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The Five Rights of Delegation

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Inmate’s Right to Refuse Dialysis Affirmed

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In Other News...

Juvenile Standards Time Line for Compliance. The new edition of the Standards for Health Services in Juvenile Detention and Confinement Facilities is hot off the presses (see Spotlight on page 3 for a summary of changes). Here is important information for accredited juvenile facilities. Note that this time line is revised from the one published in the Q&A column of the Winter 2011 issue.

- June 1: All juvenile facilities seeking initial accreditation will be surveyed under the 2011 edition of the Standards.
- June 1 through September 30: All currently accredited juvenile facilities will be surveyed under the 2004 edition.
- October 1: All juvenile facilities will be surveyed under the 2011 edition.

The Legal Health Record. The NCCHC publication catalog now offers The Legal Health Record: Regulations, Policies, and Guidance, 2nd Edition. Published by our supporting organization the American Health Information Management Association, this important book explains, from a record manager’s perspective, how to create health records that are better organized and offer better legal defensibility, and how to lead teams through the processes necessary to clearly understand and organize strategies and work flows. As health records migrate to electronic environments, this book will assist in meeting the related challenges. The tools and strategies provided straddle the legal and record management/information technology arenas. Key features: expanded explanatory information; components of the legal health record; customizable forms and templates; litigation response and subpoenas; EHR system attributes that affect the legal health record; details about e-discovery, federal rules of civil procedure and uniform rules. By William Kelly McLendon, RHIA, and Michael R. Lowe, JD, technical editor. AHIMA Press (2011). Soft cover, includes CD-ROM, $59.95

To Order: Order both books online at www.ncchc.org/pubs.
What’s New in the 2011 Juvenile Standards

by Jennifer E. Snow, MPH, CCHP

Don’t be overwhelmed by the new Standards for Health Services in Juvenile Detention and Confinement Facilities—this article will break it down for you into the most need-to-know changes.

Some standards were renumbered or combined (e.g., ectoparasite control is now addressed under Y-B-01 Infection Control Program) and there are subtle changes throughout, but here we will focus solely on the most substantive. By no means will we address every change here, so read through all of the 2011 standards to ensure you are familiar with them. The first step to compliance will be walking through the new standards with your staff and, for each standard that applies to your facility, incorporating all of its compliance indicators into your policy and procedure manual. Speaking of Policies and Procedures (Y-A-05), a new compliance indicator requires the responsible physician to also sign the manual.

Two New Standards
Everyone should be aware of the two new standards: Y-B-03 Patient Safety and Y-B-04 Staff Safety. These standards, classified as important, encompass what we already do to ensure patient and staff safety by instituting non-punitive error reporting systems, preventing near-miss and adverse clinical events and ensuring that juveniles and staff alike are in a safe and healthy environment.

Chronic Disease Services
Designated an important standard previously, Chronic Disease Services (Y-G-01) has been changed to essential, therefore, compliance is required in order to achieve accreditation. This is a key fact to keep in mind due to the substantial changes to the standard. You will note the addition of major mental illness and seizure disorder to the list of chronic diseases, and compliance indicators now include the appropriate elements of treatment plans. Staff should now maintain a list of patients with chronic diseases and be sure to update patient problem lists with such diagnoses.

Continuous Quality Improvement
The 2011 juvenile standards introduce exciting changes to Continuous Quality Improvement Program (Y-A-06). Depending on the average daily population, facilities will implement basic or comprehensive CQI programs, which will include annual process and outcome CQI studies in which a problem is identified, a study is completed, a plan is developed and implemented, results are monitored and tracked, and improvement is demonstrated or the problem is restudied. The new compliance indicators represent a significant change to the requirements of the standard. Remember that an outcome study assesses whether expected outcomes of patient care were achieved; in other words, outcome studies examine whether patients are improving under the care provided. Note that the responsible physician should be involved in the CQI program through means such as identification of thresholds, problem solving or interpreting data. Annual reviews of the effectiveness of the program will be required.

Suicide Prevention Program
Changes to monitoring potentially suicidal juveniles (Y-G-05 Suicide Prevention Program) will be a central concept for staff training. Whereas actively suicidal juveniles should be placed on constant observation, potentially suicidal juveniles should be monitored on an irregular schedule with no more than 15 minutes between checks. If, however, the potentially suicidal juvenile is isolated, constant observation is required. The new compliance indicators describe what a suicide prevention program should do in a bit more detail. Treatment has been added to the key components of a suicide prevention plan and, of course, treatment plans addressing suicidal ideation and its reoccurrence should be developed, and patient follow-up should occur as clinically indicated.

Continuity of Care
Additions to Y-E-12 Continuity of Care During Incarceration include the timely clinician review of findings with the patient. Treatment plans should be used to guide treatment for episodes of illness and include the elements noted in the new compliance indicators; clinicians should use diagnostic and treatment results to modify the treatment plans as appropriate. Pay attention to the new compliance indicators addressing a juvenile’s return from an emergency room visit or hospitalization. Physicians’ clinical chart reviews should be of sufficient number and frequency to ensure that clinically appropriate care is ordered and implemented by on-site health staff. This activity was moved from the 2004 Y-A-06 standard and its purpose is a bit different here, which we will discuss in a future column.

Procedure in the Event of a Juvenile Death
The Procedure in the Event of a Juvenile Death (Y-A-10) standard now includes two pieces to accompany the clinical mortality review: administrative review and, in the event of a suicide, a psychological autopsy. These three activities are the requirements of a death review under this standard and should be reflected in your policy.

Health Training for Child Care Staff
Please be aware that child care staff who work with juveniles should receive health-related training at least every two years (Y-C-04 Health Training for Child Care Staff).

continued on page 4
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Juvenile Standards (continued from page 3)

This time frame is new. While it is expected that 100% of the child care staff who work with juveniles are trained in all of the areas described in the standard, compliance now requires that at least 85% of the staff present on each shift are current in their health-related training. This indicator has been revised, as it previously required 100%. The prevention of heat-related illness has been added to the training that child care workers assigned to outside programs (e.g., Outward Bound programs, forestry camps and routine outdoor recreation) should have.

New Frequency Requirements and More

- Under Y-A-04 Administrative Meetings and Reports, documented health staff meetings should occur at least monthly (a new compliance indicator) and statistical reports will now be required quarterly rather than annually.
- The frequency of consulting pharmacist inspections has been increased to quarterly, from every six months, and all off-site locations should be included (Y-D-01 Pharmaceutical Operations).
- Inventories of items subject to abuse (e.g., needles, syringes and other sharps) are now required daily, rather than monthly, under Y-D-03 Clinic Space, Equipment, and Supplies.
- Another notable addition is that of inquiry to employers, state boards and the National Practitioner Data Bank as part of the credentialing process (Y-C-01 Credentialing).
- The Medication Services standard, Y-D-02, now states that juveniles entering the facility on prescription medication should continue to receive the medication in a timely fashion as prescribed, or acceptable alternate medications should be provided as clinically indicated.
- It is worth mentioning that under Y-D-04 Diagnostic Services, stool blood testing kits are no longer required to be kept on site.
- Finally, a notable change occurred in Y-E-04 Health Assessment, where gynecological assessment is now required during the initial health assessment as clinically indicated, rather than for every female youth.

We will go into more detail on revised standards in future articles and Q&A columns. Feel free to send your questions as you are preparing to transition to the 2011 edition.

Jennifer E. Snow, MPH, CCHP, is NCCHC’s director of accreditation. To contact her, write to accreditation@ncchc.org.

About ‘Spotlight’

The articles in this series shed light on the nuances of NCCHC’s Standards for Health Services, exploring the rationale behind various standards, the intended outcomes, compliance concerns, the impact on the accreditation process and more. The complete series is available in the Resources section at www.ncchc.org, along with an archive of Standards Q&A columns.

For more in-depth information about the standards, attend one of the preconference seminars at NCCHC’s annual spring and fall conferences.
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Inmate’s Right to Refuse Dialysis Affirmed

by Fred Cohen, LLM

Troy Reid, a prison inmate in Maryland, has end-stage renal disease. The medical record clearly supports the diagnosis and the medical necessity of thrice-weekly dialysis. In Stouffer v. Reid (MD 2010), the state’s highest court found that Reid is so afflicted that without this dialysis, his illness or death will be accelerated due to the multiple negative consequences of the buildup of bodily fluid.

