitted in writing. Cancellations postmarked or faxed by March 10 will be refunded less a $50 fee. No refunds will be made for cancellations after March 10. Delegate substitutions are allowed, but NCCHC must receive written notification. Registrants who fail to attend and do not notify NCCHC are responsible for full payment.

Registration Center
All attendees must check in at the registration desk on the third floor of the Flamingo, where badges and conference materials will be distributed. Registration hours begin at 8 a.m. on Saturday and Sunday, and 7 a.m. on Monday and Tuesday.

Guest Registration
Guests or spouses of registered attendees receive a special rate of $45, which provides access to all exhibits, shows, and conference materials. Please notify NCCHC if you will be bringing a guest. All guest registration fees are due at the time of preregistration.

Preconference Seminar Fees
Guest $ 45 $ 45
One day $160 $160
Guest $ 45 $ 45

Registration Fees

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Preconference Seminar Fees
Fees cover all materials and refreshment breaks.
- Full-day seminars $170
- Half-day seminars $85
- Rethinking Mental Health Care in Corrections (Sunday) Free
* preregistration required

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Sponsored by the National Commission on Correctional Health Care and the Academy of Correctional Health Professionals
Find complete conference information and online registration at www.ncchc.org.
Disabled Inmate Can Sue State

The U.S. Supreme Court in January ruled unanimously that a Georgia prisoner could sue the state for damages under the 1990 Americans with Disabilities Act. In the original case, a 41-year-old inmate said the state did not accommodate his disability, according to Associated Press reports. He said that his cell was so narrow that he could not turn his wheelchair, and that he seriously injured himself trying to reach the toilet. Georgia was backed by 12 other states in arguing that states should be immune from inmate lawsuits brought under the ADA. In a ruling that avoids federalism issues, the justices focused on the alleged constitutional violation, not the ADA, in finding that the 11th U.S. Circuit Court of Appeals should not have dismissed the inmate's claims.

$5 Million for Mentally Ill Offender Act

President Bush signed a 2006 appropriations bill that provides $5 million in funding for the Mentally Ill Offender Treatment and Crime Reduction Act, which he signed into law in 2004. The funds will support a grant program “to help states and counties design and implement collaborative efforts between criminal justice and mental health programs,” says Sen. Mike DeWine (R-OH), who sponsored the 2004 act and helped secure the 2006 funding. “If we can break the cycle by giving [nonviolent, mentally ill offenders] necessary mental health treatment, we can offer hope and a better chance of rehabilitation,” he said in a news release.

SAMHSA Opioid Treatment Guide

The Substance Abuse and Mental Health Services Administration has released a Treatment Improvement Protocol (TIP) with guidelines on effective practices and care for opioid treatment programs, which serve people addicted to heroin or other opiates. TIP 43 explains that medication-assisted treatment integrates pharmacotherapy with psychosocial and medical treatment for a more comprehensive, individually tailored program. To download the guide, go to the Web at www.samhsa.gov/products/manuals/tips.

FDA Improves Rx Drug Insert Format

No longer will clinicians have to hunt for key information in prescription drug inserts. To help reduce medication errors, the FDA has unveiled a “clear and concise” format. Major features: a new Highlights section with the most important prescribing information about benefits and risks; a Table of Contents; the date of initial approval to easily determine how long a product has been on the market; and a toll-free number and Internet site to encourage reporting of suspected adverse effects. Also, drug makers will be required to list all substantive changes made within the year. The FDA also requires drug makers to submit label information in a new electronic format for easy access to product information.

Incarceration Stats

The latest from the U.S. Department of Justice's Bureau of Justice Statistics. The first item below comes from “Probation and Parole in the United States, 2004”; the others are from “Prisoners in 2004.” Both reports are online at www.ojp.usdoj.gov/bjs.

• The number of adults in prison, in jail, on probation or on parole in the United States reached almost 7 million in 2004. This is roughly a 30% increase since 1995.

• At year-end 2004, nearly 2.3 million people were behind bars. Of these, 1.4 million were in federal and state prisons, 713,990 were in local jails, 102,338 were in juvenile facilities, and the remainder were in other types of facilities.

• The U.S. prison population rose 1.9% in 1994. This increase is lower than the 3.2% average annual growth rate during the last decade. However, 10 states had population increases of at least 5%; 11 reported decreases.

