Any correctional health care providers come from a private practice environment in which we do anything possible to improve the comfort of our patients. We are all, first of all, caregivers, and good ones. While this caring is positive and important, in corrections not everything that is possible is practical. This subject came up yet again at a meeting of health services managers for the Oregon Department of Corrections. Discussing the many requests we receive for items and accommodations that clearly are not related to medical necessity, we realized that there is wide variability in practice regarding “comfort” orders. Since this subject resurfaces so often, we have written this article to shed light on the issues and describe what we are doing about it.

Job #1: Health Care

A 1976 Supreme Court case—Estelle v. Gamble—established the constitutional right of inmates to health care for their “serious medical needs.” This is the legal basis for health services in corrections.

With the positive evolution of health services in correctional settings, our time is consumed with delivering quality services to sick patients. And as inmate populations grow older, we increasingly are called upon to deal with very serious medical conditions. In the mental health arena, we have become the caregivers of some of the most disturbed patients in our society. (For a vivid illustration, see the PBS Frontline program “The New Asylums,” which received the 2005 Emmy Award of Excellence in Communication.)

Given the demands to deliver more and more “real” care, health staff time is an important resource that we must ration carefully, in much the same way that we ration our financial resources. We can no longer afford the luxury of spending a lot of time discussing nonmed- ical issues with patients.

Nevertheless, our staff has long come under pressure—from inmates and often from security staff—to intervene in areas of inmate comfort and prison operation.

Physicians, nurses and mental health staff are called upon to make bunk assignments, define inmate work (by restricting people from jobs they don’t like) and prescribe such elective items as mattresses, pillows and shoes. We are asked to make medical orders in the chart about how an inmate is shackled and even about what procedure to order when an inmate is searched.

Dealing with these requests can be touchy. After all, health care staff do have the power to bend the rules for our patients. Unlike just about everyone else, we can issue orders that result in a given inmate being treated differently from the others. We must wield this power carefully, always evaluating the medical evidence that supports such orders.

Sometimes there are objective reasons to bend the rules. Frequently, however, there is no clear, evidence-based indication for a medical order (“I am allergic to pork and can’t work in the kitchen”). Often it is outside our area of expertise or responsibility (“I need wide shoes.” “I need a soft pillow.”) Sometimes it simply seems more expedient to do as we are asked (“This patient needs a medical order for somebody to push his wheelchair”).

Consistent, Evidence-Based Care

There are many reasons for us to work toward a more objective, evidence-based approach to our work in correctional health care.

First, finding objective evidence of bona fide serious medical problems helps us to practice effective health care. For example, if a patient says he has severe nasal allergies but has no mucosal congestion or redness of the eyes, there is no objective evidence of serious illness. If the patient says he has diabetes, we check a hemoglobin A1c to confirm his claim.

At the Oregon DOC, we also work within the concept of levels of therapeu tic care. We avoid prescribing elective and unnecessary items, even if there is no or minimal treatment cost involved.

Frequently, there is no objective, evidence-based intervention, in which case we should perhaps decline to discuss the issue. For example, no medical study supports the use of one kind of mattress over another. When we discuss such unproven remedies, we are taking this time from more important medical issues that need our attention.

Sometimes it seems easier to “give in,” but in the long term we will spend more time and energy if we do so. For example, patients sometimes argue for comfort items in a manipulative way, and by giving in to the request, we are encouraging manipulation. The Oregon Accountability Model says that our primary goal is to “hold inmates accountable,” even while delivering care.

Also, by practicing and prescribing in a consistent, objective, evidence-based way...

Continued on page 16
Happy Birthday to Us!

This is a year of important anniversaries: 30 years since the landmark Supreme Court decision in Estelle v. Gamble, 30 years since the first National Conference on Correctional Health Care, 15 years since the launch of NCCHC’s certification program for correctional health professionals (see page 4 for a brief history).

Not to toot our own horn, but CorrectCare is celebrating its own anniversary: Volume 20, Issue 1, marks 20 years of publication. The very first issue appeared in August 1987 and was intended mainly to promote the 11th National Conference. Printed in black and white on broadsheet newsprint, the paper ran eight pages, two of which listed conference programs and registration information. It also had some photos from the previous year’s conference (everybody looks so young!). Humble as it was, the newspaper covered some weighty topics, including articles on competency for correctional health professionals informed about this complex and ever-changing field.

Before long, a bit of color was introduced to the paper, along with ads, but truth be told, it wouldn’t have won any design awards. No matter, it had a mission and its staff pursued it capably. In fact, Volume 2, Issue 4, saw the introduction of a feature editor: “Paul Harding.”

And who was this elusive Mr. Harding? None other than Bernard P. Harrison, JD, the Commission’s other cofounder. Along with running NCCHC, Harrison almost singlehandedly wrote and edited the paper but out of modesty refused to use his real name.

CorrectCare has come a long way since those early years, but, in a sense, not really. We’re now much fonder of color, graphics and call-outs, but we remain steadfast in our mission: to feature timely news, articles and commentary on the subjects that our readers care about.

We welcome your feedback.

Resources You Can Use

Straight Talk on Opioid Treatment in Corrections

The use of opioid replacement therapy (methadone) is widely recognized in the medical community as a safe and effective treatment for withdrawal from and addiction to heroin or other opioids. In fact, this medical treatment model is endorsed by the American Medical Association and the American Society of Addiction Medicine. Such treatment also has a positive impact on related health problems commonly found in correctional facilities, such as hepatitis C and HIV infection.

To help correctional administrators better understand the issues and the potential benefits of opioid replacement therapy, NCCHC is sending a brochure to administrators at thousands of jails and prisons. Created in collaboration with the Substance Abuse and Mental Health Services Administration, the brochure outlines how correction-based opioid therapy programs (OTPs) can help in treating inmate addictions cost-effectively. It also touches on the federal guidelines on operating OTPs in correctional facilities, and explains how NCCHC can assist facilities interested in establishing OTPs.

The brochure also is posted at the Accreditation section of our Web site.
Guest Editorial

Hurricane Rita Leaves Lessons in Its Wake

BY OWEN MURRAY, DO, MBA

N o matter how thorough your disaster plans or how many drills you’ve had, when a hurricane hits, there are lessons to be learned. In Texas, Hurricane Rita taught us plenty, and we are now the stronger for it. We will share those lessons at NCCHC’s Updates conference in April. Here’s a preview of Hurricane Rita: The Texas Story.

Out of Harm’s Way
On Saturday, Sept. 24, 2005, the fourth most intense hurricane ever and the third largest witnessed in the Gulf of Mexico, hit the Texas-Louisiana coast. At its zenith, Hurricane Rita had sustained winds of 185 miles per hour with gusts peaking at 225 miles per hour. The path of devastation extended well over 300 miles inward from Port Arthur, Texas, up through Tyler. The effects of the storm were seen from the Bahamas and Cuba through Florida, Texas and Louisiana all the way into Arkansas. The death toll from the storm stands at 119, with damages exceeding $9.4 billion. Officials in Galveston County ordered a mandatory evacuation to begin at 6 p.m. on Sept. 21. This evacuation included the University of Texas Medical Branch in the city of Galveston, and its associated hospitals, schools and research centers. The 125-bed prison hospital on the Galveston campus is jointly managed by the Texas Department of Criminal Justice and UTMB. Together, TDCJ and UTMB began the largest evacuation of hospitalized offenders ever seen in this country. They also had to evacuate TDCJ’s 350-bed Carole Young medical facility in Texas City, about 15 miles north of Galveston. Overall, more than 10,000 offenders from 10 prison facilities were moved prior to the hurricane coming ashore. The hospitalized offenders were relocated primarily to the University of Texas hospital in Tyler, although patients were scattered as far away as Dallas, El Paso and Atlanta based on their medical condition and the involvement of the Federal Emergency Management Agency. Infirmary patients and general population offenders were moved into other facilities and accommodated in common areas such as the gymnasium and inside recreation yards. Health care and security staff were relocated with the offenders to provide continuity of care and appropriate staffing.

Lasting Lessons
Rita lasted for roughly 24 hours, but the aftereffects were felt for months. Many lessons were learned that have given rise to significant changes in policy, procedure and practice. First and most importantly was the need for a formal operations plan. The emergency response policy in place at the time of the storm was inadequate in both detail and direction. It was apparent that the lack of specifics led to significant off-the-cuff decision making. Additionally, the necessary detail relating to integration and coordination of response activities with the department of corrections, state and federal agencies, and regional medical centers was notably absent. The second major lesson involved the transfer of medical information between facilities, EMS and external medical centers. The electronic medical records employed in the system played a critical role in ensuring continuity of care and treatment as patients moved rapidly throughout the state. Despite the advantages of the EHR, the transfer of information still required significant organization and coordination at both central and local levels. The most critical piece was to coordinate with the pharmacy to ensure timely medication delivery and administration.

Finally, the nature and practice of a “command center” model to aid and support the logistics, integration and coordination of the emergency response was invaluable. Operating at a distance from ground zero, a select group of decision makers were able to manage resources and personnel efficiently, without the pressure of dealing directly with the disaster.

Owen Murray, DO, MBA, is executive director for clinical services and chief physician executive for UTMB Correctional Managed Care, Galveston, TX.

NCCHC Award Nominations
1145 W. Diversey Parkway
Chicago, IL 60614
Fax (773) 880-2424
For more information, call (773) 880-1460 or e-mail info@ncchc.org.

Nomination Form
2006 Bernard P. Harrison Award of Merit

NCCHC’s highest honor pays tribute to an individual or group that has demonstrated excellence and service to the field of correctional health care, either through an individual project or a history of service.

Please type or print.
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Name of nominee(s) ________________________________
Address ___________________________________________________________________
City ______________ State __________ Zip __________
Phone number __________________________ E-mail __________________________
Organizational affiliation (if applicable) __________________________
Organization address ___________________________________________________________________
City ______________ State __________ Zip __________
Position/job title __________________________

Nominator Information
Name __________________________
Phone number __________________________ E-mail __________________________

Supporting Documentation
- Describe the nominee’s duties and length of time in his/her profession.
- Explain the reason for nomination (e.g., professional accomplishments).
- Describe how the nominee’s accomplishments have contributed to the field of correctional health care.

Please return completed form and supporting documentation by Friday, May 12.