Reid, however, has some doubt about the existence of his disease and wishes to refuse the proffered treatment. The court held that the inmate, a competent adult, had the common law right to do so. Why is it, then, that the prison commission has gone through three court proceedings to obtain an injunction requiring that Reid accept dialysis? Forced dialysis, I should add, is not a pretty picture, with an unwilling patient strapped to a dialysis machine for hours and days at a time.

State’s Arguments

I strongly suspect that the state’s actual reason for pursuing this matter is to create liability insulation. The reasons overtly advanced, however, are the duty to preserve life, maintain orderly prison administration and sustain the ethical integrity of the medical profession. The Court of Appeals reviewed and rejected each of these factors, finding, in effect, that Reid’s interest in bodily integrity was stronger in each instance than the state’s purported interests.

The opinion emphasizes that this is not a facial challenge to a statute (or some general, legislative-like rule). Rather, the outcome reached is highly dependent on Reid’s situation and the trial record.

There are several legal principles on which this decision might have rested. A liberty interest protected by the 14th Amendment to the U.S. Constitution (see Cruzan v. Director, 1990), a constitutional right of privacy or a common law right to refuse medical treatment that may survive imprisonment (see Mack v. Mack, 1993). The ultimate decision here supportive of the inmate’s position is based on the common law. The court’s opinion, however, meanders over all three legal principles in seemingly random fashion. Indeed, I found the opinion’s craftsmanship so poor that the court managed to convert an inherently fascinating legal–ethical dilemma into a dull, prodding, repetitive opinion.

Iowa Precedent

The state argued strongly that Polk Co. Sheriff v. Iowa District Court (Iowa 1999) should be adopted in Maryland. As the court notes, in Polk, Jerrell Brown, a pretrial detainee, was held in the Polk County jail awaiting trial on drug-related charges. While in jail, he received kidney dialysis treatments three times per week for a year and subsequently refused to continue with the dialysis treatments. The county sheriff filed an application in the district court seeking an order to compel Brown to submit to emergency treatment stemming from his refusal to continue dialysis. Medical testimony presented at the hearing for emergency treatment revealed that Brown’s kidneys were “minimally functional” and unless Brown received the treatment, he would die within one week, probably due to cardiac arrest.

Brown did not testify at the hearing. A psychiatrist who evaluated Brown one day before the hearing testified. The court considered both his oral testimony and written report. According to the psychiatrist, “Brown was competent, appeared to be of at least average intelligence, and understood the risks of ... discontinuing the treatment.” The psychiatrist testified further that “Brown said that spending any further time in any correctional facility was unacceptable and that he was going to stop his dialysis treatment ‘whether he was looking at another month, or another year, or another five years in incarceration.” The psychiatrist’s report also revealed that Brown stated that “he was tired of the routine of being taken to the hospital in jail garb and in manacles only to have to return to jail.” Further, according to statements in the report attributable to Brown, “[Brown] … decided to refuse any future dialysis until March 4, 1999,” which according to Brown was his pretrial conference date … When [the psychiatrist] expressed doubt that Brown could live until March 4, Brown responded that he really did not care.” As Brown explained, “I’d be dead, so there would be nothing to worry about.”

The district court judge concluded that under the 14th Amendment, Brown’s liberty interest was superior to the state’s interest in compelling Brown to submit to dialysis. As a result, the court rejected the sheriff’s request for an order compelling medical treatment. Subsequently, the sheriff filed a petition for a writ of certiorari in the Iowa Supreme Court, which was granted. The Iowa Supreme Court held, in balancing Brown’s diminished liberty interest to refuse treatment against the State’s countervailing interests in preserving life, preventing suicide, protecting the interests of innocent third parties, maintaining the ethical integrity in the medical profession, and maintaining prison security, order, and discipline, we conclude the State’s interests must prevail.

The fact that death was certain in the event that Brown discontinued dialysis and that the dialysis procedure “is not painful and produces no serious side effects” informed the Iowa Supreme Court’s decision that the state’s interest in preserving life weighed heavy in the balance. In rendering its decision, the court gave little or no consideration to...
the mental and emotional pain to Brown resulting from unwanted kidney dialysis treatment.

Back to Maryland
The present court was simply not persuaded that the state’s interest in the preservation of life outweighs Reid’s right to refuse medical treatment. Reid was skeptical about his medical condition because “the information that was provided to him from medical professionals ... turned out to be inaccurate.” The information provided to him was “that he would immediately suffer severe symptoms if he discontinued dialysis, which subsequently did not happen when [Reid] ceased dialysis for weeks at a time.” Even though Reid was “ill-informed in his own wisdom,” as found by the trial judge, he expressly refused to continue with “medical treatment that he [found] objectionable.” As the Court of Special Appeals (the intermediate court) noted:

[When a competent adult refuses medical treatment, the State’s interest in preserving the particular patient’s life will not override the individual’s decision. Even in cases where a patient’s condition is curable, the State’s interest in preserving life is diminished because the life that the [S]tate is seeking to protect in such a situation is the life of the same person who has competently decided to forgo the medical intervention. The State’s duty to preserve life must also encompass a recognition of an individual’s right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity.

Maintaining Security and Order
This is, in effect, the “are we being hustled?” argument. It may be that Reid is somehow trying to obtain his release and should that occur then we have the alarming specter of Maryland inmates with kidney disease throwing off their dialysis hookups and heading for the exit doors. If not, then there may well be general unrest because official decisions have been undermined, expertise and discretion impaired, a perception of a loss of administrative control and, well, you get the point.

The Maryland court simply was not buying these paper-thin arguments and found that the record did not support any of these fears. Reid’s right to refuse was found sufficiently strong to overcome the state’s transparent speculations.

Medical Integrity
The state argues basically that there is a sound diagnosis and an appropriate case plan put forward by respected physicians. Rejection of the physician’s diagnosis and proposed cure, it is argued, creates an ethical dilemma for the physicians, although exactly what that is, is not specified.

The court states that merely because health care professionals recommended kidney dialysis or other treatment for Reid, and he rejected that recommendation, did not harm the integrity of the medical professional. An inmate, by virtue of his incarceration, is not divested of his right to disagree with his medical providers. Although Reid is found to have both a common law and constitutional right to refuse unwanted medical treatment, in the present case the decision is based on Reid’s common law right to refuse medical treatment and therefore the court does not elaborate the constitutional question. Thus, the Court of Special Appeals is upheld and Reid’s decision-making autonomy is upheld.

Author’s Comment
This decision takes its place as one of the more important judicial rulings on inmates’ right to refuse medical treatment. If Reid persists then he will most assuredly die from kidney failure. Should this be considered as sanctioned, albeit not instantaneous, suicide?

Suicide case law in corrections would reach a very different result: Inmates do not have the right to commit suicide while in official custody. Corrections officials are under a duty to prevent suicide and to save life when an attempt is discovered. Is there a conceptual disconnect, then, between the Reid decision and custodial suicide law?

Fred Cohen, LLM, is the coeditor of the Correctional Law Reporter. This article is in press for a future issue of CLR, ©2011 Civic Research Institute, Inc., and is reprinted here in slightly abridged form with permission of the publisher. All rights reserved.
For subscription information, contact Civic Research Institute, 4478 U.S. Route 27, P.O. Box 585, Kingston, NJ 08528; 609-683-4450; www.civicresearchinstitute.com.
Update: National Survey of Prison Healthcare
As reported in the Fall 2010 issue, a new National Survey of Prison Healthcare is being developed by the CDC’s National Center for Health Statistics and the Bureau of Justice Statistics. Three objectives are cited: to provide an overall picture of the global structure of health care services in the nation’s prisons; to close gaps in information about availability, location and capacity of services provided; and to identify the extent to which electronic medical records are used.

“Valid and current data on infrastructure, capacity and utilization of healthcare are essential to supporting research and studying the effects of changes in correctional healthcare,” according to a CDC notice in the Federal Register.

The data collection will begin with a pilot test of the questionnaire with nine prison officials; in Fall 2011, the survey will be mailed to one official in each state’s department of corrections as well as the Federal Bureau of Prisons.

Data to be captured include the extent to which services are contracted; staffing; the types of medical, dental, mental health and pharmaceutical services provided; and whether services (including specialty care) are provided on- or off-site. Drilling down further, the survey will ask about intake physical and mental health assessment practices, credentials of staff performing screenings, vaccinations against major infectious diseases and smoking allowances. Discharge planning data to be collected include the availability of bridge medications, Medicaid reenrollment processes and the number of inmates with mental illness linked to housing prior to release. The NSPH will also collect data on how DOCs maintain health records including the format (paper and/or electronic) of specific types of health records.