• On Dec. 31, 2004, 24 state prison systems were operating at or above capacity. The federal system was 40% over capacity.

• The growth rate of women in prison (4.8% average from 1995 to 2004) is rising faster than that of men (3.1%). In 2004, 7% of prisoners were women, up from 6.1% in 1995.

Lit Review

• The Scope and Impact of Treatment of Latent Tuberculosis Infection in the United States and Canada; Sterling et al.; American Journal of Respiratory and Critical Care Medicine, Jan. 19, 2006.

• The Mental Health of Federal Offenders: A Summative Review of the Prevalence Literature; Magaletta, Diamond, Dietz & Jahnke; Administration and Policy in Mental Health, Jan. 1, 2006.

Behind the Scenes With a Health Care Recruiter

When it comes to recruiting, times are rough all over. From Maryland to Hawaii, health professionals—and nurses in particular—are in short supply. Imagine, then, the difficulty when your territory encompasses 37 states, 109 correctional facilities and 100 or so health services vacancies at any time.

Capt. Beverly Dandridge, MSN, FNP, CCHP, doesn’t have to imagine it. That is the challenge she faces daily as the national medical recruiter for the Federal Bureau of Prisons.

Unexpected Career Path

Although Dandridge is passionate and tireless in performing her current job, she never saw it coming. A self-described introvert, her first love was patient care, and she spent many years in clinical practice, advancing to become a certified critical care nurse and nurse practitioner.

Her high level of competence led to positions with ever greater management responsibilities. She left the world of community hospitals in 1996 to join the Bureau of Prisons, and within a year was named health services director at a prison camp. A year later, she was selected as the director of nursing at a new BOP medical center in Massachusetts.

At the time BOP facilities staffed their own sites, with department heads often taking the lead. So, with a staff of zero at the outset, necessity forced Dandridge to hone her skills at recruiting and managing a team of 40 nurses. “Once I got the concept, I took off,” she says. But Dandridge wasn’t just reeling in warm bodies. She also developed a nursing program from scratch, writing job descriptions, staff orientation plans and performance measures, all the while ensuring competencies, meeting accreditation standards and numerous other tasks.

Her success was noted by the Bureau’s central office, and in 2003 it came calling. And calling. Despite some initial reluctance (“I was content where I was,” she explains), she accepted the newly defined job of national nurse recruiter and moved to Washington, D.C.

Today Dandridge is part of the BOP health services staffing and recruitment team, but she remains the sole employee dedicated to recruiting for BOP sites nationwide. She also is a commissioned officer of the U.S. Public Health Service and recruits for that agency. “I am so multitasked it is unbelievable,” she says.

Broad Focus

Guiding her myriad activities is the strategic plan Dandridge developed for national recruitment and retention for all health care disciplines. Many of the strategies used at the local level still apply, she says, but the nature of her job has given her a broader focus.

As before, individual facilities look for and hire their own staff, but their vacancies are also compiled into a monthly report that Dandridge receives. She then recruits using the standard methods—placing ads, attending career fairs, seeking referrals—and “filters” suitable candidates to the facility for interviewing.

At the same time, however, she functions as an ambassador for correctional health care, constantly building awareness and interest in this specialty among potential candidates who might not even know it exists. “Often I am not recruiting but rather planting seeds,” she explains.

In this capacity, Dandridge speaks and exhibits at professional conferences, gives presentations at universities and visits with community groups. She also targets programs whose students are obligated to work with underserved populations for a specified time period.

When making her pitch, Dandridge promotes the correctional specialty, emphasizing its multidisciplinary focus, for example, and its strong health education focus. She touts the advantages of the federal prison system, such as its tight quality improvement programs and the federal benefits package. Not surprisingly, she often must clear up misconceptions and quell fears.

Dandridge is on the road about two weeks out of each month and, in short, she is “always on.” “You never know who you’re talking to,” she says, citing a case where two allied health students heard her speak about women in the military, but, intrigued by her job, later contacted her about correctional health care.

A Good Listener

Despite all the talking she does, Dandridge insists that listening is key to her success as a recruiter. “When I receive a phone call, I listen to the inquiry. In the first 30 seconds I can hear the person’s interest, sincerity, confusion or concerns. Sometimes I know it’s going nowhere. But I know how to tailor my responses, and I’ve learned what to emphasize.”