Nomination Form
2006 B. Jaye Anno Award of Excellence in Communication

This award honors outstanding communication vehicles that are innovative, multidisciplinary in nature and have had a positive impact on the field of correctional health care. The award is defined broadly to incorporate many types of communication vehicles, such as article series, presentations, publications, Web sites, television and radio programs, and videotapes. The award also may be given to an individual for a body of work.

Please type or print.
Nominee Information
Communication vehicle and medium __________________________
Name of nominee or representative __________________________
Organizational affiliation (if applicable) __________________________
Address ___________________________________________________________________
City ______________ State __________ Zip __________
Phone number __________________________ E-mail __________________________

Nominator Information
Name __________________________
Phone number __________________________ E-mail __________________________

Supporting Documentation
- Describe the nominee’s communications / communication vehicle.
- Explain the reason for nomination (e.g., impact on the field).
- Describe how the nominee has contributed to the field of correctional health care.

Please submit your nomination and supporting documentation by Friday, May 12.
CCHP Celebrates 15 Years: Break Out the Crystal!

BY PAULA J. HANCOCK, MED

This spring, more than 100 correctional health professionals will participate in the CCHP exam at test sites in Nevada, North Carolina, Oregon and Wisconsin. These individuals, like those who took the first exam 15 years ago, hope to distinguish themselves as professionals who have the knowledge expected of leaders working in the field of correctional health care.

Getting Started

In the early 1970s, when researchers began working on the American Medical Association’s Jail Project, they found that many of the people providing health care in our nation’s jails were ill-equipped and ill-trained for the job. Later, however, the correctional health care profession experienced tremendous growth and increased professionalism. Health care providers were doing amazing things and making great strides in improving the quality of care in jails, prisons and juvenile facilities. At the time, there was no mechanism to recognize these individuals for their accomplishments or their professionalism. Guided by an ad hoc committee of the NCCHC board, the Certified Correctional Health Professional program was launched to fill this void. The response was immediate and enthusiastic, with more than 200 individuals taking the first exam in November 1990.

“There are too few incentives for persons to work in the institutional environment, and the shot in the arm that the CCHP program offered was genius in the making,” said Ernest Williams, MD, MPH, CCHP, medical director of Orange County (CA) Corrections. “However, too few of us avail ourselves of this opportunity to demonstrate to our peers that we have been determined to be proficient, accomplished and knowledgeable—by a well-known and established national organization.”

Ongoing Development

Over the years, the Board of Trustees has worked to be responsive to the needs of and changes in the correctional health care field. Greater interest in correctional health care from academia, more clinical research trials, and attention from the public health sector and federal agencies have contributed to changing attitudes toward the correctional health community.

“Substantial progress has been made in both the image and the reality of the correctional health profession due to the CCHP program,” said Joanne I. Dormann, RN, CCHP-A, accreditation consultant for the UMass Correctional Health Program. “Working with clients who are underserved and have numerous unmet needs, it is evident that this program serves not only the client and the correctional health professional, but also the community as a whole.”

One outcome of the increased attention to the field is better and more opportunities to participate in educational activities focused on correctional health care issues. These opportunities led to new recertification requirements for annual continuing education in correctional health activities. These requirements ensure that CCHPs are maintaining and enhancing the knowledge and skills they demonstrated on the exam.

Increased professionalism, opportunities and respect has inevitably given rise to leaders who have excelled and made significant contributions to the field. These individuals are recognized by the Advanced CCHP program, a component that the program founders envisioned from the start. Since 1993, the most elite in our field have pursued and attained Advanced Certification. It is no surprise that many of the CCHP-As are also members of the original class of CCHPs.

One of these is Judith Hudson, RN, CCHP-A, assistant division director for the American Correctional Health Services Association (ACHSA) Corrections. “The certification program has encouraged our medical professionals to more fully recognize correctional health care as a distinct specialty and to take pride in what they do,” said Hudson. “Our colleagues could get jobs at any health institution in the country but have chosen to care for, in many cases, the least of our brothers. They do not do this for recompense, but rather to make a difference.”

CCHP Exam Dates and Sites

- April 9: Las Vegas, at the Updates in Correctional Health Care conference
- April 20: Portland, OR, in conjunction with the Oregon chapter of the American Correctional Health Services Association (ACHSA)
- May 11: Durham, NC, at the ACHSA conference
- May 15: Wisconsin Dells, WI, at the Wisconsin Corrections Conference
- August 5: Regional sites to include Eureka, CA; Chicago, IL; Trenton, NJ; Columbus, OH; Harrisburg, PA; Humble, TX; Everett, WA; and others
- October 29: Atlanta, at the National Conference on Correctional Health Care

Application deadlines are generally the first day of the month preceding the test month (the deadline has passed for the May exams, however). If you are interested in hosting an exam at your facility or proctoring an exam, please contact us at cchp@ncchc.org or (773) 880-1460.
Forensic Psychiatrist Exemplifies CCHP Dedication

BY MATISSA SAMMONS

While every Certified Correctional Health Professional is special, those who have taken part in the program since its inception 15 years ago merit special recognition. (See page 4 for a brief history of the program.)

Advanced CCHP Jeffrey Metzner, MD, was among the 182 individuals in the first group to obtain this unique certification in 1991. As part of our anniversary celebration, we are devoting this expanded CCHP Profile to this consummate professional.

Providing adequate mental health care in corrections has never been easy. But things have improved significantly over the past 30 years, driven primarily by litigation. Nobody knows this better than Jeffrey Metzner, MD, CCHP-A, who gravitated to this field shortly after beginning his career as a psychiatrist 30 years ago.

Now working as a psychiatric consultant and as a clinical professor of psychiatry at the University of Colorado, Metzner’s career is a textbook example of the dedication and skill required to make positive change in a field sorely in need of it.

Metzner graduated in 1975 from the University of Maryland School of Medicine and completed his psychiatric residency and medical internship at the University of Colorado Health Sciences Center.

His interest in corrections began in 1980, when he was involved in a landmark federal lawsuit that ultimately forced a dramatic change in prison conditions—including mental health care—across the state.

Ramos v. Lamm challenged the constitutionality of living conditions at the “Old Max” penitentiary, citing, among other things, failure to provide adequate numbers of qualified mental health staff. The judge ordered the prison closed, and asked the Colorado Psychiatric Society to review the state’s proposed remedial plan.

Formative Experience

As a CPS member with an interest in forensic psychiatry, Metzner was asked to be part of a committee charged with that task. “During the early 1980s, not many psychiatrists were willing to work in correctional institutions,” Metzner recalls. “Due to my interest in forensic psychiatry, I thought it was important to be familiar with jails and prisons.”

He agreed to help in the Ramos case and spent the next year reviewing proposed plans, finding them all unacceptable. The governor’s office then hired him to help write a remedial plan, which was accepted by the court.

For the next 12 years, until the case was closed in 1994, he monitored the mental health aspects of the plan he helped create. He also was chief of psychiatry for the Colorado prison system in 1980-1981.

The Ramos case was the launching pad for Metzner’s long career as a correctional psychiatric consultant. In short order, plaintiff’s attorneys began to ask him to consult in class-action suits, many of which lasted for years in the era before the Prison Litigation Reform Act of 1996. (PLRA made it more difficult for prisoners to file lawsuits in federal court due to provisions for administrative remedies, “three strikes” and physical injury requirements.)

Metzner eventually began to work for defendants, judges, special masters and court monitors, as well as plaintiffs. To date, he has evaluated mental health systems in jails and prisons in over 30 states as well as in Puerto Rico and the Virgin Islands.

Informed Observations

With that breadth of experience, Metzner is highly attuned to trends, past and present, in correctional mental health care—including the burgeoning caseloads in U.S. prisons and jails. This he attributes largely to the deinstitutionalization policies of recent decades.

While they were not entirely without merit, he views such policies as shortsighted. “[They] failed to recognize the importance of the need for adequate access to inpatient psychiatric beds both on a short-term and long-term basis,” he says.

With the closure of psychiatric hospitals and other mental health care settings in the community, too many seriously mentally ill individuals lost access to care and ended up in correctional facilities, which were ill-prepared to help them.

Metzner estimates that serious mental illness afflicts 10% to 15% of the incarcerated population, and that 20% to 25% will need mental health treatment at some point during their incarceration. These are sobering figures, especially given U.S. Department of Justice reports that 2,135,901 inmates were held in prisons or jails at year-end 2004. But those numbers don’t tell the whole story. Metzner says that widespread problems such as overcrowding, budgetary constraints and insufficient numbers of qualified mental health staff exacerbate the difficulty of providing adequate treatment.

Further, the lack of discharge services and continuity of care upon reentry often results in recidivism among mentally ill inmates.

One positive development Metzner notes is jail diversion programs for misdemeanor and certain felony offenders. Such programs may provide medicating, housing, day programming and mental health treatment. “They are clearly cost-effective in the long run and provide much more adequate treatment in a more humane environment,” he says.

Commitment to Professionalism

As evidenced by his many activities, appointments and awards (see box at right), Jeff Metzner takes his work very seriously. And despite the significant problems that remain in this discipline, he relishes the rewards of his work: “Being part of positive changes in a correctional environment in providing needed services to a very ill and underserved population.” It’s no surprise, then, why he chose to seek—and for 15 years maintain—professional certification, including advanced status in 1994. He sees it as a way to “support the concept of increasing professionalism among health care workers in corrections.”

Matissa Sammons is the professional services assistant at NCCHC.
One of the many valuable benefits of membership in the Academy of Correctional Health Professionals is a free subscription to the Journal of Correctional Health Care. Now in its 12th year, this quarterly publication is the only national, peer-reviewed scientific journal with an exclusive focus on correctional health care topics. It also offers continuing education credits for physicians, nurses, psychologists, CCHPs and others through a self-study exam in each issue. (Members also may access the exam at the Academy Web site at www.correctionalhealth.org.)

Now, through a new partnership with Sage Publications, your subscription to the Journal packs in even more benefits. The Journal will be included in Sage Journals Online (SJO), an online delivery platform developed by HighWire Press. SJO hosts many prestigious and highly cited journals, and represents one of the largest lists in the humanities and social sciences as well as an extensive science, technical and medical (STM) offering.