Do Indoor Tobacco Bans Reduce Smoking?
Yes and no, according to a new study published in Nicotine & Tobacco Research. Titled “Tobacco Use by Male Prisoners Under an Indoor Smoking Ban,” the article describes a survey of 200 recently incarcerated male prisoners in a facility with an indoor smoking ban. Tobacco use was prevalent prior to arrest (77.5%) and actually increased during incarceration (81%). However, per-capita cigarette consumption declined by 7.1 cigarettes per day. The study also found that “most prisoners recognize the risks” of smoking (e.g., addiction, lung cancer and heart disease) and 70% said they wish to quit. “This creates an ideal setting for intervention,” the authors conclude. “Evidence-based cessation assistance should be made freely available to all incarcerated smokers.”


Second Consecutive Year of Decline in Jail Populations
For the second time since the Bureau of Justice Statistics began its annual survey of jails in 1982, the nation’s jail population has declined, dropping 2.4% at the end of June 2010 compared to a year earlier. This follows a 2.3% drop in 2009. The decline was mostly concentrated in large jails holding 1,000 or more inmates. Among the 170 jail jurisdictions in that category, two-thirds reported a decline and six reported a drop of more than 1,000 inmates, accounting for 46% of the decline nationwide. Jails were operating at 86% of their rated capacity at midyear 2010, the lowest percentage since 1984. However, the total rated capacity for all jails reached 866,974 beds at midyear 2010, up 2% from 849,895 beds a year earlier.

Source: www.bjs.gov/content/pub/press/jim10stpr.cfm
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Program Dates and Times
Sunday, July 10 – 8 am to 4 pm
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• Sponsored breakfast and luncheon programs
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• Continuing education credit

Quality Content
This program will address many of the major mental health care issues that challenge facilities, along with emerging concerns that can have a big impact. Speakers will share strategies for providing quality care along the continuum. Attendees will leave equipped to implement these strategies and improve mental health services at their facilities. The seminar also offers a unique opportunity to connect with others who share a commitment to improve inmate-patient outcomes and drive change in correctional settings. Go online for the complete schedule and abstracts.

Poster Presentations
Educational posters will be on display along with the exhibits for easy viewing. Get your first look during the session breaks on Sunday morning, when you can enjoy refreshments while chatting with the poster presenters about the topics addressed in their work. The posters will remain on display throughout the seminar.

Special Invitation!
All attendees are invited to take part in a roundtable discussion on both mornings before the educational sessions begin. With a focus on emerging trends and hot topics, these gatherings are the best time to interact with your peers, debate issues, seek advice and express your opinions. You are guaranteed to come away with a lot of great ideas.

Seminar Learning Objectives
At the conclusion of this seminar, participants should be able to...
• Demonstrate an increased understanding of pervasive as well as emerging mental health problems within correctional populations as well as related management issues
• Identify best practices in evaluation, treatment and management for incarcerated individuals with mental illness
• Enhance skills necessary to manage mental health care delivery in correctional settings
• Develop mental health programs that incorporate the NCCHC standards for mental health services

Registration Information
• Regular registration: $250
• Academy member: $200
• Guest registration: $60

2 Ways to Save Money!
• The Academy of Correctional Health Professionals is a cosponsor of the seminar and its members save $50 on seminar registration fees. If you are not a member but would like to take advantage of this discount, you may join when you register for the seminar. To learn more about the Academy and the many benefits of membership, visit the Web at www.correctionalhealth.org.
• If you are a medical director or physician leader, extend your stay and attend the Medical Director Boot Camp July 12-13. Register for both events and save 50% on the Correctional Mental Health Seminar fee. Enter promotion code LASVEGAS on the registration form. Learn about the Boot Camp in the Education section at www.ncchc.org.

Presented by the National Commission on Correctional Health Care
Copresenters: Academy of Correctional Health Professionals, American Psychiatric Association, American Psychological Association
For details about the seminar or to register, visit the Education section at www.ncchc.org.
The role of registered nurses is continuously evolving and trends point to increased managerial and leadership responsibilities, with RNs expected to organize and supervise the work of other health care personnel. Crucial to success in this function is the ability to delegate routinely and effectively.

Today, many correctional facilities are relying on RNs to provide much-needed management and leadership in providing care to thousands of inmates in adult and juvenile institutions. Many of these RNs are veterans in correctional care but new to the management role, and some are even new to the correctional health care delivery system. These RNs could face some challenges in delegating certain tasks to both licensed and unlicensed health workers.

Delegating a task is sometimes intimidating to new lead RNs or RN supervisors. Many are unclear on the fundamental principles of delegation. Although it is an effective management tool, delegation also has a legal component and if not done correctly could result in liability. Delegation has been defined in many ways, but according to the American Nurses Association, it is transferring responsibility for the performance of an activity while retaining accountability for the outcome. This ANA definition is the basis for the legal dimension of delegating a task. It means that the person who delegates (delegator) an activity is ultimately responsible for the outcome of the actions by the person performing the delegated activity (delegatee).

To be an effective delegator, the RN must know the scope of practice of each licensed health worker in the clinic areas as well as the tasks permitted to be performed by licensed vocational/practical nurses, unlicensed workers such as certified nursing assistants and inmate-workers.

Some correctional institutions are starting to use unlicensed personnel as a cost-saving measure. Tasks that are often delegated to these personnel include the following:

1. Obtaining vital signs (CNAs)
2. Assisting in the performance of activities of daily living (CNAs and inmate-workers)
3. Recording intake and output (CNAs)
4. Transferring patients (CNAs and inmate-worker)
5. Collecting specimens (CNAs)
6. Administering medication except by intravenous route (LVNs/LPNs)

These are some of the RN tasks that cannot be delegated to an LVN, LPN or unlicensed worker:

1. Performing a comprehensive assessment
2. Validating assessment data
3. Formulating the nursing diagnosis for the patient
4. Identifying goals derived from the nursing diagnosis
5. Determining the nursing plan of care, including appro-
appropriate nursing interventions derived from the nursing diagnosis.

6. Evaluating the effectiveness of the nursing care provided

**The Five Rights of Delegation (Plus One)**

Nurses are well aware of the five rights of medication administration. Similarly, in 1997 the National Council of State Boards of Nursing enumerated the Five Rights of Delegation to guide nurses in correctly and effectively delegating activities.

**Right Task**

This pertains to the appropriateness of the activities or tasks to be delegated. Appropriateness of activity must be individualized to meet the unique needs of each patient. Is the task within the scope of work of the delegatee? Does your institution have policies and procedures specifying the type of activities that can be performed by unlicensed staff such as CNAs and inmate-workers? The delegator must be aware of the tasks that are permitted and not permitted for each person working in the correctional setting. The institution should describe in writing what are the expectations and limitations of clinical activities and which staff can perform those activities. Many RNs in the correctional setting rely on CNAs to gather vital signs, record intake and output and aid with performance of ADLs regardless of the patient’s condition. This practice, although allowed, will increase the RN’s liability.

**Right Circumstances**

This is based on the RN’s assessment of the overall nursing needs of his or her assigned clinical area and developing a plan to meet those needs. The RN identifies the specific goals for the area and implements interventions to achieve the stated goals. For example, a one-day postoperative patient needs to ambulate. To whom would you delegate the task of assisting the patient to ambulate? What about a patient who had a recent stroke and is just beginning to eat orally? Should an inmate-worker be allowed to assist this inmate with feeding? The complexity of the tasks should match the skills and experience of the delegatee. Knowing the right circumstances can help the RN to delegate specific tasks for each staff member safely and effectively.

**Right Person**

Again, the RN as a delegator must know the scope of licensure and the allowed tasks for each health care staff member (licensed and unlicensed). The RN must also consider the experience and skills of the delegatee before assigning the task. How often has the delegatee performed the tasks in the past? Is the delegatee comfortable with doing the task? Is the task within the delegatee’s scope of licensure or duties? Usually, simple and basic tasks with a predictable outcome are delegated to less experienced staff whereas more complex activities should be reserved for those with more experience. As a delegator, you should know the level of skills and aptitude of each staff member under you. Will you delegate an LVN to do a cell-front assessment of a patient who complains of chest pain because you are doing something else at that time? Remember, licensed vocational nurses have very limited scope in performing patient assessment. What if the LVN reported back to you that the inmate is fine and later the inmate had a massive cardiac arrest and died? Ultimately, the RN is responsible for the outcome.