With dozens of inquiries per day, mostly by e-mail, Dandridge has the “response” part down to a science. Her reply is clear, methodical and detailed. She describes the agency, the application process and the job itself, with “templates” for each professional discipline.

Dandridge also assists with the application process, which takes at least three months and often six, due in part to rigorous security checks. “Some people get discouraged and want to drop out, so I make sure to follow up and nurture them.”

That points to another quality Dandridge says is essential for a recruiter: “You have to be passionate.” Besides approaching her intense workload with enthusiasm, for her it also means commitment to the correctional health care mission and genuine interest in the people she helps.

To keep tabs on her vast network of contacts, Dandridge maintains a log with key information. Even so, it’s difficult for her to gauge her success in job placements. “That’s one frustration. I refer so many people for jobs, but I don’t always hear back from the facilities.” She hopes to obtain tools to better track outcomes.

One outcome is unmistakable, though: a satisfied customer. “It makes my day when somebody is happy and appreciative. That negates the stress.”

The Big Picture

Given the broad scope of her job, Dandridge is in good position to assess the state of the correctional health care labor market as well as large-scale trends.

One trend making a huge impact is the increase in chronic care conditions such as diabetes, arthritis and even end-stage renal disease, which are becoming pervasive in prisons. Clinicians with expertise in these conditions are like gold, so when Dandridge encounters them, she doesn’t let them get away.

Increasing incidence of dementia and other mental health deprivities also will pose significant challenges, she says. Thus, correctional institutions should prepare now, establishing standards and creating appropriate confinement settings.

To maximize the potential in the labor market, Dandridge seeks out candidates of diverse ethnicities and backgrounds, and multilingualism is viewed as an asset.

Long-term, demographic factors suggest that nursing and other shortages will persist, and that, says Dandridge, is a major concern. She advocates a shift from specialization toward general practice, bolstered by better incentives for practitioners to consider correctional settings as a desirable career option.
Position Statements Keep Pace With Changing Times

Occasionally an issue arises that is not addressed by NCCHC’s standards or has changed since the standards were last revised. As necessary, NCCHC adopts position statements on these matters to assist correctional institutions in developing their policies and procedures. In October 2005, NCCHC updated its position statements concerning administrative management of HIV, licensing of health care providers and women’s health care. Reprinted here is the core of the statement on restricted licenses to medical professionals working in corrections.

Licensed Health Care Providers in Correctional Institutions

Background

State licensing boards are agencies charged with the responsibility of protecting the health and safety of the public by ensuring that health practitioners have attained the appropriate education and abide by ethical and professional standards of conduct. In addition, each state has a medical practice act that governs the issuance of licenses and the practice of medicine within its jurisdiction. When a physician violates these professional standards or the medical practice act, a state board is empowered to modify, suspend, or revoke that physician’s license.

Some medical providers, whether working in a corrections environment or not, may develop diseases or exhibit behaviors that make it inappropriate for them to practice their profession without some sort of supervision. State licensing boards, therefore, occasionally modify a license for a physician or other provider in need of professional counseling and rehabilitating, for drug, alcohol, or other impairments.

In addition, some state licensing boards, in an effort to accommodate selected recent immigrant physicians, have granted special licenses to these physicians so that they may work in special institutional settings. These individuals do not meet the requirements of a fully licensed physician.

Different state boards will refer to these modified licenses by different names, including “temporary,” “probation,” “stipulated order or agreement,” “practice restriction,” “institutional,” “restricted,” “disciplinary,” “provisional,” “conditional,” and “conditional.” This position statement will use the term “restricted” throughout.

The practice of medicine in a correctional setting is a discipline that requires knowledge of medicine as well as law and criminal justice. Working in a correctional facility provides an excellent opportunity for motivated physicians to encounter a variety of medical conditions and illnesses, treat patients, and have a major impact on public health. One of the challenges faced by physicians and other health practitioners in corrections is to provide necessary patient care within a rigorous security environment and in concert with security personnel. Another challenge is to provide constitutionally required care within a limited budget. Yet another challenge is to keep resources in pace with the growing number of inmates. The best physicians will be particularly adept at providing and advocating good quality care within an environment that at times may seem to provide disincentives to patients and practitioners alike.