The SJO platform makes it easy to access content online, allowing Academy members to access the full text of JCHC at no additional expense. The platform has many robust features and functionality, including the ability to link to the full text of cited articles of other journals hosted on the SJO and HighWire Press platforms.

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FDA Approves Inhalable Insulin

The Food and Drug Administration has approved the first inhaled form of insulin. Intended for treatment of adult patients with type 1 and type 2 diabetes, this is the first new insulin delivery option approved since insulin was discovered in the 1920s. The product, called Exubera, is a powdered form of recombinant human insulin (rDNA) that is inhaled into the patient’s lungs using a special inhaler.

In clinical studies, the inhaled insulin reached peak concentration more quickly than regular insulin administered by injection. With the inhaled product, peak levels were achieved at 49 minutes (range 30-90) compared to 105 minutes (range 60-240) with regular insulin. In type 1 diabetes, inhaled insulin may be added to longer acting insulins as a replacement for short-acting insulin taken with meals. In type 2 diabetes, inhaled insulin may be used alone, along with oral (non-insulin) pills that control blood sugar, or with longer acting insulins. Exubera is not to be used by patients who smoke or quit smoking within the last six months, nor is it recommended in patients with asthma, bronchitis or emphysema.

Baseline tests for lung function are recommended after the first six months of treatment and every year thereafter, even if no pulmonary symptoms are present.

The product is made by Pfizer. Learn more via an FDA news release online at www.fda.gov/medicines/. A retrospective epidemiological study examined medical records of more than 2,000 HIV patients, comparing those who started HAART with a CD4 count of 200 cells/mL or less with those who began treatment with a CD4 count of 350 cells/mL or more. Those who began treatment with a higher count were less likely to develop kidney problems, peripheral neuropathy and lipodystrophy.

It has been widely believed that delaying treatment lessens toxicity by reducing exposure to drugs and their side effects. In contrast, this study suggests that earlier treatment minimizes side effects. The study was conducted by researchers at the Centers for Disease Control and Prevention and the University of Colorado Health Sciences Center.

Depression Linked With Mental Decline

Elderly people who suffer from depression are more likely to develop mild cognitive impairment within six years than those free of depression. Further, the more severe the depression, the greater the risk of mental decline, according to a study in the March issue of Archives of General Psychiatry.

Researchers at the San Francisco VA Medical Center and the University of California, San Francisco, studied 2,220 people age 65 and older. Nearly 20% of those with moderate to high depression at the start of the study had developed cognitive impairment after six years, compared to just over 13% of those who had mild depressive symptoms and 10% of those who had no symptoms of depression.

Unhealthy Gums Point to Unhealthy Body

The evidence is “increasingly strong” that chronic gum disease “can pose risks” for diabetes, heart disease and premature delivery, according to a report in the Feb. 24 HealthDay News e-newsletter. The topic was discussed in depth at a February conference sponsored by the American Dental Association and the American Medical Association. While speakers noted that “definitive proof” is lacking, one long-time researcher said periodontal disease “represents a modifiable risk factor to moderate or reduce other illnesses” and that it is “so common that even if it accounts for a small portion of conditions, the public health consequences would be great.”

Possible Cure for Opioid Addiction

New research has discovered that trifluoperazine, a long-approved oral antipsychotic drug, can stop the addictive properties of opioid painkillers in mice, according to information from the University of Illinois at Chicago Medical Center, where the research was conducted.

The researchers injected a small dose (half a milligram) of trifluoperazine into laboratory mice addicted to morphine. After a few hours their addiction was gone.

This is said to be the first study to demonstrate the anti-addictive property of trifluoperazine, which is used to treat schizophrenia and other mental diseases. The drug inhibits activation of an enzyme that plays an important role in enabling users to tolerate opioids. “Trifluoperazine targets this pathway, which then stops the addiction. When this occurs, you can still use a relatively low dose of the painkiller to achieve fairly good pain control and no drug dependence,” said one of the researchers.

The study is scheduled for publication in the April 10 issue of the journal Neuroscience Letters.

NCCHC is issuing clinical guidelines for the most common and most problematic conditions seen among youths in confinement. As with the other clinical guidelines already available for adult populations, the juvenile guidelines are based on nationally accepted guidelines promulgated by other organizations but adapted for correctional populations and environments. All will be posted online at www.ncchc.org; go to the Resources section then click on Clinical Guidelines. Also see page 14 for more information.

• Asthma
• Seizure disorder
• Obesity (nearing completion)
• HIV (in development)
• Diabetes (in development)
• Hypertension (in development)
Don’t Let Outside Consultations Be a Liability Minefield

BY DEANA JOHNSON, JD

You have probably determined that your inmate patient needs an outside neurological consult for a lingering arrest-related injury. You fully document the justification for the consult, the request is granted and the appointment scheduled. On the selected day, the inmate is transported by security and meets with the specialist. You are fully protected from liability, right? Not so fast.

What systems does your institution have in place to schedule any recommended follow-up, monitor to make sure the inmate is transported to any such follow-up appointments and ensure that missed appointments are rescheduled?

Also, since many practitioners in the free world have a poor understanding of realistic limitations on prison medical care, they often make treatment recommendations your department simply cannot comply with, such as metal braces that can be used as weapons or drugs that are not on your formulary. When your department cannot comply with the recommendations, the inference arises that the inmate is not receiving the care recommended by the specialist you elected to send him to.

Case in Point

Dr. V served as the medical director at a large city jail. One of his inmate patients was shot in the wrist during arrest. The result was an inability to straighten four fingers on the dominant hand (claw hand). Dr. V was relieved when the sheriff’s office granted his well-documented and agreed-on recommendation for a brace. It was approved by security and meets with the department’s advice about timing of transports.

After the initial appointment with the specialist, the recommending provider from your facility needs to review and initial the specialist’s recommendations. In the likely event that your department cannot comply with all of the requests, there needs to be documented communication with the specialist as well as the resulting consensus for treatment. For instance, if your pharmacy does not stock a particular drug, document an agreement as to an alternative medication. That way, it does not appear your department ignored recommendations. Dr. V made it to the initial appointment with the neurosurgeon. The specialist recommended a brace containing metal stabilizers, daily physical therapy and a follow-up appointment in six weeks. The metal brace was not allowed by security. The inmate was approved for only one follow-up appointment because of court, transport and reason for missed appointment. You also can see if security is heeding the medical department’s advice about timing of transports.

An Alternate Ending

Returning to Dr. V, if his department had these systems in place, here is what would have happened:

1. When the neurosurgeon recommended the metal brace, Dr. V would have documented a conversation and institution-appropriate alternative.
2. When Dr. V’s trial exhibits and, most likely, the key to his defense verdict.

Deana Johnson, JD, is a partner in the Atlanta branch of Cruiser & Mitchell, LLP, Norcross, GA, and represents correctional medical companies and providers. E-mail her at djohnson@cmlawfirm.com.

Byline

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NYC Jails Stop Routine TB Skin Testing
In January, the New York City Board of Correction permitted the city’s health department to discontinue routine Mantoux skin testing of all newly admitted jail inmates. As reported in the Fall 2005 CorrDocs, the Society of Correctional Physicians newsletter, over 60,000 incoming inmates were screened using the Mantoux text from May 2003 to April 2004 but no infectious cases were identified. The jails will now screen selectively following a list of procedures detailed in the article. The health department also is interested in using Quantiferon for screening. Find the article at www.corrdocs.org.

Your Best MRSA Defense: Good Hygiene
"Improving hygiene practices and environmental conditions may help prevent and interrupt future MRSA outbreaks in prison settings." That was the conclusion of a study reported in the CDC Journal Emerging Infectious Diseases in March. In the study, information collected by interview and medical record review was analyzed to evaluate hygiene factors. The study focused on MRSA outbreaks in a Missouri prison. Infection was significantly associated with a low composite hygiene score, and transmission among inmates appeared to be responsible for the outbreak. Find the report at www.cdc.gov/ncidod/EID/vol12no03/05-0625.htm.

Good Night, Sleep Tight...
The skin wounds caused by MRSA are sometimes mistaken for spider bites. They probably aren’t, but a new biting pest may soon show up in your facility. Bedbugs are reaching “epidemic” proportions in New York City, and they’re becoming a serious nuisance in other parts of the nation, as well, the Associated Press reported Jan. 22. They are large enough to be seen, but hide easily and usually come out only at night. Often the only signs of their presence are tiny spots of fecal matter, specks of dried blood on bed sheets and the bites. The article also notes that bedbugs are “efficient and active travelers ... nearly impossible to eradicate ... can go a year without feeding ... reproduce rapidly and don’t die easily.”

Opioid Treatment Expands in Corrections
The American Association for the Treatment of Opioid Dependence reports “significant progress” in expanding access to methadone and buprenorphine treatment in various criminal justice jurisdictions. Its 2005 annual report cited opioid treatment programs in jails in Baltimore, MD, and Orange County, FL, as well as a program being implemented in New Mexico jails. AATOD’s Criminal Justice Project receives funding through the Robert Wood Johnson Foundation Innovators Award.

Telemedicine Takes Hold in Kentucky
The Kentucky Department of Corrections expects to save $350,000 per year by implementing telemedicine in its six state prisons, according to a Jan. 19 article in the Lexington Herald-Leader. The system will be used for consultations with specialists, and will incorporate medical records, lab results, pictures and video. Also in the works is a wireless electronic medical record system in which caregivers carry and make entries into tablet computers.

Setback in the War on Meth
Law enforcement agencies have made headway in reducing production of methamphetamine, but a new menace is emerging: In Iowa, drug treatment centers are “flooded with meth addicts as users turn to imported crystal methamphetamine from Mexico,” the New York Times reported Jan. 23. The imported meth “tends to be far more potent and expensive,” leading to more overdoses and burglaries. This trend is leading to a shift to increased efforts toward demand-reduction and treatment.

AIDS Resources for Corrections
The AIDS Education and Training Centers National Resource Center has launched a “resource site for those providing training of caregivers of incarcerated and formerly incarcerated individuals.” Part of the ARCTC Web site, the corrections-focused site has links to curricula and other materials, as well as to resources geared toward corrections. Go to http://aidsctc.org.
At Missouri Prison, Health Education Is ‘Fair’ Game

BY JAMIE SHIMMUS

Three months of planning, staff involvement at every level and 80,000 photocopies. Those are just a few of the elements that came into play last summer as Western Missouri Correctional Center geared up for its annual health fair.