**Right Directions and Communication**

This is a very important aspect of the delegation process. For the delegatee to perform the assigned task, the delegator must provide clear, straightforward and easy-to-understand direction. This direction should match the educational level, experience and skills of the delegatee. With giving direction comes ongoing communication. A delegator should maintain open communication before, during and after the performance of the delegated activities. Here are two examples of giving direction on monitoring urine output of a patient with catheter delegated to a CNA during the health services team’s morning meeting.

Vague direction: “CNA Smith, please record the output of Mr. Doe.” Clear direction: “CNA Smith, please monitor and record Mr. Doe’s urine output every two hours and let me know immediately if his urine output every two hours is less than 100 ml and if the urine color changes. I am available if you have questions.”

**Right Supervision and Evaluation**

The RN as a delegator should provide ongoing supervision before, during and after the performance of the delegated activity. Remember, when you delegate a task, you transfer only the performance of the task; the accountability remains with you as the delegator. Therefore, constant supervision is essential to ensure that the delegated activity is performed safe and effectively. As a delegator, you also need to evaluate the effectiveness of the delegation. Is the result of the delegated task the outcome you expected? This is also your opportunity to provide feedback to the delegatee on how he or she did. Giving constructive feedback will help the delegatee gain confidence in performing delegated activities in the future. With the example above, you could say to CNA Smith, “Good job of telling me that continued on page 12”
you noticed decreased volume on Mr. Doe’s catheter bag for the past two hours. His catheter got clogged and I flushed the catheter and was able to remove the clot. Urine is flowing again.”

See page 11 for an example of a matrix that the RN may use in making decisions in delegating certain elements of nursing care.

Right Documentation
Although the National Council of State Boards of Nursing listed only five rights of delegation, as a correctional RN, you must also remember the sixth “right,” which is the right documentation. The nursing care plan should reflect the tasks of each staff member and who will be supervising for the delegated tasks. It is also important to put in your institution’s operating procedures the clinical activities that are in the scope of licensure of your licensed staff and the permissible activities of your unlicensed staff.

Safe Delegation
Inherent in each of the rights is the concept that merely because one can delegate a task does not mean that the task should be delegated. The more unpredictable the outcome, the less likely it is that a particular task can be safely delegated. The delegator must consider all aspects of the delegation, including whether delegating the task will ensure the provision of competent and quality nursing care.

The nursing process provides an easy-to-remember framework for delegation. Under assessment, the delegating RN determines if delegation is appropriate (right circumstances) and what tasks may be legally delegated (right task). Planning includes determining whether the delegatee is competent to perform the act (right person) as well as ensuring that it will be safely carried out. This may include formal training, certification or return demonstrations. Implementation includes the RN observing, by either direct or general supervision, that the delegatee safely and competently performs the task (right direction and communication, right supervision). Evaluation provides an analysis of whether the delegation was safely and successfully completed.

Delegation is not a mysterious art but a management function that can be learned and improved with practice. Delegating activities, if done correctly, will help correctional RNs to function efficiently while providing timely, appropriate and quality nursing care to the inmate population they serve.

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### Resources
- State Board of Registered Nursing to determine the scope of licensure of RNs in different states. In California, the website is www.rn.ca.gov.
- State Board of Vocational or Practical Nursing and Psychiatric Technicians to determine the scope of licensure of LVNs, LPNs and psychiatric technicians. In California, the website is www.bnpt.ca.gov.
- State Board of Registered Nursing position on the practice of unlicensed assistive personnel such as CNAs. In California, the website is www.rn.ca.gov/pdfs/regulations/npr-b-16.pdf.

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You Need an OTC Commissary in Your Facility!

by Jeffrey E. Keller, MD, FACEP

When I was an undergraduate, before I switched to premed, I was an economics major. Maybe because of that training, when I look at jail medical practices, I tend to look at all of the costs of medical practice, not just the monetary costs. For example, the total cost of providing a medication to a patient in the jail includes the cost of the medication (of course), but it also includes the cost of the various people, like nurses, pharmacists, deputies and practitioners, who spend time creating the prescription. Thinking of costs in this way can change our perspective of what something "costs."

Consider the case of the man with heartburn. We’ll call him “Jeffrey.” He doesn’t know it, but he is about to go to jail. Before Jeffrey goes to jail, if he wants to purchase something like ranitidine (Zantac) for his heartburn, he would go to a store and buy it. He doesn’t need to see a medical professional. He doesn’t need a prescription. In most places, he doesn’t even need to wait—convenience stores sell ranitidine 24/7. The monetary price Jeffrey will pay for 50 tablets of ranitidine at the store is around $7. The cost in terms of time is how long it takes him to run to the store. The total cost in time to the store to provide the ranitidine to Jeffrey is 30 seconds—how long it took the store clerk to ring up the sale.

Now think of the same guy in jail. Jeffrey still has heartburn. Let’s say he still has money—now in his commissary account. He is still willing to buy ranitidine. But ranitidine is not on the jail commissary list. He can buy ramen noodles or a Snickers bar, but not ranitidine. To get it, he has to put in a “request for medical care” form. What happens now varies from jail to jail and prison to prison. I am going to present a typical jail scenario.

Breaking It Down

The act of requesting nonemergent medical care costs Jeffrey $10. The form is then triaged by a nurse and Jeffrey is scheduled to see a practitioner. Since the clinics are crowded, the appointment is made for five days hence. In the meantime, he continues to have heartburn. On the scheduled day, he comes to the medical clinic. He waits, say, an hour in the waiting area. He then has vitals taken by a nurse. The practitioner, unsurprisingly, orders a prescription of ranitidine for Jeffrey. The order is sent to the pharmacy and is delivered the next day. It is paid for from the jail medical budget.

Total monetary cost to Jeffrey is $10. Total monetary cost of the prescription to the jail is around $6. Total price to everybody in time is, well ... a lot. Jeffrey had to wait five days. The jail medical staff had to process and triage the request for medical services (10 minutes total?). A nurse and a practitioner had to see the patient in clinic (another 15 minutes total between the two?). A chart is generated, which then has to be filed (30 minutes?). Deputies spent some time getting the patient to the clinic and back. The pharmacist spent time filling the prescription. The UPS/FedEx delivery service ... well, you get the drift.

It doesn’t matter if I am overestimating the time. Just remember that we have to multiply whatever time figure we come up with by every request for an over-the-counter product that is handled this way. Not just ranitidine, but also foot fungus cream, cough drops, rash cream, ibuprofen, acne cream, nasal spray and on and on.

Why not put OTC medical items on the commissary and let inmates purchase them without having to go through the medical service? This seems to me like a no-brainer all the way around. Put the ranitidine on the jail OTC commissary so that Jeffrey can purchase it without having to involve the medical staff. Jeffrey benefits by having much easier access to OTC products at a cheaper price. The medical staff benefits by not having to deal with requests for OTC products and having that much more time to spend with truly sick patients.

I can hear you objecting: “We don’t charge inmates a fee to access medical clinic.” “Nurses can give inmates a week’s supply of OTCs; the inmate does not have to see the practitioner.” These objections miss the point that the main cost of making inmates go through “the system” to get OTC medications is time! The savings in time to nurses, for example, allows them to spend more time with truly sick and needy patients.

Factors to Consider

If you decide to set up an OTC commissary system, here are a couple of items to consider.

Indigence. What happens if Jeffrey has no money on his books? One way to deal with this is to allow indigent inmates to buy certain medical commissary items on credit (meaning that they “go into the hole” with their books, and if they ever get funds, the money is paid back). Another is for the jail just to absorb the cost of certain medical OTC products for indigent inmates—that is still cheaper than making them kite and go to clinic. The jail pays for the medication either way!

Inappropriate OTC items. Certain items that are available OTC at your local store should not, in my opinion, be offered on a jail commissary. This includes any item that can be abused or that can cause serious harm when taken in overdose. I would include the following: dextromethorphan cough medicine, Benadryl and other first-generation...
antihistamines (though I would allow purchase of second-generation OTC antihistamines, like Claritin) and pseudoephedrine (used in meth production). No Ex-Lax, of course! Too tempting to play practical jokes on your neighbors!