When correctional physicians do not advocate appropriate medical care for their patients, they risk harming to:

- their patients;
- their employer, in the form of lawsuits or public outcry;
- the public, in the form of health threats or increased cost for patient care upon release; and
- the medical profession and its canons of ethics.

Correctional systems, perhaps in an attempt to save money or adhere to a security procedure that has not been adapted for medical care, may create pressures to modify or avoid necessary patient treatment. Restricted licensed physicians, perhaps due to their inability to easily find employment elsewhere, may be susceptible to pressures or excessive supervision placed on their medical autonomy. To be an effective patient advocate, a physician must be able to resist pressures and constraints on independent medical practice.

State medical and dental boards must report to the National Practitioner Data Bank (NPDB) disciplinary actions related to professional competence or conduct taken against the licenses of physicians, providers, or dentists. State medical and dental boards also must report revisions to adverse licensure actions. Correctional employers should check a prospective physician’s credentials by contacting the NPDB and state regulatory agencies.

Position Statement

The National Commission on Correctional Health Care and the Society of Correctional Physicians advocate that physicians, nurses, and other licensed health care professionals working in corrections be fully licensed. Corrections departments should employ only health care professionals who may freely work in a community setting. State licensing boards should not issue licenses that restrict licensed health care professionals’ employment solely to correctional environments. NCCHC and SCP believe that such practice imparts a sense that patients in a correctional environment are undeserving of qualified care that is similar to care available in the community. This concept is anathema to the important medical canons of ethics and disregards the important public health role correctional health care can play.

Further, correctional systems should not employ licensed health care professionals whose licenses are restricted to government institutions, including corrections. It conveys a substandard image of correctional health care that can inhibit patients from seeking necessary care; adversely affects recruitment of other health professionals; and potentially leads to unwelcome public reaction when there is a negative patient outcome. The public specter of inadequacy in the correctional medical system may erode the system’s ability to attain the resources necessary to operate the system effectively.

It is important to note that this issue transcends physician qualification. It also applies to nurses, physician assistants, psychologists, and dentists. These practitioners should be held to the community standard for competent health care whether they provide services to inmates or the nonincarcerated population. It is inappropriate to build a correctional health care system on health care practitioners who have licenses limited to corrections only.

All NCCHC Position Statements are posted online at www.ncchc.org.
While end-of-life care in correctional settings is becoming more prevalent, little is known about health care providers' perceptions and practices concerning advance directives for prisoners, according to Susan Franzel Levine, MD, MPH, associate medical director at The Connecticut Hospice, Branford, CT. A former professor in the University of Connecticut Health Center's Department of Medicine, Levine sought to shed light on this subject at the Connecticut Department of Corrections. She reports her findings in the latest issue of the Journal of Correctional Health Care. She conducted a survey of physicians and nurses most likely to care for seriously ill inmates: those who work in the DOC infirmary and those in the UConn med-surg unit where DOC inmates receive inpatient care. Of 197 surveys mailed, 85 were returned—a 43% response rate.

The questionnaire was designed to assess the providers' knowledge of, prevalence of, and procedures for completion of advance directives, as well as their perceptions and beliefs on these and related issues.

Key Findings
Fewer than 1% of inmates have advance directive discussions. Fewer still complete an advance directive, and those that do nearly always have a do-not-resuscitate order. The providers agree that discussions usually occur at the least optimal time: when an inmate is critically ill. The most optimal time would be upon entry to the DOC, they said, although in practice this seldom happens. When asked to speculate as to why advance directives are not addressed more often, many respondents said that an inmate's fear of abandonment was a primary reason. Nevertheless, study results overall suggest that most barriers are systems issues.

The question of whether mental illness and competency are relevant to advance directive discussions was unclear to respondents. Cultural and religious differences were not felt to be particularly relevant.

Recommendations
Based on these and other findings, Levine offers four recommendations for improving end-of-life care of prisoners:

1. Increase awareness and knowledge of advance directives by providing in-service training.
2. Develop a policy regarding the consistent timing and location of advance directive discussions.
3. Develop a policy about the consistent transfer of advance directive information to the hospital.
4. Increase awareness of pain medication procedures and formularies.
Medications can be part of the plan. But never the whole plan. You and the patient are partners in developing pain management strategies that work. Because there are multiple contributors to maintaining chronic pain, there must be multiple treatment regimens for the patient to be successful. All pain has social, emotional, physical and environmental consequences. In order to develop an effective approach to managing pain, all aspects must have their own protocols developed in conjunction with the inmate, who knows his circumstances best.