WMCC first held the fair about 10 years ago. Since then, it has become so successful—in the eyes of inmates as well as health and correctional staff—that the 2004 event caught the attention of NCCHC accreditation surveyors, who nominated it for Program of the Year. Last November, six WMCC representatives took the stage at the National Conference on Correctional Health Care and proudly accepted the award.

Western Missouri Correctional Center

Facility: WMCC is a medium- to maximum-security prison that can accommodate patients of all medical acuity levels. Located in Cameron, a rural community 50 miles northwest of Kansas City, it was built in 1989 on a flat campus in a flat, circular design that is handicapped-accessible throughout. Two housing units are dedicated to handicapped inmates.

Correctional Population: In 2005 the average daily population was 1,910. The facility houses only males, many of whom are sent here because of serious medical needs or handicapped status.

Health Care Staffing & Services: The health services department is managed under contract by Correctional Medical Services and operates 24 hours a day. Some services and staff are subcontracted (e.g., 2 physicians, mental health, dental). Staffing includes 43.5 full-time employees, including a health services administrator and a director of nursing, who oversees about 20 nursing positions. A full-time mental health chief manages 5.8 FTEs. Dental services are provided 60 hours per week, radiology 40 hours, phlebotomy 40 hours, optometry 20 hours and physical therapy 8 hours.

Accreditation: WMCC has been continuously accredited since 1996; it was last surveyed in 2005.

Quoteworthy: “NCCHC accreditation and standards compliance provide an excellent guide for the requirements in specific areas of health care delivery.” —Joy Dawn Hailey, RN, CCHP, health services administrator

When health fair time rolls around each year, everyone at WMCC has a part to play, and they do so with enthusiasm.

National recognition aside, why go through so much trouble? It all comes down to enhancing patient care. Health education is one of her department’s most essential functions, says health services administrator Joy Dawn Hailey, RN, CCHP. But given the nature of the “students”—inaccurated men of varying backgrounds, intelligence and educational levels—it’s one of the most challenging.

While staff educate patients at every opportunity, the fair enables them to reach individuals who normally don’t request health services. Screenings also identify problems that might not have been detected through regular medical care.

Apart from acute illnesses and disabilities, WMCC inmates have high prevalence of health problems that are well-suited to education and screening in a health fair setting: chronic diseases that arise from unhealthy lifestyles and are worsened by noncompliance with management measures, as well as those related to aging. Most common, says Hailey, are heart disease, diabetes, infectious and sexually transmitted diseases, and seizure disorders.

A Day at the Fair

The one-day health fair is a huge collaborative effort that involves every member of health services and representatives of virtually every other department. Numerous community health agencies also participate.

Last year, 480 inmates attended the fair, and participation has been even higher in previous years. Due to security concerns inmates must pre-register, and they receive passes to enter at specific times during the event, which lasts from 8:30 to 4:15.

The 15 educational booths ranged from classic medical topics such as cardiovascular, endocrine and even melanoma to issues such as substance abuse, fire and safety, and spiritual health. Health checks covered seven areas, including blood pressure, blood glucose, testicular, dental and glaucoma. These checks paid off: Hailey says that findings requiring follow-up and, in most cases, treatment were detected in about two dozen inmates.

An outcome that is truly a bonus is the growing involvement by nursing students, who rotate among the booths. After this positive exposure to prison health care, three former students joined the staff as nurses over the past two years.

Classes and Handouts

While it is high-profile, the health fair isn’t the only way WMCC staff reach out to educate inmates. Each month, Hailey and director of nursing Jinece Rees, RN, offer in-depth classes in the “therapeutic community” unit. Designed to reward positive behavior with special benefits and amenities, the unit houses from 50 to 100 inmates, depending on who qualifies. Classes address subjects such as prostate cancer and hepatitis, with a test at the end to evaluate the program’s effectiveness.

“The guys are very interested in those classes,” says Rees, who notes that inmates in this unit also borrow materials from the health department to provide peer education on less complicated subjects. And always, paper handouts are available to everyone. Administrative assistant Dawn Swinderman—the stalwart soul who makes thousands of copies for the health fair—is always on the alert for contemporary, reader-friendly resources from trustworthy sources.

“We’ll put 200 copies of materials in the education bookshelf, and believe me, they go fast,” says Rees. All of those copies take a bite out of the paper budget, but it’s for a cause the department values highly.

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Keeping Your Cool When You’re Hot Under the Collar

JERILYN C. DUFRESNE, LCSW

BY ROBERT S. WATTERS AND
JERILYN C. DUFRESNE, LCSW

Calm down. Just relax. Take a deep breath. How often have you heard those words or said them to others? But when we are under pressure and feel stressed, it’s not so easy to “just relax.”

Providing health care services in correctional settings calls for the ability to keep your cool, even in the most stressful of situations. As we know, that’s easier said than done.

Besides having to deliver top-notch treatment, you also have to be concerned about licensing and regulatory issues, not to mention working with other staff members who are also stressed.

The Crisis Prevention Institute offers many tips on staying calm—being able to detach emotionally from what’s happening. CPI recommends the following:

1. Don’t become part of the problem. If you yell back, or answer sarcastically, you’re dealing with an inmate, coworker, supervisor or family member, don’t allow the other person to drag you into a tug-of-war. Drop the rope and the power struggle will end.

2. Turn It Off

   When we’re in a difficult situation it’s very easy to say things to ourselves like, “I hate this job. I’m no good at it. I don’t have to take this from anyone!” Instead, we can stay much more rational if our self-talk is positive. “I can do this. I’m well-trained. No matter what happens, I have enough experience and developing respectful workplace attitudes.”

3. Avoid power struggles. No matter what, don’t allow the other person to drag you into a tug-of-war. Drop the rope and the power struggle will end.

4. Tune in to your body. Are your teeth clenched? Hands in fists? Shoulders tight? The first step in relaxing your body is to take a deep breath. As you inhale, your whole body relaxes. Take a mindful breath.

5. Use positive self-talk. When we’re in a difficult situation it’s very easy to say things to ourselves like, “I hate this job. I’m no good at it. I don’t have to take this from anyone!” Instead, we can stay much more rational if our self-talk is positive. “I can do this. I’m well-trained. There are other staff here to support me.”

Sometimes it may seem simplistic, but we’ll believe what we tell ourselves. If I believe that the situation is dire, or that I don’t know what I’m doing, my anxiety level will increase and my performance will decrease. The opposite will happen if I say more positive things to myself.

You’re in Control

Here are a few steps that can help reduce your symptoms of stress:

First: Try to pay attention to how you respond to the situations you encounter. The calmer you remain, the more professionally you will be able to do your job.

Second: Choose some relaxation techniques that will help you deal with the reactions you’ve identified. Make sure that you choose something that feels comfortable to you.

Third: Practice the techniques you select even when you’re not upset or stressed. Like any new skill, you’ll get better as you practice. You’ll find yourself feeling calmer all of the time—and you’ll be able to call on the techniques to help you when you do begin to feel stressed.

You work in an extremely stressful environment. However, as a professional you have the ability to control how you respond to the situations you encounter. The calmer you remain, the more professionally you will be able to do your job.

Robert S. Watters is executive director of the Crisis Prevention Institute, Inc. Jerilyn Dufresne, LCSW, is the director of communications. To contact Dufresne, send an e-mail to editor@crisisprevention.com.

Based in Brookfield, WI, CPI is an international training company specializing in reducing workplace violence and developing respectful workplaces. To learn more, visit the Web at wvce.ee.crisisprevention.com

Soothe Your Stress With Proven Relaxation Techniques

There is no one relaxation technique that is perfect for everyone, but here are some you might want to try—alone or in combination with each other:

1. Breathe Deeply

   This is probably one of the simplest yet most powerful relaxation techniques. There are many different breathing exercises designed to reduce anxiety. A good one to try is breathing in slowly through the nose for a count of five, then exhaling from the nose for a count of five. It’s important to breathe deeply from your diaphragm. You’ll know you’re breathing through your diaphragm if you can see your abdomen expand and contract. Practice taking these slow, deep breaths for a few moments when you’re not stressed; then use the same technique when you are.

2. Turn It Off

   Too much noise or too many distractions can heighten anxiety. Turn off the television, computer, telephone and pagers. Enjoy the quiet, listen to some soft music or tune into the sounds of nature.

3. Close Your Eyes (Not on the job!)

   Close your eyes for a few moments and visualize a favorite peaceful place. It could be a mountaintop, a beach, or a spot deep in the woods. Go there in your imagination by recreating the sights, smells and sounds of this special place. You’ll come back feeling refreshed.

4. Relax Your Muscles

   Often when our muscles are tense, we don’t even realize it. Progressive relaxation techniques help you recognize your own tense spots by systematically tightening and relaxing muscles in various parts of your body. Audiotapes and CDs are available that guide you through a series of progressive relaxation steps.

Getting a massage can help, too. A common reaction to stress is the tightening of shoulder and neck muscles. Massage helps to work out the tension in muscles and improves circulation to keep you loose and relaxed.

5. Channel Excess Energy

   You can relieve many symptoms of stress and anxiety by releasing both physical and emotional energy. There are many ways to get rid of excess energy. Do things that give you pleasure—go for a bike ride or a hike, watch an old movie, attend a concert or sporting event. At least once per week, plan a purely enjoyable activity. Any form of exercise is especially effective at clearing the mind and reducing physical tension.

6. Talk It Out

   Talking with someone you trust also can have a profound and calming effect. Studies show that venting things that give you pleasure—go for a bike ride or a hike, watch an old movie, attend a concert or sporting event. At least once per week, plan a purely enjoyable activity. Any form of exercise is especially effective at clearing the mind and reducing physical tension.

7. Laugh It Up

   Finally, another fun way to burn off stress: Laugh! Laughter initiates the release of endorphins, the body’s natural relaxants. Plus, keeping a sense of humor and not taking things too seriously can help prevent a lot of stress before it even starts.

Adapted with permission from the Crisis Prevention Institute, Inc.
A Framework for Correctional/Mental Health Partnership

BY ERIK N. SCHLOSSER, PhD

Providing mental health services in corrections has many challenges. One of the biggest is working in a setting that puts the highest priority on security. Correctional and mental health staff view situations differently, and may minimize the point of view of the other holds. This article will discuss the different worldviews of correctional and mental health staff, examine how common ideas, language and practices can help each to accomplish their respective missions.