Sometimes, inmates don’t like purchasing medical items from the commissary. They get it free if they go through the medical clinic. Time is not as important to them as it is for us. The solution is to make purchasing OTC items from the commissary cheaper than going through medical. Here’s one way to do this is this: When an inmate comes to the medical clinic requesting, say, ranitidine, rather than ordering the item through the pharmacy, pull the item from the commissary and charge the inmate a small “urgent access fee.” The idea is that you want it to be cheaper and easier for inmates to purchase commissary items without going through the clinic.

**Stocking the Shelves**

What items can be offered on an OTC commissary? Remember that any OTC medical item you do not make available on the commissary can be obtained only by an inmate by going through the medical process. Here is one possible list:

A. Rash medications
   1. Antifungal foot cream
   2. Hydrocortisone cream
   3. Benadryl cream
B. Acne medications
   1. Stridex pads
   2. Benzoyl peroxide
C. Stomach medications
   1. Antacids (Rolaids)
   2. Ranitidine
   3. Omeprazole
   4. Gas-X
   5. Beano
D. Diarrhea medications
   1. Fiber tablets or Metamucil
   2. Pepso-Bismol
   3. Imodium
   4. Kapectate
E. Constipation medications
   1. Fiber tablets or Metamucil
   2. Stool softeners (Colace)
F. Diet supplements
   1. Vitamins
   2. Calcium
   3. Lactaid (for lactose intolerance)
G. Cold and flu medications
   1. Saline nasal spray
   2. Afrin nasal spray
   3. Cough drops
   4. Sore throat lozenges
   5. Loratadine (but not other antihistamines or decongestants)
   6. Ibuprofen
H. Muscle ache remedies
   1. Muscle rub
   2. Ibuprofen
I. Psoriasis and dandruff medications
   1. Dandruff shampoo
   2. Coal tar shampoo
   3. Coal tar lotion
   4. Hydrocortisone cream

Jeffrey E. Keller, MD, FACEP, is the president of Badger Correctional Medicine, Idaho Falls, ID. Contact him at jkeller@badgermedicine.com.
Correctional Nursing Practice: What You Need to Know (Part 6)

NCCHC’s Certified Correctional Health Professional program offers specialty certification for RNs. The CCHP-RN certification is the formal recognition of the specialized knowledge, skills and experience deemed specific to the practice of nursing in a correctional setting. Whereas nursing licensure establishes legal authority for an individual to practice nursing, specialty certification reflects achievement of the special knowledge and skills needed for a particular practice area.

This column, written by members of the CCHP-RN task force, discusses various areas of correctional nursing practice covered in the CCHP-RN exam outline. This will assist nurses preparing to take the exam as well as explain the key concepts of the specialty for the novice correctional nurse. Learn more about the CCHP-RN program at www.ncchc.org/cchprrn, where you can also view the entire test outline (see downloads).

Therapeutic Communication and Behavioral Management

The American Nurses Association’s Corrections Nursing: Scope and Standards of Practice states that nurses are patient advocates and maintain a therapeutic and professional nurse–patient relationship with appropriate professional role boundaries. To provide quality health care for patients in correctional settings, nurses must be able to communicate with patients, other health care providers, correctional staff and outside providers.

Therapeutic communication is defined as the face-to-face process of interacting that focuses on advancing the physical and emotional well-being of a patient. Nurses use therapeutic communication techniques to provide support and information to patients. It may be necessary to use a variety of techniques to accomplish nursing goals in communicating with a patient (see list of common therapeutic communication techniques).

Correctional nurses must attend to the therapeutic nature of the interactions taking place with patients. Caring, the essence of a nurse–patient relationship, must be forefront in determining communication and action. Working among correctional colleagues can lead to an unconscious shift to a custodial relationship with inmates. This dilutes the nurse–patient relationship and can decrease nurse effectiveness. Custodial actions by the nurse are those that are not therapeutic in nature and are not aligned with nursing goals. Correctional nurses need to guard against assimilating into the custodial environment, thus changing the nature of the nurse-patient relationship.

Behavioral Management

Behavior management is a frequently used communication modality in correctional nursing. Patients often require redirection and constructive guidance to improve their behavior and reach health and wellness goals. In order to continue a therapeutic relationship, nurses must be able to apply methods for deescalating or redirecting inappropriate patient behavior, whether it’s simply shouting or arguing, or more dangerous, such as striking out or breaking an object. Rather than ignoring feelings or emotions, behavior management allows the nurse to use displayed behaviors constructively.

Behavior has three elements: a triggering event (antece dent or cause), the behavior itself and the consequences of the behavior. The nurse must first define the behavior by, for example, describing the action. Next, look for events or other clues to explain what may have triggered the behavior. Finally, consider the consequence, such as changes in the environment or in the behavior of other people.

Behavior management may include medication, group or individual therapy sessions or just communicating with the person or people involved with the behavior. It is important to set realistic, obtainable goals tailored to the individual. You may have to divide your plan and goals into small, easy-to-do parts and be creative. Other behavior management techniques include positive reinforcement, setting boundaries and limits, and being honest with the patient.

Behavior management in correctional health care settings is challenging. In these confined areas, individuals are mixed together who may not be compatible. This is why classification guidelines are used to help minimize potential behavior outbursts. Nurses must establish and maintain effective working relationships with the patient, other health care providers and correctional staff simultaneously, while also assessing the environment for its conduciveness to appropriate or inappropriate behavior. Also, changing behavior is an ongoing process and needs to be reevaluated on a continuous basis.

Changing behavior can be hard work so do not forget to reward yourself and the patient for success, no matter how small.

Susan Laffan, RN, CCHP-RN, CCHP-A

Susan Laffan, RN, CCHP-RN, CCHP-A, is co-owner of Specialized Medical Consultants, based in New Jersey, and also works in the emergency department of a hospital in that state. This column is coordinated by Lorry Schoenly, PhD, RN, CCHP-RN, an independent consultant specializing in correctional health care and social media; she is based in Pennsylvania. Both are members of the CCHP-RN task force. For correspondence, write to editor@ncchc.org.

[Editor’s note: The ANA book is available in the Publications catalog at www.ncchc.org.]
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ATRIPLA can be used alone or in combination with other antiretroviral agents.

INDICATION

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IMPORTANT SAFETY INFORMATION

WARNINGS: LACTIC ACIDOSIS/SEVERE HEPATOMEGALY WITH STEATOSIS and POST-TREATMENT EXACERBATION OF HEPATITIS B

• Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogs, including tenofovir disoproxil fumarate (DF), a component of ATRIPLA, in combination with other antiretrovirals.

• ATRIPLA is not approved for the treatment of chronic hepatitis B virus (HBV) infection, and the safety and efficacy of ATRIPLA have not been established in patients coinfected with HBV and HIV-1. Severe acute exacerbations of hepatitis B have been reported in patients who have discontinued EMTRIVA® (emtricitabine) or VIREAD® (tenofovir DF), which are components of ATRIPLA. Hepatic function should be monitored closely with both clinical and laboratory follow-up for at least several months in patients who are coinfected with HIV-1 and HBV and discontinue ATRIPLA. If appropriate, initiation of anti-hepatitis B therapy may be warranted.

* Pill not shown at actual size.

DHHS = Department of Health and Human Services.

Information on adjacent pages.

**WARNINGS**

Please see Important Safety Information, including:

- Since ATRIPLA contains efavirenz, emtricitabine, and tenofovir DF, ATRIPLA coadministration with related products and warnings and precautions should be considered.
- Concomitant use of ATRIPLA with voriconazole, atazanavir (with or without ritonavir), or Saquinavir should not be used as the only protease inhibitor in combination antiretroviral therapy. Efavirenz should not be administered with HEPSERA or Epzicom. Nervous system symptoms are not predictive of the less frequent psychiatric symptoms.
- ATRIPLA should not be administered with HEPERA (adefovir dipivoxil).
- Serious psychiatric adverse experiences, including severe depression (2.4%), suicidal ideation (0.7%), nonfatal suicide attempts (0.5%), aggressive behavior (0.4%), paranoid reactions (0.4%), and manic reactions (0.2%), have been reported in patients receiving efavirenz. In addition to efavirenz, factors identified in a clinical study that were associated with an increase in psychiatric symptoms included a history of injection drug use, psychiatric history, and use of psychiatric medication. There have been occasional reports of suicide, delusions, and psychosis-like behavior, but it could not be determined if efavirenz was the cause. Patients with serious psychiatric adverse experiences should be evaluated immediately to determine whether the risks of continued therapy outweigh the benefits.