**Chronic Care Approach**

Chronic pain is similar to any chronic disease that needs managing. Hypertension and diabetes are examples of problems that need management at multiple levels. They will not be “cured.” There are medications that can help, but unless lifestyle changes are adopted, it will take more and more drugs for less effect over time. The goal in chronic disease management is to maximize functioning while minimizing damage. The same is true for chronic pain.

**Establish a Foundation for Change**

Unless beliefs change, behavior will not change, and the outcome will be the same.

1. **Stop looking for the “cause.”** Shift from the medical model to the rehabilitative model. Pain is analogous to essential hypertension. Who knows why their blood pressure is high? You treat what you have. This is often the case with muscular- skeletal pain (95% of chronic pain problems). When doctors persist in exploring the etiology of the pain, the patient continues to be concerned that something bad is “wrong” and could be set right if only it were discovered. In the pain clinic, we often discovered that it was harder for doctors to give up looking for a cause than it was for patients. For patients, it is often a relief to start rehabilitation efforts. When we told one patient that he would probably always have some degree of pain, he expressed relief that he could move on with his life and not feel that, somehow, he should still be looking for an answer.

2. **Normalize the experience of pain for the patient.** Chronic pain is not abnormal nor is it a sign that something is wrong. Cite the statistics for the huge incidence of chronic pain (Part 1). Empathize with the suffering, but communicate the need to move beyond it. Reducing the fear and anxiety associated with worry about a serious medical problem will allow the inmate to participate in treatment.

3. **Explain the goals of pain management.** The goal is not to eliminate pain, but to minimize the impact it has on the individual’s daily functioning. Minimizing pain along the way, if that happens, is a bonus.

4. **Communicate that you will work with the patient in rehabilitation efforts.** Patients may believe you will lose interest in them if they don’t have a “real” medical problem. Schedule regular brief meetings with them to review progress (not pain!).

5. **Reactivation will be painful, but not damaging.** Hurt does not equal harm, in chronic pain.

**Treatment Plans**

- **Giving inmates the perspective above will allow the following type of treatment to work.**
- **1. Treat any coexisting depression (commonly found) or sleep disturbance with minimal and appropriate medication.** Pain and depression have been shown to follow similar pathways in the brain, and treatment for one helps reduce the other.

- **2. Begin a physical reactivation and reconditioning program.** This is the key to managing chronic pain. Even in the absence of medication, research shows that moderate depression and all degrees of chronic pain respond positively to a gradual, staged reactivation (stretching and strengthening). There is undoubtedly some physiological basis for this change, as well as the psychological increase in self-confidence and self-efficacy that comes from taking control.

- **An initial visit and exercise “prescription” from a physical therapist will provide the inmate with the confidence that she is not harming herself.** This can be done in a group setting, especially when there are many low back pain patients, for example. There are standard back exercises. Inmates can do them in their cells. There is no need for special equipment for most exercises.

- **3. If you decide to use medications, try NSAIDs (along with antidepressants if indicated). There are more than 26 nonsteroidals in five categories that each work differently.** If one doesn’t work, another will. A major study recently showed ibuprofen has the best efficacy and the lowest incidence of side effects. Use NSAIDs only in conjunction with the exercise program. These nonsteroidal anti-inflammatories have been demonstrated to have pain reduction effects beyond reducing inflammation (UW Pain Center).

- **4. If your state allows the prescribing of opioids, you can consider them, with all the concerns associated with giving dependency-producing drugs to previously chemically dependent inmates. If you use them, a time limit of 10 to 20 days might be reasonable with the understanding that significant progress in strengthening and reconditioning goals be met or the drugs “are not doing you any good” and should be discontinued. Inmates should know from the beginning that an increase in pain at the end of the drug trial will not merit a return to these drugs.**

- **Keep in mind that when the inmates are released from prison, they are unlikely to be prime candidates for long-term opioids prescribed by a community physician. Setting them up for failure when they get out is counterproductive.**

- **5. Give inmates an activity diary in which they record exercises and daily activities such as walks.** You will review this at visits. Do not have them record their pain levels! This reinforces their focus on pain rather than pain-free activities. A sheet of paper divided into sections for each hour of the day will enable them to keep track of physical activity.