Understanding the worldview of the other is important for creating effective communication. Correctional staff see their mission as maintaining order through the use of reward and punishment. Inmates are viewed as people not to be trusted, who have done wrong and are likely to repeat past behaviors. Correctional staff are exposed routinely to the dirtier parts of correctional work, such as violence and abuse and the games inmates engage in, which can diminish their view of inmates.

Mental health staff see inmates as potential clients. Clients receive mental health services to become more stable and change problematic behaviors. While mental health staff are aware of the games and behaviors of inmates, the focus is on their potential for change. Along with years of empathic listening and, usually, a lack of formal training in evaluating psychopathy and malingering, this can result in an incomplete view of inmates.

It is possible to build a framework for communication within these different worldviews. Such communication rests on building common ideas, language and practices.

Common Ideas

There are three ideas that correctional staff can understand and appreciate about their role in mental health care. First, inmates are part of the mental health business. I often tell correctional staff in training that I may be the only one in the room who came to prison to work with the mentally ill, but all of us in corrections work with the mentally ill. This point is illustrated by providing information on the percentage of inmates in the institution who are mentally ill, and the fact that the number of mentally ill people who are incarcerated compared to the number residing in state hospitals. Seeing this reality can help correctional staff expand their mission from maintaining order to providing mental health services.

Second, the idea that mental health staff may not know or appreciate the types of treatment and behavioral changes, correctional staff may not understand what mental illness is, how therapy works or who gets medications. A basic review of legal precedent instituting mental health services as necessary (Botzering v. Godkina, 1977) and the concepts of negligence and deliberate indifference (Estelle v. Gamble, 1976; Farmer v. Brennan, 1994) can establish the importance of maintaining adequate mental health care in corrections. Reviewing case law particular to one’s own state also can be helpful.

The third idea is that correctional staff see inmates more than mental health staff do. Correctional staff are in a unique position to observe inmate behaviors in various settings, while mental health staff tend to be limited to observations in clinic settings. Information on an inmate’s sleep pattern, appetite, energy level, social interaction and significant changes in behavior can help mental health staff to assess an inmate more accurately. Tell correctional staff that they are your eyes and ears out there; this can help them to view their work in a new light.

Finally, the idea that “good therapy makes for good security and good security makes for good therapy” is one that can help both correctional and mental health staff appreciate each other’s role. When inmates do the work of therapy, their behavior often improves, which helps correctional staff maintain order. Similarly, when inmates feel that the facility is safe and that the correctional staff have control of correctional staff, they report less anxiety and are more willing to consider making prosocial behavioral changes. Less secure facilities encourage anti-social behaviors, and inmates are less willing to attempt prosocial behaviors in strongly antisocial settings.

Common Language

If common ideas are helpful in building alliances, using a common language is essential. For mental health staff, describing psychiatric diagnoses and symptoms in plain English, becoming familiar with custody terminology and addressing custody issues are critical in communicating effectively between the two groups.

Think of how frustrating it is when an auto mechanic drones on about your car in language that you don’t understand. Correctional staff might feel similarly when listening to mental health staff talk about personality disorders or flat affect. If we want correctional staff to provide information on inmates’ functioning, we must give them a list of things to look for that makes sense to them.

When training correctional staff on the signs and symptoms of mental illness (NCCHC Standards for Health Services in Prisons 2003, p. 38), use examples and words that make sense to the audience. A personality disorder (PD) can be described as a personality that creates more problems than it solves. Antisocial PDs have problems with authority and lack remorse. People with borderline PD have a mood that “changes on a dime” (reactive mood) and feel things very intensely. People with psychosis see things that aren’t there, or hear things that aren’t there; they have a brain disease, which is different from PDs.

Use examples from movies and television to flesh out clinical examples: “Fatal Attraction” for borderline PD; “Jerry Maguire” (Caba Gooding Jr.) for narcissistic PD; the movie “Cobb” and the television show “NYPD Blue” (Dr. Jennifer Devlin character) for bipolar disorder.

Custody terminology involves terms that correctional staff use to answer inmate placement questions. Suitability for general population, classification systems and safety concerns are key elements in determining where and with whom an inmate is to be housed. Make sure to address these issues during mental health evaluations in order to provide correctional staff with information relating to their job.

For example, if an inmate appears anxious, ask about safety concerns, and let housing staff know what you learn. Sometimes an inmate is not appropriate for general population due to a severe mental illness or similar problem. Sharing this information with correctional staff also role models how you would like them to work with you.

Custody issues that mental health staff can address include whether an inmate is a risk to sell or others, will the inmate get bossed around, whether this is the best place for this inmate given the resources of this particular unit. Considering these questions and providing timely information enables mental health staff to assist correctional staff in their mission, and helps correctional staff see mental health staff as partners.

Common Practices

Building common practices is a final step in creating effective communication. Offender management reviews or similar meetings occur on each housing unit, usually on a weekly basis. Mental health staff can attend these meetings during a specific time allotted to address issues pertaining to inmates having mental health problems. This can be done without revealing confidential information, and can enable both mental health and correctional staff to develop specific responses to an inmate’s behavior.

Other practices that provide an opportunity for interaction include debriefing after referrals, tapping into the grapevine at work, showing care for correctional issues and providing training to correctional staff. A recent survey by the Utah Department of Corrections revealed that about 50% of correctional staff work a second job, and two-thirds have to work overtime or another job to make ends meet. Developing an awareness of such issues allows mental health staff to understand better what correctional staff go through.

Mutual understanding using common ideas, language and practices can result in an improved ability to accomplish our diverse missions in corrections.

Erik N. Schlosser, PhD, is a clinical psychologist at the Central Utah Correctional Facility, Gunnison. To contact him, send an e-mail to eschlosser@utah.gov.

Correctional Medicine Around the Globe

The Society of Correctional Physicians is hosting a one-day educational conference that will take a look at correctional medicine in the US, Iraq, Africa and the Caribbean. Find out what’s happening in different parts of the world, how these health markets might affect your facility, and how you can make a difference.

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Medical care for juveniles must be approached in a manner different from that for adults. Still in the process of growth and development, adolescents require assessment and care that is specialized for their unique needs. To aid correctional health care practitioners in accurate assessment and diagnosis as well as effective management of chronic conditions, NCCHC is issuing clinical guidelines for the most common and most problematic conditions seen among youths in confinement.

The Commission’s juvenile health committee is charged with developing the guidelines, which must be approved by the policy and standards committee. As with the seven clinical guidelines already available for adult populations, the juvenile clinical guidelines are based on nationally accepted guidelines promulgated by other organizations but adapted for correctional populations and environments.

The first two adolescent guidelines to be issued address asthma and seizure disorders. Like all clinical guidelines developed by NCCHC, these will be reviewed periodically and updated as necessary to ensure they reflect the latest consensus recommendations as well as contemporary medical practice.

**Common and Problematic**

The juvenile health committee chose to first focus on asthma because of the fact that it is fairly common among confined youth yet often goes undetected in the community prior to their confinement. Often, it’s only when youths are admitted to a juvenile facility that they receive proper diagnosis, education and treatment for this reactive airway disease.

Further, assessment of adolescents for asthma is especially important because evidence suggests that early treatment to prevent inflammation may prevent progressive development of irreversible lung disease.

Seizure disorder guidelines were also a priority for the committee. A condition of recurrent, unprovoked seizures, epilepsy is more common among juveniles in confinement than in the community, likely because of a greater incidence of birth trauma and head injuries among this population. In most cases, youths with epilepsy have been diagnosed as such. But complicating matters is the fact that some seizures are not due to epilepsy. Thus, epilepsy must be distinguished from seizures that result from toxic, metabolic or other abnormalities such as substance abuse or drug withdrawal, which may not require long term therapy.

**Correctional Focus**

The NCCHC juvenile clinical guidelines are unique because they address issues, concerns and controversies specific to correctional populations. For instance, the “diagnosis” section of the seizure disorder guidelines notes the difficulty of assessing epilepsy in a patient who is abusing drugs: While the resultant seizure may be an isolated event, true epilepsy cannot be ruled out because an underlying chronic disorder may have caused the drugs to trigger a seizure. All of this, of course, has implications for the medication regimen that is ordered.

Treatment strategies must take into account the realities of correctional settings. For instance, the asthma guideline discusses “keep on person” policies regarding inhalers, noting that most juvenile institutions do not permit “keep on person” medications. However, the guideline supports such policies for inhalers, with the caveat that the patient must be carefully evaluated for dosage, illness and ability to comply. The possibility of inhaler abuse also must be weighed.

NCCHC guidelines also devote a section to “correctional barriers.” In a typical youth facility, for instance, environmental problems such as inadequate ventilation, poor temperature control and dirty air filters can exacerbate asthma complaints, as can exposure to chemical restraints such as pepper spray.

Each guideline ends with suggested quality improvement monitors that facilities can employ to help ensure successful care of chronic conditions.
Volume 12, Issue 1 embarks on an exciting chapter in the history of the Journal of Correctional Health Care. We have a new publisher, a new look and many new features. Sage Publications is a highly regarded publisher of scholarly, educational and professional journals, books and electronic media. Sage brings many strengths to our partnership.

For subscribers, one of the most valuable is access to Sage Journals Online, a rich yet user-friendly site that enables readers to search for articles, link to cited works, receive e-mail alerts and much more [see page 6]. Check out this wonderful resource at http://jchc.sagepub.com.

In keeping with these improvements, we have updated our policies and procedures for accepting and processing articles. This includes a new publication agreement that must be signed by all authors, as well as more rigorous documentation concerning disclosures and permissions.

Further, the Journal offers continuing education credits for physicians, nurses, psychologists and CCHPs through the self-study exam in each issue. Therefore, we also ask authors to supply learning objectives and questions relevant to their articles. An overview of these policies and procedures plus copies of guidance documents and forms are posted at the Journal section of the NCCHC Web site, www.ncchc.org.

As for our first issue published with Sage, I believe you will find the articles informative and insightful in their presentation of empirical and scientific findings. As always, your comments and suggestions are most welcome.

John R. Miles, MPA, is the editor of the Journal. Contact him via e-mail at journal@ncchc.org.