**Nervous System Symptoms**

- Fifty-three percent of subjects reported central nervous system symptoms including dizziness (28.1%), insomnia (16.3%), impaired concentration (8.3%), somnolence (7.0%), abnormal dreams (8.2%), and hallucinations (12.2%) when taking efavirenz compared to 25% of subjects receiving control regimens. These symptoms usually begin during Days 1-2 of therapy and generally resolve after the first 2-4 weeks of therapy; they were severe in 2.0% of subjects, and 2.1% of subjects discontinued therapy. After 4 weeks of therapy, the prevalence of nervous system symptoms of at least moderate severity ranged from 5% to 9% in subjects treated with regimens containing efavirenz. Nervous system symptoms are not predictive of the less frequent psychiatric symptoms.

**New Onset or Worsening Renal Impairment**

- It is recommended that creatinine clearance (CrCl) be calculated in all patients prior to initiating therapy and as clinically appropriate during therapy with ATRIPLA, and routine monitoring of CrCl and serum phosphorus be performed for patients at risk of renal impairment, including patients who have previously experienced renal events while receiving adefovir dipivoxil. ATRIPLA should not be given to patients with CrCl <50 mL/min. Renal impairment, including cases of acute renal failure and Fanconi syndrome (renal tubular injury with severe hypophosphatemia), has been reported with the use of tenofovir DF. ATRIPLA should be avoided with concurrent or recent use of a nephrotoxic agent.

**Reproductive Risk Potential**

- ATRIPLA may cause fetal harm when administered during the first trimester to a pregnant woman. Women should not become pregnant or breastfeed while taking ATRIPLA. Barrier contraception must always be used in combination with other methods of contraception (eg, oral or other hormonal contraceptives). Because of the long half-life of efavirenz, adequate contraceptive measures are recommended for 12 weeks after discontinuation of ATRIPLA. If the patient becomes pregnant while taking ATRIPLA, she should be apprised of the potential harm to the fetus.

Please see Important Safety Information, including Boxed WARNINGS, for ATRIPLA and brief summary of Full Prescribing Information on adjacent pages.
ATRIPLA® (efavirenz 600 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg) tablets

Brief Summary of Prescribing Information. For complete prescribing information consult official package insert.

WARNINGs: LACTATE DEHYDROGENASE LAPTOPHEMATOPENIA WITH STRATEGIES and POST-TREATMENT EXAERATION OF HEPATITIS B

Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogs including tenofovir DF, a component of ATRIPLA, given alone or in combination with other antiretrovirals. A majority of these cases have been in women. Usually and protracted elevation of serum transaminases and other hepatic enzyme levels has been present. The fatal cases have been associated with increases of five or more times the upper limit of normal for ALT and bilirubin levels. These cases have generally been accompanied by anuria, oliguria, or other signs and symptoms of impaired hepatic perfusion. In some patients, liver biopsy has shown features of hepatocellular necrosis, cholestasis, and/or bile duct proliferation. There have also been postmarketing reports of severe acute exacerbations of pre-existing mild-moderate hepatitis B in patients receiving antiretroviral therapy. The mechanism and long-term consequences of these events are currently unknown. A careful relationship between risk factors and adverse events should be established.

ATRIPLA should not be administered to patients without BMD.

ADVERSE REACTIONS FROM CLINICAL TRIALS EXPERIENCE:

In Study 934, the most common adverse reactions (incidence ≥10%, any severity) for components of ATRIPLA, included diarrhea, nausea, fatigue, headache, dizziness, depression, insomnia, arthralgia, myalgia, upper respiratory tract infections, and rash. ATRIPLA was generally well tolerated. No new safety signals were observed in the ATRIPLA group compared with the tenofovir DF group. The most commonly reported adverse reactions with ATRIPLA were those of antiretroviral therapy. Abnormalities in laboratory findings during clinical trials included hyperglycemia and increases in alanine aminotransferase (ALT) and aspartate aminotransferase (AST).

Children: ATRIPLA use has been studied in children ≥6 years of age in clinical trials. The safety and effectiveness of ATRIPLA in children have not been established. Use in children <6 years of age is not recommended. Clinical trials in children <6 years of age who received ATRIPLA have been conducted in the context of antiretroviral treatment of HIV disease and were not conducted to evaluate the safety and effectiveness of ATRIPLA in this population. Therefore, only the safety and effectiveness of the components used in ATRIPLA have been studied in children <6 years of age.

Hepatotoxicity:

In patients receiving antiretroviral therapy, the incidence of new-onset or worsening hepatic disease or other identifiable risks for liver toxicity (See Adverse Reactions).

Postmarketing Experience: The following adverse reactions have been identified during postapproval use of ATRIPLA. Because postmarketing observations are based on experience with multiple antiretroviral HIV-1 therapies, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. None of the following reactions have been causally related to ATRIPLA.

Noninfectious: Anemia, neutropenia, vomiting, nausea, rash, headache, arthralgia, myalgia, dizziness, insomnia, abdominal pain, dyspepsia, flatulence, fatigue, chills, fever, weight loss, appetite increase, hair loss, pain, diarrhea, constipation, cough, elevated blood pressure, muscle spasm, back pain, vision changes, palpitations, or other cardiovascular events; significant decreases in blood pressure; unexplained weight gain; arthralgias, myalgias, or muscle spasms; acute renal failure; and metabolic acidosis.

Antiretroviral Pregnancy Registry - ATRIPLA use during pregnancy (including the first trimester) should be avoided, if possible. Physicians are encouraged to register all pregnant women who become pregnant while taking ATRIPLA by calling 1-888-285-3939 or by访问antiretroviralpregnancyregistry.cdc.gov.

ATRIPLA WARNINGS:

Hepatotoxicity: In patients receiving antiretroviral therapy, the incidence of new-onset or worsening hepatic disease or other identifiable risks for liver toxicity (See Adverse Reactions).

Liver toxicity should be considered when ATRIPLA and other antiretroviral agents are used in combination. ATRIPLA should be discontinued if transaminase levels increase and ATRIPLA is not believed to be the cause of the increased transaminase levels.

Other laboratory abnormalities in patients receiving ATRIPLA include: hyperbilirubinemia, increases in ASAT, ALT, AST, GGT, and especially ALT, and increases in alkaline phosphatase. Increases in AST, ALT, and GGT may be proportional to increases in CD4 cell count. Increases in ALT and/or GGT have been observed in patients, particularly those with baseline AST, ALT, or GGT >ULN.

Patients with significant steatosis on liver biopsy have had elevations of AST and ALT even when liver enzymes were normal on repeat tests. However, significant elevations in AST and ALT do not indicate whether the liver disease is progressive. In patients with severe hepatomegaly and steatosis, the benefits of treatment with ATRIPLA should be weighed against the potential risks of the liver disease. Use of ATRIPLA should be discontinued if signs or symptoms of hepatic injury develop or if the transaminase level increases to >5 times ULN.

Liver toxicity may be risk factors. Particular caution should be used when administering nucleoside analogs to any patient with known risk factors for liver disease; however, cases have also been reported in patients with no known risk factors. Treatment with ATRIPLA should be discontinued if the transaminase level increases to >5 times ULN, as ATRIPLA-related increases in AST or ALT may also occur in patients with prior liver disease.

Patients who have pre-existing hepatic impairment or have been treated with nucleoside analogs should be monitored more closely.

Patients with serious psychiatric adverse experiences should seek immediate medical evaluation to assess the possibility that the symptoms may be related to the use of efavirenz, and if so, to determine whether the risks of continued therapy outweigh the benefits. It is recommended to monitor psychiatric symptoms in patients receiving antiretroviral therapy. Several cases of increases in liver enzymes and hepatotoxicity have been reported in patients with serious psychiatric adverse experiences who were receiving antiretroviral therapy.
Emtricitabine - No postmarketing adverse reactions have been identified for inclusion in this section.

Nephrotoxicity - The urine output should be monitored in patients receiving concomitant therapy with ATRIPLA, efavirenz, and tenofovir DF. Since nephrotoxicity can occur at any time during therapy, patients should be instructed to report any symptoms of nephrotoxicity promptly.