- **6. Schedule time-contingent, not symptom-contingent, follow-up appointments.** Seeing a doctor or a nurse is a reward. Make sure you are rewarding that which you want to see increased. For chronic pain inmates, it will take you less time if you schedule 15-minute appointments every few weeks than if you “require” them to have exacerbation of pain to see you. You do not see them between visits for the pain.

- **7. At appointments, review with the inmate her progress. Compliment her ability to do exercises under difficult circumstances. It should be clear to the inmate that her efforts “earn” her appointment times. Chat with the inmate and make it pleasant.**

- **8. Provide cognitive behavioral group sessions on improving functioning and increasing activity levels.** Sessions for patients with pain problems will aid their continuing progress. The sessions should be run by a psychologist, who will make sure that they don’t turn into “my pain is worse than your pain” sessions.

- **9. Provide psychosocial and physical education group classes.** Structured classes can be taught by a nurse, doctor, psychologist or counselor using a standard curriculum that focuses on coping and managing pain.

The goal of these treatment plans is to implement self-management techniques supplemented by coaching from the provider. Skills will be learned, attitudes will be changed and the inmate will learn (more) self-care more prepared to be responsible for his own health needs.

*Kelly J. Egan, PhD, MHA, is director of mental health for the Washington Department of Corrections.*
A Health Record for Every Inmate?

Q Do the NCCHC standards require that a jail start a health record for everyone who is admitted?

A No. Each inmate admitted must have a receiving screening completed and documented (standard J-E-02 Receiving Screening). Most jails keep the receiving screening documents in a general file for easy access or future reference since they should not be readmitted. However, a health record must be created if any health intervention is provided after the receiving screening (J-I-01 Health Record Format and Contents). A copy of the receiving screening forms should be included in this record.

Critical Incident Debriefing

Q I am hearing concerns about the psychological intervention known as “critical incident stress debriefing.” Recent studies have questioned its effectiveness and even report that some of its techniques may cause psychological harm. Your standard on suicide prevention lists “critical incident debriefing” as a key component of a correctional facility’s suicide prevention program. How do you define this term?

A This aspect of essential standard G-05 Suicide Prevention Program offers the opportunity for everyone affected by a suicide—staff and inmates alike—to discuss the incident and their feelings in a supportive environment. The standard does not require that everyone participate, and in light of studies showing the potential for harm, caution should be exercised when dealing with a highly stressful situation.

The standard’s Discussion section defines critical incident debriefing as “a process whereby individuals are provided an opportunity to express their thoughts and feelings about a critical incident…develop an understanding of critical stress symptoms, and develop ways of dealing with those symptoms.”

This process “can be accomplished by an in-house response team or outside consultants prepared to handle high-stress situations. Where feasible, persons who are certified or specially trained in critical incident stress debriefing should be used. Practical guidelines are available from organizations such as the International Critical Incident Stress Foundation (www.icisf.org).

How the debriefing is done—including details about whether staff and inmates will meet together or separately, when, where and led by whom—are administrative and clinical decisions that should take into account the nature of the incident and the environment. Since different approaches may use similar names, the health administrator should not choose someone to intervene after a suicide without understanding their philosophy and techniques.

Look for a future article to discuss critical incident debriefing, including guidelines for assessing professional services and potential problems to avoid. If you have questions or comments on this subject, please write to judithstanley@ncchc.org.

Cell-side Intervention

Q In our maximum security prison, the segregation area is a very controlled environment since the inmates here are considered dangerous individuals, known to attack staff and other inmates. The superintendent has asked health services to limit these inmates’ trips to the facility clinic whenever possible. We want to cooperate with security concerns, but do not wish to violate standards or give less than appropriate care. How far can we go in providing “cell-side” interventions?

A The standards most directly relevant are P-A-09 Privacy of Care and P-E-07 Nonemergency Health Care Requests and Services, although several other standards come into play: P-A-01 Access to Care; P-D-03 Clinic Space, Equipment, and Supplies; P-E-09 Segregated Inmates; and P-I-02 Confidentiality of Health Records and Information. It may be helpful to share copies of these standards with the correctional authorities so that they have the “big picture” from the health services perspective.