The Complete Lineup: Volume 12, Issue 1

- Predictors of Prior Incarceration and Alcohol Use Among Soon-to-Be-Released Adult Male Inmates
  Torrance T. Stephens, PhD; Ronald Braithwaite, PhD; Nancy E. Sprance; TeniFuyo Reeves Louis

- Hepatitis B Vaccination in Prison: The Perspectives of Formerly Incarcerated Men
  Jessica M. Buck, BA; Kathleen M. Morales, PhD; Andrew Margolick, MHP; Gloria Eldridge, PhD; James Sosman, MD; Robin MacGowan, MHP; Diane Binson, PhD; Deborah Rucanek, ScD; Timothy P. Plancon, MD; The Project START Study Group

  Anasseril E. Daniel, MD; Jennifer Fleming, BA

- A Study of Young Offenders With Learning Disabilities
  Deborah Shelton, PhD, RN, BC

- Juveniles in Detention: How Do Girls Differ From Boys?
  Sonia A. Alcachino, PhD; Elizabeth Shaffer-King, MA; Rachel Hammel, BA

- Poison Center Utilization by Correctional Facilities
  Denise L. Kurta, RN, CSPI; Rita A. Meexos, DSC, CSPI; Edward P. Krenzelok, PharmD, FAACT, DABAT

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based way, we educate our patients about reasonable expectations in the health care arena. Such education is essential for our patients, many of whom will parole in the near future.

We also do ourselves a favor. Many correctional health professionals are frustrated with continual demands for nonmedical intervention. This simply is not what we have studied and trained for. By freeing ourselves up to practice our profession, we will increase our job satisfaction and effectiveness.

Finally, we minimize liability risk when we apply policies consistently between and within our institutions.

We all know how inmates respond when they perceive that “the other guy got extra socks from health services” and they didn’t.

Remedying the Problem
Since 1994, the Oregon DOC has followed level-of-care policies and procedures that address these issues. (The policy is posted with this article at the CORRECTCARE archive, online at www.ncchc.org.)

Since caregivers may become worn down from nonmedical requests from time to time, we suggest the following measures to reduce inappropriate requests and to help health staff handle those that do arise.

1. Provide regular, consistent education to patients about the proper role of health services in their lives, with emphasis on their expectations about necessary medical care, comfort items and levels of care (see “Notice” at right). Subsequent messages could be worded more simply.

2. Be consistent with medical, nursing, dental and mental health orders. Generally, we should default to declining to provide comfort items or nonmedical orders unless there is a clear-cut medical reason with a solid foundation in evidence-based practice.

3. Consider developing a “formula” for nonmedical interventions. What form this will take is open to ongoing dialogue. (But don’t ask us to intervene in job assignments. If you don’t like your job, discuss that with the assignments officer.)

4. Develop a review process for nonmedical interventions at every institution and apply it consistently.

5. For all medical interventions in this area, there should be accountability for who made the order and why. Develop policy that ensures that health staff are held accountable and that provides for time-limited, written medical orders.

Michael Puerini, MD, CCHP, is chief medical officer at OSCI, Salem, OR, and Steven Shelton, MD, CCHP-A, is medical director at ODOC. This article was written with assistance from Bridgett Whalen, RN, health services manager at TRCI, Umatilla; Garth Gulick, MD, staff physician at SRCI, Ontario; and Daryl Ruthven, MD, ODOC chief psychiatrist.
For the third year, the correctional mental health conference will feature lively and energetic programming on a topic of vital importance to our field. The program format is designed to encourage attendees from various settings and of varying skill sets to interact and share information for the benefit of all. By sowing the seeds for interdisciplinary collaboration and cooperation, we can make real progress in designing and delivering systems of high-quality, comprehensive care. As we consider how to cultivate quality care, we ultimately must think about broad-scale intervention, focusing not only on the individual, but also on how to effectively reintegrate individuals with their families and communities. After attending this special conference on correctional mental health care, you will be able to share your new knowledge with colleagues and help to transform care.

Beautiful San Diego

California’s second largest city, San Diego prides itself on being America’s most hospitable city. And it is, without a doubt, beautiful and inviting. Bordered by Mexico, the Pacific Ocean, the Anza-Borrego Desert and the Laguna Mountains, San Diego enjoys a gentle Mediterranean climate and blue skies that keep watch on 70 miles of beaches. With San Diego International Airport only 3 miles northwest of downtown and the electric Gaslamp Quarter, you’ll move from jet lagged to jet setting in a quick taxi trip. Within a few blocks of the hotel are world-class dining, shopping and entertain-ment. For a good introduction to the city, check the Web at www.sandiego.org.

Program Highlights

This two-day program will take place on Sunday, July 10, from 9 am to 5 pm, and Monday, July 11, from 9 am to 4 pm. You will have the opportunity to choose concurrent sessions from three educational tracks. Breakfast and luncheon programs will be sponsored on both days.

Session Topics

- Assessing and Treating Adolescent Substance Abuse
- Beyond Diagnosis: The Soul of the Psychopath
- Bipolar Disorders: Managing Medications in Juveniles
- Conducting Psychological Autopsies
- Designing a Managed Care Model for Mental Health Services
- Differentiating Medical Conditions From Mental Health Disorders
- Essential Nursing Skills for Managing the Mentally Ill
- Leadership in Mental Health: Uncommon Cures for Common Flaws
- Medication Management Compliance
- Mental Health Aspects of an Aging Population
- Opioid Treatment: The Latest Strategies in Substance Abuse Programming
- Oral Manifestation and Substance Abuse
- Principles of Care for Co-occurring Disorders
- Psych Medecine Use: Rational Approaches Instead of Polypharmacy
- Psychological Effect of PTSD in Women
- QI Metrics: Measuring What Matters
- Reducing Recidivism Through Substance Abuse Treatment
- Screening and Treatment in Special Housing Units
- So You Are Being Sued, Now What?
- Substance Abuse Intervention Programs for Women
- The Ins and Outs of Discharge Planning
- Training Correctional Officers in Mental Health

For detailed program information, visit www.ncchc.org.

Program Site and Accommodations

The program will take place at the Manchester Grand Hyatt, a luxurious hotel that boasts the largest waterfront property on the West Coast. Situated in the heart of San Diego, the hotel features well-appointed guest rooms with available high-speed Internet. A special rate of $149 has been arranged for meeting participants, but to receive this rate you must reserve your room by June 8. Call the hotel toll-free at (800) 233-1234 and be sure to tell the reservations agent that you are attending the NCCHC meeting to receive the discounted rate. To learn more about the hotel, visit the Web at http://manchestergrand.hyatt.com.

Continuing Education

- Psychiatrists and other physicians: This activity was planned and implemented in accordance with the Essentials Areas and Policies of the Accreditation Council for Continuing Medical Education. NCCHC is accredited by ACCME to provide continuing education for physicians. Physicians may earn up to 13 hours of Category 1 credit.
- Psychologists: NCCHC is approved by the American Psychological Association to offer continuing education for psychologists. NCCHC maintains responsibility for the program. This activity is approved for up to 13 hours of credit.
- Nurses: NCCHC is approved as a provider of continuing nursing education by the Illinois Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. This activity is approved for 15.6 contact hours.
- CCHPs: The Certified Correctional Health Professional Board of Trustees has approved this activity for 13 hours of Category 1 credit for recertification.
Nationwide Career Opportunities

Over 100 locations throughout the nation that offer a range of clinical and administrative opportunities within ambulatory and chronic care settings, and medical referral centers managing acute and long term medical-surgical and mental health conditions in urban and rural environments.

Excellent Benefits

Health and life insurance, sick and annual vacation leave, plus 10 paid holidays per year, continuing education funds, Federal Law Enforcement Retirement Plan, and a Thrift Savings plan (similar to 401K).

Career Pathways

Work as a civil service employee for the Federal Bureau of Prisons, or as a Commissioned Officer in the US Public Health Service Commissioned Corp.**

YOU can have a significant role in the health of the nation by providing quality care within federal correctional health care facilities.

For additional information, please contact:

CAPT Beverly Dandridge, FNP, MSN
Senior Program Management Consultant, Nurse Recruiter
Federal Bureau of Prisons, Health Services Division
320 First Street, N.W. – Room 1060
Washington, DC 20534
1-800-800-2676
bdandridge@bop.gov

** Some age restrictions

The Federal Bureau of Prisons is an Equal Opportunity Employer.
Excursions. Ask your concierge for advice. The city offers luxurious hotels, unique shopping, dazzling stage shows, first-rate dining and world-class golfing, not to mention the exciting nightlife and gaming. Visitors give high marks to these popular attractions:

• Blue Man Group
• Cirque du Soleil
• Elvis-A-Rama Museum
• Fremont Street Experience
• Lake Mead

Nature Calls 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 climbing enthusiasts and photographers. Mt. Charleston offers hiking and other outdoor activities in the breathtaking High Sierras. And beautiful Lake Mead is perfect if you’re into water sports.

Tour For a great diversion, consider a tour. On offer are helicopter views of the length of the Strip from 9:30 a.m. to 1:30 a.m. Exact fare of $1.75 is required.

Shows Las Vegas presents performances by some of the most famous singers and comics in show business, as well as lavish productions featuring statuesque showgirls, stunning sets and incredible special effects. Tickets for most shows and headlining entertainers can be purchased by phone, at showroom box offices or online at vegasshows.com. Hotel lounges also offer some of the best and most economical entertainment around.

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Las Vegas: One of a Kind

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 and gaming. Visitors give high marks to these popular attractions:

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Upgrades in Correctional Health Care

The Updates Conference is guaranteed to provide the professional education you need. By incorporating attendee feedback with the successful activities and programs from years past, NCCHC and the Academy of Correctional Health Professionals have designed a rich program that makes the most of your valuable time. This year’s high energy event offers customized learning tracks that make scheduling easy.

Program Highlights

Updates offers access to experts, resources and tools to help you address complex professional and clinical issues. Need to learn about current trends? Seeking creative solutions for perennial problems? The 45 educational sessions will offer ideas you can implement right away. And don’t overlook the value of networking and the exhibits!