Hepatotoxicity - The liver enzyme serum aspartate aminotransferase (AST) and alanine aminotransferase (ALT) should be assessed at baseline and periodically during therapy with ATRIPLA, efavirenz, and tenofovir DF. In patients who have undergone a change in treatment regimen, the liver enzyme levels should be assessed prior to the initiation of therapy and at regular intervals thereafter, in particular once per month for the first 3 months of therapy, and then every 6 months thereafter. If a significant rise in liver enzymes occurs, the physician should consider discontinuing therapy with ATRIPLA, efavirenz, and tenofovir DF. The drug should be avoided in patients with evidence of active liver disease. The physician should also be aware of the possibility of an idiosyncratic reaction that could lead to a clinically significant increase in serum liver enzyme levels.

Nucleoside analog reactions - Methotrexate - methotrexate concentration. Co-administration of efavirenz in HIV-1 infected subjects with a history of injection drug use resulted in decreased plasma levels of methotrexate and signs of opiate withdrawal. Methotrexate dose was increased by a mean of 22% to alleviate withdrawal symptoms. Patients should be monitored for signs of withdrawal and their methadone dose may need to be adjusted. In patients stabilized on methadone, a 10% reduction in the oral dose of methadone may be necessary. In patients stabilized on injectable naltrexone, an additional 100 mg/day of naltrexone should be added to the regimen.

Tamoxifen - Use with caution in patients receiving concurrent tamoxifen therapy due to the potential for CYP2D6 inhibition.

Risperidone - Use with caution in patients receiving concurrent risperidone therapy due to the potential for CYP2D6 inhibition.

Bristol-Myers Squibb & Gilead Sciences, LLC. Foster City, CA 94404

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Type 2 Diabetes on the Rise Among People Under 20

Long known as an “adult-onset” disease, in the past decade type 2 diabetes has afflicted “tens of thousands” of people younger than age 20, according to a recent Washington Post article. Apparently brought on by childhood obesity, the disease is now diagnosed in about 3,700 youth each year, the CDC estimates. Diabetes causes or exacerbates myriad medical conditions, and the article notes that these youth “are breaking new scientific ground: No one has any idea how they will fare over the course of a lifetime.” Although the number of cases remains relatively small, the trend may represent “the tip of the iceberg,” especially given studies that find high rates of prediabetes among youth. This makes it important for pediatricians to assess for risk factors and signs of insulin regulation problems.

Source: The Washington Post, March 21

HIV Infection a Risk Factor for Heart Failure: Study

To determine whether HIV is a risk factor for heart failure, researchers from the University of Pittsburgh School of Medicine conducted a retrospective cohort study of 8,486 HIV-infected and HIV-uninfected veterans enrolled in the Veterans Aging Cohort Study Virtual Cohort and the 1999 Large Health Study of Veteran Enrollees from January 2000 through July 2007. During the study period, 286 incident HF events occurred. Adjusting for age and race/ethnicity, HIV-infected veterans had an increased risk of heart failure (hazard ratio of 1.81). This association persisted among veterans who did not have a coronary heart disease event or an alcohol abuse or dependence diagnosis before the heart failure. Findings were significant at the 95% confidence level. “Ongoing viral replication is associated with a higher risk of developing HF,” the researchers conclude. The study was published in the April 25 Archives of Internal Medicine.


New Guidelines on Preventing Bloodstream Infections

Catheter-related bloodstream infections are one of the most deadly and costly threats to patient safety, according to the Centers for Disease Control and Prevention. In April, the CDC and the Healthcare Infection Control Practices Advisory Committee released new guidelines that outline steps to eliminate such infections. Major areas of emphasis include educating and training health care personnel, using maximal sterile barrier precautions during catheter insertion, cleaning skin with chlorhexidine (an antibacterial scrub) and avoiding routine replacement of certain catheters. Replacing a 2002 version, the “Guidelines for the Prevention of Intravascular Catheter-Related Infections” were developed by clinical scientists from the National Institutes of Health Clinical Center Critical Care Medicine Department aided by 14 other professional organizations and are available on CDC’s HICPAC website.


Viral Hepatitis Trainings

The National Training Center for Integrated Hepatitis HIV/STD Prevention Services offers two new online trainings discussing recent advances in the diagnosis and treatment of hepatitis for front-line workers. One focuses on hepatitis b and one on hepatitis c. Each training consists of a 45-minute online video plus a brief follow-up questionnaire. The user will receive a printable certificate of completion.

Online trainings:
- www.knowhepatitis.org/recentadvanceshepb
- www.knowhepatitis.org/recentadvanceshepc
Studies Capture National Data on Self-Injurious Behavior in Prisons

by Jaime Shimkus

The literature on inmate self-injury expanded considerably in the first quarter of 2011 with the publication of two major studies from different groups of researchers. Both involved surveys of state prisons and aimed to assess the prevalence of self-injury as well as management interventions, although the specific research questions and methods differed.

Smith and Kaminski

First up was “Self-Injurious Behaviors in State Prisons: Findings From a National Survey,” published in the January issue of Criminal Justice ad Behavior. Conducted in 2008 by Hayden Smith and Robert Kaminski of the University of South Carolina, the study targeted 785 state prisons identified as providing mental health services and housing at least 200 inmates. Surveys were mailed to chief mental health professionals, and responses were received from 230 respondents in 473 facilities (some respondents reported summary data for multiple facilities). Thus, the responses represent 60% of the facilities sampled. The two-page, 20-item questionnaire explicitly excluded suicidal behaviors.

SIB is nearly universal in state prisons, the data show, with 98% of respondents reporting at least one inmate who engaged in self-injury at the time of the survey. The average prevalence overall was 2.4% and for serious self-injury 0.7% (“serious” self-injury is not defined in the article). At the high end, some prisons reported that nearly one-third of inmates self-injure and up to 10% do so seriously.

The most common manifestations are by scratching with an object (96%) and cutting (94%). Other highly common methods are head banging, scratching without an object, opening old wounds and inserting objects. Write-in responses included some very rare but harmful and bizarre acts. Asked which methods were of most concern in the prison system, respondents most often cited cutting with an object, which the authors presume to be because of its frequency and difficulty of prevention. However, about 3 out of 5 respondents said it was moderately to very difficult to keep implements away from self-injurers.

More than 9 in 10 respondents said they have a procedure for preventing SIB, such as assessment at intake (83%), counseling/psychiatric services (81%) and use of a watch cell/special placement (81%). The many write-in responses were categorized as either therapeutic (e.g., behavioral management plans) or, less commonly, punitive (e.g., disciplinary actions). A common practice was to apply suicide protocols to self-injurious acts.

The data analysis also examines institutional correlates to SIB, such as security level, ratio of staff (mental health and correctional) to inmates, and population size and gender. Here, significant findings are that self-injury is more prevalent in maximum-security facilities, and that prevalence rises as the ratio of staff to inmates increases.

This article also provides a fairly detailed literature review of the topic and previous findings related to correctional populations. Overall, the authors say, their prevalence statistics are congruent with previous research.

Abstract: http://cjb.sagepub.com/content/38/1/26

Appelbaum et al.

In March, Psychiatric Services published “A National Survey of Self-Injurious Behavior in American Prisons,” authored by Kenneth Appelbaum, Judith Savageau, Robert Trestman, Jeffrey Metzner and Jacques Baillargeon (from four different state university medical schools). Here, the researchers emailed an invitation to mental health directors in all state systems and the Bureau of Prisons to complete a 50-item questionnaire either online or in hard copy. The response rate was 77% (30 systems).

Conducted in 2009-2010, the pilot-tested survey asked about self-injurious behavior events, including their definition, frequency, tracked data, impact on operations and resources, diagnoses, management and the roles of mental health and custodial staff. Survey responses were augmented with data obtained from reliable external sources concerning system-specific inmate census, operational capacity and design capacity, as well as corrections expenditures.

Only 56% of the responding systems reported that they maintain data on SIB events; thus, respondents often had to provide a “best estimate” for many of the questions.

About two-thirds of systems had no policy definition of self-injurious behavior; most of these used unwritten definitions. However, 74% said that they do distinguish between self-injurious and suicidal behaviors. Usually, a mental health clinician makes the determination, although some systems also allow medical clinicians or custodial staff to do so.

Responses suggest that in the average prison system, fewer than 2% of inmates per year engage in SIB, but such events occur fairly frequently—at least weekly in 85% of systems and more than once daily in some systems. Typically, outside medical treatment is not needed. The events most often involved inmates with Axis II disorders and were most common in maximum-security and lockdown.