NCCHC (P-E-07) distinguishes between triaging health care requests (“sorting and classifying…to determine priority of need and the proper place for health care to be rendered”) and sick call (“evaluation and treatment of an ambulatory patient in a clinical setting”). Clinical setting is defined as “an examination room or treatment room appropriately supplied and equipped” to address health care needs (P-E-07). Clinical encounters are “interactions between inmates and health care providers that involve a treatment and/or exchange of confidential information” (P-A-09).

Privacy is to be respected at all times, and when security personnel must be present due to risk to the safety of the health care provider or others, efforts are made to afford partial visual and verbal privacy (P-A-09).

Cell-side triage of health care requests is fine. However, when triage indicates a need to examine, treat or delve into confidential information, the inmate must be taken to a clinical setting. So while routine blood pressure checks could be done in the cell with the door open (not by the inmate pushing his arm through a slot), an extensive examination of heart and lungs requires a clinical setting. Likewise, mental health staff may ask about the inmate’s well-being at the cell door, but if the reply to “Do you need to talk?” is positive, a clinical area is needed where confidential exchanges can take place. A clinical area can be set up in the segregation area provided that it has the necessary equipment and supplies (see P-D-03) for evaluation and treatment. For example, if a sink is lacking, then “alternate appropriate means of hand sanitization” must be available. Otherwise, the inmate must be taken to the central clinic for assessment and/or treatment. Officers assigned to segregation must receive training on their role in protecting the confidentiality of any health information they are exposed to because of their duties (P-I-02). In such a setting, any joking, teasing or reference to confidential health information by staff would only exacerbate tension.

As health staff aware of the potential risks these inmates present, you will want to work as a team with correctional staff without compromising the ethics of your professions. Often it is the quality of respect and nonverbal interaction between health and correctional staff that the inmates pick up on and respond to, either positively or negatively.

Judith A. Stanley, MS, CCHP-A, is NCCHC’s director of accreditation and oversees the development and revision of standards. R. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president, liaison to the policy and standards committee, and an accreditation surveyor. Send your questions to info@ncchc.org.
Exhibitor Opportunity

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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).
7. Proofs must accompany all ads.
8. Cancellations must be received in writing before the insertion order deadline.
9. Acceptance of advertising does not imply endorsement by NCCHC.
Employment

Board Certified Physicians
The University of North Texas Health Science Center at Fort Worth, Department of Family Medicine is accepting applications for Board Certified Internal Medicine and Board Certified Family Medicine physicians. Through our partnership with John Peter Smith Hospital, positions are available in our Division of Community Medicine clinics located throughout Tarrant County. Competitive salary, excellent benefits. Please apply online at http://www.bsc.unt.edu.

Elizabeth Palmorozzi, M.D.
Associate Professor and Chair
Department of Family Medicine
UNTHSC
855 Montgomery Street
P.O. Box 7350 Fort Worth, TX 76107
Fax: 817-735-5089

The UNT Health Science Center enjoys a smoke-free campus and is an EEO/Affirmative Action Institution.

Take Charge of Your Future
The Academy CareerCenter is the most comprehensive career and recruiting site serving the correctional health care field. Employers and job seekers can learn more at http://careers.correctionalhealth.org.

Marketplace

National Conference Proceedings on CD
Conference-goes loved taking home the proceedings manual from NCCHC meet-ings for future reference, but they hated lugging those heavy books. Now they have them best of both worlds—and you can too, even if you didn’t attend the conference.

Educational session abstracts, presentation notes and handouts from the 2005 National Conference in Denver are available in a convenient CD-ROM format, $80 plus shipping & handling. Order online at www.ncche.org or call (773) 880-1460.

Clinical Practice, 2nd Edition
Written and edited by 40 practitioners in prison systems and public health nationwide, this new edition of Clinical Practice in Correctional Medicine comprehensively covers the issues specific to correctional settings—essential, practical information not available in other books. This critically acclaimed text explores all major areas of correctional medicine, from intake to hos-pice care, including clinical management of diseases common among inmates, ethical concerns, organization of health services delivery, patient-provider relations, legal issues and more. This edition delivers new sections on nursing and emergency ser-vices, plus new chapters on hepatitis C, psychiatric nursing, self-inflicted injury, methadone in corrections, annual health examinations, telemedicine, geriatric care and end-of-life care. Edited by Michael Puits, D.O. published by Elsevier/Mosby.

hardcover, 560 pages, $89. Order online at www.ncche.org or call (773) 880-1460.