Conference Objectives

• List major health care issues that commonly affect incarcerated individuals, including HIV, hepatitis, hypertension, diabetes, mental illness and substance abuse
• Describe current legal, ethical and administrative issues, and ways to prevent potential problems that arise in correctional settings
• Employ new practices for the treatment of major health care issues in order to better manage common medical and nursing problems found in correctional settings
• Express increased understanding of common correctional health care issues by exchanging ideas with colleagues about new developments in specialty areas

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Essential Exhibits: The Lineup

From the opening reception Sunday evening to the final break and raffle drawing late Tuesday morning, the Exhibit Hall will be your place to relax. You’ll have plenty of time to talk with representatives from leading companies whose products and services can assist you in your job. List current as of March 9.

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Physical Restraint: Intervention of Last Resort

BY JUDITH A. STANLEY, MS, CCHP-A

The National Commission receives many inquiries about the use of physical restraints in correctional facilities. Because of this high interest—and, frequently, confusion—this Spotlight column will focus on the “restraint” component of essential standard I-01 Use of Physical Restraint and Seclusion in Correctional Facilities.

First Things First
Before we delve into interpretation of the standard, a few points must be made clear. First, this standard does not address the custody restraints used to transport inmates or those required due to the inmate’s security classification. In such cases, use of these motion-limiting devices is a routine correctional procedure set by jurisdictional authorities.

Health staff are not involved in these cases unless there is a health-related reason to alert custody of a contraindication or a modification needed for a particular inmate. For example, if an inmate with a broken leg cannot tolerate the usual leg shackle restraint, health staff must alert security that the inmate’s treatment protocol needs to be modified for this inmate. (See standard A-08 Communication on Special Needs Patients.)

A second point is that, whether correctional or clinical, all staff who apply restraints must be trained to do so. However, in cases where the restraints are for clinical reasons, there is no requirement that health staff must apply them. In fact, it’s common for a team of trained correctional staff and health staff to be involved, with correctional staff actually applying the clinically ordered restraints.

Third, different devices are used for different types of restraint. Custody ordered restraints include cuffs, belts, leg shackles and chains, as well as leather or “soft” devices. Restraint methods used for clinical reasons are limited to those used in community clinical settings. These include fleece-lined leather, rubber or canvas hand and leg restraints, two-point and four-point restraints, and restraint chairs. Inmates are not to be restrained in an unnatural position, such as hog-tied, facedown or spread-eagle.

Finally, for both types of restraints, health staff must make a physical assessment of the inmate initially and periodically, usually in coordination with trained security staff monitoring the inmate. This includes checking for circulation and nerve damage, airway obstruction and psychological trauma. Also, each of the inmate’s limbs should be exercised for at least 10 minutes every 2 hours to prevent blood clots.

See the Compliance Indicators for specific actions required of health staff for clinically ordered restraints (Indicator 2) and custody ordered restraints (Indicator 3).

All of this makes sense when we consider the intent of this standard: “[W]hen restraints are used for clinical or custody reasons, the inmate is not harmed by the intervention.”

Custody vs. Clinical Restraints
The usage of physical restraint addressed by this standard is limited to emergency situations in which an inmate’s behavior presents a danger to self, other inmates or staff.

Clinically ordered restraint, by definition and practice, is used only after noninterventional interventions have failed as a last resort for the shortest amount of time needed for the inmate to regain control. It may never be used as discipline or as a way to control unruly behavior. As with clinical restraint, in good correctional systems, custody ordered restraint is an infrequent intervention used as a last resort. Corrective procedural definitions of the circumstances when custody may intervene, if allowed by jurisdictional directive, custody restraint also may be used as a disciplinary measure.

In all circumstances, officers must be trained how to intervene safely. Many jurisdictions provide training in one or more techniques of nonviolent intervention or de-escalation.

Most of the confusion surrounding the use of physical restraints stems from the reason for the behavior that leads to an inmate’s restraint. While such behavior can be caused by any number of reasons, it is the reason for the behavior, not the behavior itself, that dictates the role of health staff.

For example, an angry inmate yelling and threatening to harm an officer could be psychotic and responding to voices, or simply very upset because his wife did not come to visit as she had promised. A woman refusing to enter her cell may be protesting what she perceives as an unreasonable early termination of her recreation time, or may be experiencing a flashback of being raped in a locked bedroom.

It is not always difficult to distinguish between instances of restraint for custody vs. clinical reasons. In situations where the inmate is known to have behavioral manifestations of mental illness (and communication between health staff and security about special needs must be ongoing, of course), the officers will be quick to alert health staff on duty for the physician’s orders for controlling the situation.

On the other hand, some inmates are well-known among staff for ill temper or violent behavior that’s unrelated to any illness, and unfortunately may need periodic custody restraint to prevent harm to others. But it can be challenging to determine the reason for out-of-control behavior in inmates newly admitted to facilities, those whose medical or mental health history is not known, and those who present with both clinical problems and difficult personalities. This is why custody staff must alert health staff when an inmate is put into restraint for presumably custody reasons.

Health staff then must review the health record for any contraindications or required accommodations and immediately communicate these to custody staff (Compliance Indicator 3.a.1.). When health staff assessing the restrained inmate note a medical or mental health condition, the physician is notified immediately so that appropriate orders can be given (3.b).

Clinical Restraint Issues
Therapeutic use of physical restraint for medical reasons is relatively rare and generally limited to use in inpatient or inpatient settings. Most commonly it is used for those with mental health disorders, and usually, but not always, related to noncompliance with psychiatric medication.

Before using physical restraint on inmates with mental health disorders, practitioners must first determine if restrictive interventions (e.g., talk the inmate down, offer medication), as well as consider changes in the treatment plan. Further, the health record must document those prior interventions and treatment plan changes for each instance of restraint use.

If restraint is used, the question may arise as to whether the use of psychotropic medication can shorten the period of time that restraint is needed. While this may be a justification for emergency administration of psychotropic medication, it should be remembered that a restrained inmate may be willing to accept medication and so the forced technique would not be needed. (See standard I-02 Emergency Psychotropic Medication.)

CQI Monitoring
The facility’s continuous quality improvement program should monitor all incidents of clinical restraint so that patterns not related to individual inmates may be detected. (See standard A-06 Continuous Quality Improvement Program.) For example, frequent use of restraint in a residential unit for those with mental health problems would indicate a need to assess the effectiveness of treatment being provided.

Likewise, higher utilization of physical restraint in one housing unit vs. another of similar numbers and classification of inmates should prompt an examination of factors leading to such interventions, such as the unit officers’ techniques and attitudes.

In the ideal correctional setting, there would be no need for physical restraint. But we must deal with what is real, so keeping the use of this intervention to a minimum—and employing it safely when it is needed—should be the goal.

*Restraint chairs have been the subject of controversy in the health care field. Restraint chairs are being used in community settings such as inpatient psychiatric centers. Like any restraint device, they can be harmful if used inappropriately. However, when used according to accepted clinical guidelines, they are reported to offer a less stressful position for the body and can be less traumatic than other means of restraint for those who have experienced physical or sexual abuse.

Judith A. Stanley, MS, CCHP-A, is NCCHC’s director of accreditation. Reach her at judithstanley@ncchc.org.

Standard I-01: Use of Physical Restraint and Seclusion in Correctional Facilities

The standard is the same in the jail and prison versions of the 2003 Standards for Health Services: “Clinically ordered restraint and seclusion are available for patients exhibiting behavior dangerous to self or others as a result of medical or mental illness. Except for monitoring their health status, the health services staff does not participate in the restraint of inmates ordered by custody staff.”

Reach her at judithstanley@ncchc.org.

‘Spotlight’ Archives
Available Online
If you rely on the NCCHC Standards for Health Services, this series of CORRECTCARE articles will aid your understanding of the latest editions.

But you need not dig through stacks of newspapers to find them: The complete series (10 articles to date) is posted at the NCCHC Web site. Find them at www.ncchc.org/resources
Forced Psychotropic Medication

Please clarify standard Y-E-09 Segregated Juveniles. At our small juvenile center (average daily population usually under 50), the nurse is on duty on days, five days a week. It is rare that a youth is placed in segregation, but when it does happen, it is usually on the weekend. Compliance Indicator 3.d. states, “On days when health staff are not on site, health-trained child care workers or program staff alert health staff on call if a health problem is noted during the staff checks.” What does this mean? Does the nurse on call have to come in if there is a problem?

The answer—the on-call nurse uses clinical judgment based on the facility’s protocols—is one that you would expect when you consider the intent of this standard: “to ensure that juveniles placed in segregation maintain their medical and mental health while physically and socially isolated” from the rest of the population.

Staff training should include what to look for that would require notifying the on-call nurse, and what information the nurse requires in order to provide appropriate direction to staff. The on-call nurse will decide whether to come in based on the physical and mental health status and history of the youth involved, the resources available on site and the nurse’s distance from the facility.

Detoxification of Jail Inmates

Please resolve a dispute we are having at our large jail. Who should be responsible for providing detoxification services, the physician or the psychiatrist? The responsibility was not explicitly addressed in either of their staff contracts.

The relevant standard is I-02 Emergency Psychotropic Medication (essential), which is the same in the jail and prison versions of the Standards. The modifier “emergency” is key here: Under the standard, psychotropic medication may be forced only when inmates present an immediate danger to themselves or others due to their mental or medical illness. Any other forced administration must comply with current case law and the regulations of your jurisdiction.

An inmate adjudicated as incompetent to stand trial may or may not pose such danger. Thus, it becomes a clinical decision for the physician or psychiatrist evaluating the patient just before the flight.

You cannot have standing orders that all such patients are to be medicated against their will. For one thing, the patient may be willing to take the medication or may be amenable to counseling. Explaining how the medication may make the trip less stressful can calm an anxious patient into agreement.

When the patient will not agree and in the physician’s medical judgment the inmate does present an immediate danger to self or others during the trip, then an order for a one-time forced administration can be written, provided that this complies with jurisdictional law.

The physician should document clearly in the record the clinical reasons why the medication was forced, including less-invasive interventions that were tried. The transporting staff and the receiving facility both must be informed that the inmate has been medicated. Transporting staff should be alerted to the expected reaction to the medication, as well as the possibility of a negative reaction, especially if the patient has not been taking medication. These staff must be trained on how to provide assistance and summon help if necessary. Be sure your facility policies and procedures address these situations.

Family Support Resources

Our daughter has spent a good deal of her life in correctional facilities, and she is serving time again. Her crime is what she is doing to herself. She has mental health and drug addiction problems. We cannot find advocacy groups of family members in support of those who find themselves incarcerated in a system that does not appear able to help them deal with their problems and get treatment so they can stay out of prison. Do you know of any resources?

Unfortunately, many families and friends are in the situation you find yourself regarding your daughter. While your inquiry does not relate to NCCHC standards, we want to address it in this column to provide information for correctional health staff who may be asked the same question.

Your best initial contacts are the National Mental Health Association (www.nmha.org; 703-684-7722) and the National Alliance on the Mentally Ill (www.nami.org; 703-524-7600). Both organizations have national, state and local chapters, as well as subgroups that focus on issues related to mentally ill people who are incarcerated. The specialized groups are involved with initiatives such as diversion from correctional settings, quality care while incarcerated, and discharge and follow-up issues. They also may be able to direct you to other resources in your area.

Judith A. Stanley, MS, CCHP-A, is NCCHC’s director of accreditation and oversees the development and revision of standards. R. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president, liaison to the policy and standards committee, and an accreditation surveyor. Do you have a question about the NCCHC standards for health services or opioid therapy programs? Write to Standards Q&A, c/o NCCHC, 1145 W. Diversey Parkway, Chicago, IL 60614. You also may contact us by fax at (773) 880-2424, or by e-mail at info@ncchc.org.
National Conference on Correctional Health Care
Atlanta, Georgia • Oct. 28 - Nov. 1

Who Should Exhibit?
Associations; computer/software; contract management; dental supplies/equipment; diagnostic equipment; educational materials/training; EMR/health records; infection control; medical devices/equipment/supplies; pharmaceuticals and pharmacy services; publications; recruitment/staffing services; universities; uniforms/scrubs

Sponsorship Opportunities
Exhibitors can enhance their exposure by sponsoring services, sessions and events that support the conference.

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

Proceedings Manual on CD: Now distributed in popular CD format, the manual provides a lasting record of each concurrent session, including abstracts and handouts. The sponsor credit will be highly visible on the CD.

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

Exhibit Breaks: Scheduled breaks enable attendees to meet with exhibitors and network with colleagues while enjoying morning coffee and afternoon snacks.

Other Opportunities: Registration bags, lanyards, cups, badges, banners: all are good ways to gain visibility. Have other ideas for sponsorship? We’d love to hear them!

Registration Information
Exhibition hours are Sunday through Tuesday. Prices for 10’ x 10’ booths start at $1,350; double-size and premium spaces are available. Prices include one full and two exhibit-only registrations. Other representatives may register at a discount. For a prospectus with details and a reservation form, e-mail info@ncchc.org or call (773) 880-1460.

Join the Celebration
The 30th anniversary of the National Conference promises to be something special. Widely renowned as the premier annual meeting in correctional health care, this year’s event features standout programs and activities that will attract the movers and shakers in this field. This is your opportunity to meet with nearly 2,000 professionals who influence or make decisions about correctional health care products and services. And they spend significant time browsing the conference exhibits to learn about the latest medical supplies and pharmaceuticals, information technology, contract services, staffing services and more. If you exhibit at only one meeting in 2006, this has to be it!

At NCCHC’s 2005 National Conference, attendees’ postconference evaluations revealed the following:
• 95% visited the Exhibit Hall at least twice
• 94% found the exhibit hall worthwhile
• 81% visited to learn about new products and services
• 43% visited to meet with current suppliers
• 43% are authorized to make purchases

Exhibitor Benefits
NCCHC is committed to creating a sales environment conducive for you as well as meeting attendees.

• Breaks, lunch and networking in the exhibit hall, with 9 hours of exclusive exhibit time
• Opportunity to participate in the popular raffle drawings
• Company listing and promotional writeup in the Final Program, and a listing in CORRECTCARE (deadlines apply)
• Pre- and final registration lists with attendee addresses
• Special advertising opportunities for CORRECTCARE, the conference program and the conference Web site
• Virtual Exhibit Hall listing at the NCCHC Web site
• Lead retrieval scanner system available
• Priority booth selection for 2007 National Conference

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

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

Production Schedule

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Notes
1. Ad sizes encompass live area, no bleeds.
2. Color ads cost $250 per color additional per page or fraction.
3. Frequency discounts are based on total number of insertions within the next four issues. Ads need not run consecutively.
4. Recognized advertising agencies receive a 15% discount on gross billing for display ad space and color if paid within 30 days of invoice date.
5. Special opportunities are available for conference exhibitors; please see the Marketing and Resource Guide or contact NCCHC for information.
6. Electronic files (Quark, Pagemaker or PDF) preferred; include font files. We also accept camera-ready copy and film (120 line, right reading, emulsion side down). Proofs must accompany all ads.
7. Cancellations must be received in writing before the insertion order deadline.
8. We reserve the right to change rates at any time; however, we will honor the rates in effect when the order was placed.
9. Acceptance of advertising does not imply endorsement by NCCHC.
classified advertising

employment

family medicine physician and nurse practitioner

Jackson Memorial Hospital in Miami-Dade County is accepting CVs from BE/BC family medicine physicians and family medicine ARNPs for Corrections Health Services, which provides medical care in our county jail. Come to a warm and beautiful place to do meaningful and interesting work with predictable hours. Competitive salary and excellent benefits. Email CV to kvillano@um-jmh.org or rjose@um-jmh.org. Contact (305) 585-6081.

medical director

Nevada Department of Corrections seeks a medical director for the state prison system. For consideration, email current curriculum vitae to Sherri Vondrak, svondrak/doc.mv.gov.

take charge of your future

The Academy CareerCenter is the most comprehensive career and recruiting site serving the correctional health care field. Free to job seekers, it features easy searching, e-mail and RSS notification of postings, saved jobs folders, resume posting and online application. For employers, this is a convenient and cost-effective tool for finding high-quality candidates. Visit http://careers.correctionalhealth.org.

marketplace

national conference proceedings on CD

Conference-goers loved taking home the proceedings manual from NCCHC meetings for future reference, but they hated lugging those heavy books. Now they have the best of both worlds—and you can too, even if you didn't attend the conference. Educational session abstracts, presentation notes and handout standards as of the 2005 National Conference in Denver are available in a convenient CD-ROM format. $10 plus shipping & handling. Order online at www.ncchc.org or call (773) 880-1460.

clinical practice, 2nd edition

Written and edited by 40 practitioners in prison systems and public health nationwide, this 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 hospital 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 services, plus new chapters on hypertension and obesity, prostate cancer, and treatment of disabilities. $129.95. Order at www.ncchc.org or call (773) 880-1460.

otp standards

Standards for Opioid Treatment Programs in Correctional Settings

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

The Standards for Opioid Treatment Programs in Correctional Settings represent the requirements for OTPs seeking accreditation from NCCHC. To develop the standards, NCCHC used federal regulations and community standards as a guide and modified them to take into account the issues unique to providing services in a correctional facility. All of the standards are linked to specific federal regulations.

Conforming with NCCHC’s Standards for Health Services, the OTP Standards cover nine major areas: governance and administration, environmental safety, personnel and training, health care services and support, juvenile care and treatment, health promotion, special health needs, health records, and medical-legal issues. 2004. Softcover, $92.95. Order at www.ncchc.org or call (773) 880-1460.

ncchc standards

NCCHC Standards for Health Services in Correctional Settings

Developed by leaders in the fields of health, law and corrections, the Standards for Health Services provide guidance in establishing and implementing a comprehensive health services system in jails, prisons and juvenile facilities. Compliance dictates whether an expected outcome is met. Administration, environment, personnel, health services and support, mental health, juvenile care and treatment, health promotion, special health needs, health records, and medical-legal issues are covered. 2004. Hardcover, 560 pages, $89. Order online at www.ncchc.org or call (773) 880-1460.

opiod treatment

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, pharmacotherapy, training, management, patient advocacy, policy and more. Find details at www.aatod.org, or call (212) 566-5555.

mental health


achsa meeting

The American Correctional Health Services Association will hold its multidisciplinary training conference May 11-13 at the Sheraton Imperial Hotel in Raleigh-Durham, NC. Find details at www.achsa.org, or email admin@achsa.org.

jail training & expo

The American Jail Training & Expo. The American Jail Training & Expo will convene May 21-25 in Salt Lake City, UT, for the Annual Training Conference and Jail Expo. Learn more at www.corrections.com/aja, or call (301) 790-3930.

meetings

HIV Management Videoconference. “Hepatitis B & C with HIV Co-infection: A Diagnostic & Treatment Update” is part of a live satellite series on HIV/AIDS in correctional and community settings. Sponsored by Albany Medical College, the free program will be broadcast on April 19, 12:30 to 2:30 pm ET. CME and nursing education credits are available. Register at www.amc.edu/patient/hiv/hiveconf, email ybarra{j}@mail.amc.edu, or call (518) 262-4674.

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HIV/HBV Coinfection in Prison Systems

Peer-reviewed content examining:
- The scope of HIV/HBV coinfection in prison settings
- Screening and prevention strategies
- Current and emerging therapies

In the United States, approximately 1.25 million people have chronic hepatitis B virus (HBV) infection and 850,000 to 950,000 people have human immunodeficiency virus (HIV) infection. HIV/HBV coinfection is common due to shared risk and it has a significant effect on morbidity and mortality.

The challenge of HIV/HBV coinfection is intensified in the prison setting. Many prisoners have existing HIV and/or HBV infections due to high-risk behavior prior to their incarceration. Prison staff is also at risk via occupational exposure.

HIV/HBV Coinfection in Prison Systems is a comprehensive examination of the growing

HIV/HBV coinfection problem presented by 2 renowned experts in the field. Covered topics include the scope and epidemiology of HIV and HBV in prisons and jails, screening and prevention strategies, postdiagnosis evaluation, and current and emerging treatment options.

Take this opportunity to learn how to best manage and treat HIV/HBV coinfection and infection for both inmates.

Listen to expert faculty discuss the latest scientific data and address key questions.

For complete CME/CE and faculty disclosure information, go to www.projectsinknowledge.com/HIV-HBV/

Projects In Knowledge is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

This independent CME/CE activity is supported by an educational grant from Bristol-Myers Squibb Company.

Program Available Online Now! View at www.projectsinknowledge.com/HIV-HBV/

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BY E-MAIL: HIV-HBV@projectsinknowledge.com