OTP Standards
Standards for Opioid Treatment Programs in Correctional Settings. These standards represent NCCHC’s requirements for corre-ctions-based opioid treatment programs seeking accreditation. They are based on federal regulations and community standards, but take into account the issues unique to correctional facilities. Conform to the Standards for Health Services, the OTP Standards cover nine major areas: governance and administration, environmental safety, personnel and training, health care services and support, juvenile care and treatment, health promo-tion, special health needs, health records, and medical-legal issues. 2004, Softcover, $29.95. Order at www.ncche.org or call (773) 880-1460.

Meetings

Pharmaceuticals Meeting. The Annual Meeting & Exposition of the American Pharmacists Association will take place March 17-21 at San Francisco’s Moscone West Convention Center. Complete infor-mation is online at www.aphmeeting.org.

Adolescent Health. Focusing on “Public Health and the Adolescent,” the annual meeting of the Society for Adolescent Medicine will convene March 22-25 at the Westin Copley Place Hotel in Boston, MA. For details, see www.adolescenthealth.org, or call (617) 262-9600.


AGP Annual Session. The American College of Physicians’ annual meeting will be held April 6-8 at the Philadelphia Convention Center, Philadelphia. Learn more at www.acponline.org, or call (800) 233-1546 x-2600.

Opioid Treatment. The American Association for the Treatment of Opioid Dependence is holding its next national conference April 22-26 at the Hyatt Regency in Atlanta, GA. Held on an 18-month cycle, the conference addresses current evidence-based practices, pharma-cotherapy training, management, patient advocacy, policy and more. Find details at www.aatod.org, or call (212) 566-5555.


Healthcare Meetings

The Annual Meeting of the American Psychological Association will take place August 23-27 at the Moscone Convention Center, San Francisco, CA. Presented by the American Psychological Association, this conference is the theme of this year’s Mental Health in Corrections Consortium symposium. Presented by the Forest Institute of Professional Psychology, May 6-8, Kansas City (MO) Marriott Country Club Plaza. Learn more at www.forest.edu/mhccs.

The State of Michigan is an equal opportunity employer.
Down to Business (Mostly) in Denver

It was a heady mix of the new and the old-familiar at the 2005 National Conference on Correctional Health Care. In the “new” column: preconference seminars on pain management and risk management; cutting-edge sessions on emergency preparedness; book signings by eminent authors; an exhibit hall Technology Pavilion with high-tech demonstrations; a “wheel of fun” for exhibit hall raffle prizes; and last but not least, a CCHP lounge for this elite group to network and relax. On the “familiar” side? High quality, in-depth education; an extraordinary keynote address; the wine-and-cheese poster reception; stimulating roundtable discussion groups; a packed and informative exhibit hall; the Tuesday night social event, nonstop networking... Whew! And that old standby, “much much more.”

Keynoter Louis C. Tripoli, MD, gave an account of his experience as a public health expert in Iraq that was at times harrowing, humorous and deeply moving. He is pictured here with NCCHC’s 2006 board chair Nancy B. White, MA, LPC, and NCCHC president Edward A. Harrison, CCHP.

Of course we had bagpipes! What self-respecting conference wouldn’t???

The opening ceremony was a treat even for NCCHC board members who have attended umpteen meetings!

Lost anybody entertain the notion that the Society of Correctional Physicians meeting is a dull affair...

Decisions, decisions. With 100 presentations in 10 tracks over 3 days, choosing which sessions to attend wasn’t easy.

The conference boasted NCCHC’s biggest and best exhibition ever—andattendees loved it!

After long days of learning, by the time the Tuesday night party rolled around, people were ready to let their hair down... or arms up... or whatever.

Nobody attends a conference for the prizes. But they sure don’t hurt, especially when exhibitors are giving away computers, MP3 players, gift baskets and cold hard cash!

Denver’s stunning convention center offered places to retreat and take a breather from the hectic goings-on of the conference.