Nearly two-thirds of systems treat SIB events as rule infractions, and more often than not, both mental health and custodial staff are responsible for dealing with such events. The study also examines use of medications and restraints in managing self-injurers. Overall, results suggest that management approaches to dealing with these events are inconsistent both within and across systems.

Study findings point to a need for better epidemiologic monitoring and data on self-injurious behavior, the researchers say, and the importance of developing and widely using effective interventions. On a positive note, most respondents expressed interest in taking part in future discussions and research on this topic.

Abstract: http://ps.psychiatryonline.org/cgi/content/abstract/62/3/285
The idea of prescribing stimulant medications for prisoners with attention-deficit/hyperactivity disorder “presents a daunting scenario for psychiatry, nursing and custody staff,” acknowledges the author of a study in the July 2011 issue of NCCHC’s Journal of Correctional Health Care.

One deterrent to stimulant use is the prevalence of ADHD among inmates, says Kenneth Appelbaum, MD, director of Correctional Mental Health Policy and Research at the Center for Health Policy and Research of the University of Massachusetts Medical School. Although only a few studies have sought to measure the rate of this diagnosis, they report prevalence of between 9% and 45%.

Another deterrent is the potential for problems associated with provision of controlled substances in correctional settings, such as drug diversion and misuse, security concerns, demands on psychiatrists and nursing time needed to manage the medications.

Nevertheless, stimulant treatment is the “mainstay of effective intervention” for patients with ADHD and in a correctional setting can produce improvements in behavior and functioning, Appelbaum says. Some observers call for stimulant treatment as an essential best practice even if prevalence rates in the inmate population exceed 25%.

However, Appelbaum argues that the reported rates may overestimate actual prevalence of ADHD among inmates and, more to the point, the need for treatment. Thus, his study sought to determine the prevalence not of the condition but rather of the treatment in a male, state prison population. In this case, treatment means provision of stimulant under a protocol that has detailed assessment and treatment guidelines, including mandatory review and prior approval.

The Protocol and Study Findings

Before beginning stimulant treatment for ADHD, psychiatrists had to submit to the chief of psychiatry a one-page prior approval form that summarized documentation of history, diagnosis, lack of response to nonstimulant treatment and significant functional impairment. To receive treatment an inmate needed to have impaired ability to function in population or to engage in productive activities such as work, education or programming. The absence of impairment, the active misuse of substances and failure to participate in nonpharmacologic treatment were among the reasons to deny stimulants. The pharmacy dispensed stimulants only after receiving completed approvals from the chief of psychiatry.

The study population was males convicted of felonies and serving at least 2.5 years in the state prison system. The study reviewed all approval forms submitted for a 24-month period to determine the total number of potential patients as well as the numbers of approvals and denials. (See the article for details about study methods and data analysis.)

During the study period, the prison system had 16,795 male inmates (including new arrivals). During this time, 122 requests for stimulant treatment were received, and 116 (95%) were approved. Thus, the stimulant treatment prevalence was 0.7%.

Treatment approval requests were fairly stable throughout the study period, although they were higher, as expected, for the first six months after the protocol was initiated. The author concludes: “The relatively low number of inmates with compelling reasons for stimulant treatment may provide a more realistic idea of the likely consequences of allowing access to this intervention.”
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The repercussion of trauma exposure, if left untreated, can result in high-risk behavior.

Trauma Assessment, Treatment Crucial for Youth

by Alicia White, MSW, LCSW

The homeowner awoke to the sound of breaking glass. Frightened that his house was being burglarized, he called the police, who arrived shortly thereafter. The police found a teenager sitting on the front steps of the house, waiting. He had not entered the home, just used the windows for target practice. When questioned by the police, the teen, “Johnny,” admitted to throwing rocks at the house because he “wanted to be arrested.”

In my clinical practice with a large criminal defense firm in New York City, one of my responsibilities is to assess our teen clients following an arrest. When a client, like Johnny, makes a statement to the police that his desire was to be incarcerated, it is imperative to analyze his current life stressors as well as his brief, 16-year history to ascertain what led to his bizarre behavior.

Johnny’s assessment determined that external forces influenced his actions. His father was suffering from terminal cancer, his older brother was on a third tour of duty in Iraq and his family was being evicted from their home.

Frequently, an offending adolescent’s initial contact with mental health intervention is when he is brought to the attention of the juvenile justice system, which may occur following years of exposure to trauma. The youth whom I treat are often from lower socioeconomic backgrounds and have witnessed, experienced or been involved with various traumatic incidents prior to their arrest. Many have experienced loss of a relative or close friend, either by death or incarceration. It is well-documented that youth most at risk of exposure to trauma and community violence are those who are least likely to receive the attention of mental health professionals.

Exposure to acts of violence or the loss of a caretaker or close family member by death or abandonment can significantly impact the life of a child or adolescent. Ideally, treatment would begin immediately after the exposure, although it may be difficult to do. If the youth lacks the coping skills to handle a traumatic situation, stress can manifest psychologically, physically and/or behaviorally. The repercussion of trauma exposure, if left untreated, can affect the development of the brain in young children, introduce problems with aggression and lack of inhibition in school-age children and result in high-risk behavior that can manifest negatively in adolescents.

Screening and Assessment

Working with adolescents, in and of itself, presents significant challenges specific to that population. However, when a youth has been exposed to trauma, that can compound the challenges. To provide youth who have committed a criminal offense with the appropriate treatment, it is necessary to understand the correlation between the negative behavior and the trauma they have experienced.

Those working in the juvenile justice system should be able to recognize signs of depression, post-traumatic stress disorder, anxiety and other diagnosable conditions. Screening and a thorough assessment and history by a skilled clinician or mental health professional are key in successful intervention. This should occur at intake to identify trauma exposure as well as other mental health issues or personal challenges. Questions posed should assess the adolescent’s feelings of depression, sadness, worthlessness, suicidal ideation, self-dislike, self-blame, guilt, insomnia, irritability and loss of interest in activities.

This assessment, coupled with the youth’s history, development and current issues, can establish the need for treatment as well as the types of interventions to be used. Then, as soon as possible, the youth should receive appropriate treatment.

Before initiating treatment with any child it is ideal, if possible, to engage with the parent/guardian. This can prevent obstacles or barriers to treatment. It also is crucial for the mental health clinician to form a therapeutic alliance with the youth and his or her caretaker.

Treatment Options

Mental health treatment for these adolescents can vary. If engaged in psychotherapy, they receive emotional support and learn tools to understand their emotional issues and to resolve inner conflicts. In treatment they are permitted to work on their current and past challenges. It is advantageous for the youth to work on goals with the therapist that may be specific to their problems or general. The length of treatment is determined on a case-by-case basis.

Each psychotherapy treatment model depends on communication, which is employed to bring about change in the adolescent’s feelings and behaviors. Individual psychotherapy treatments used for adolescents involved in the juvenile justice system include cognitive-behavioral therapy, dialectical therapy, psychodynamic therapy and interpersonal therapy.

Additional psychotherapeutic approaches specific for youth offenders include multisystemic therapy, functional family therapy, brief strategic family therapy, intensive preventive services, aggression replacement therapy and trauma-focused cognitive behavior therapy.

If left untreated, childhood trauma can lead to more serious difficulties over time. Fortunately, most adolescents who experience mental health challenges can return to normal daily lives if they receive appropriate treatment.

Alicia White, MSW, LCSW, is a therapeutic social worker for The Legal Aid Society, New York City. She may be reached at afwhite@legal-aid.org.
Hey CCHPs! It’s a Video Celebration!

The CCHP program turns 20 this year! That calls for celebration! We will be hosting contests, awards and weekly giveaways as we build up to the big anniversary party in October at the National Conference on Correctional Health Care. Here’s a peek at what we have in store.

**Video Contest: ‘I am a CCHP’**

To kick off the celebration, we are hosting a video contest. We invite Certified Correctional Health Professionals to submit a video based on the theme “I am a CCHP.” Get creative!

**How It Works**

Create a video that illustrates what “I am a CCHP” means to you. The video must last no more than 2 minutes. To enter, you must be a CCHP in good standing. For official rules and contest entry details, check your email or visit the CCHP section at www.ncchc.org.

After the contest closes on July 20, a CCHP panel of judges will select five finalists. These five videos will be posted online for you to vote for your favorite! This voting will take place in August. (Check your email for details.)

**Prizes Galore!**

- Each video contest entrant will be entered in a weekly raffle to receive CCHP items and CCHP bucks (to be used toward the purchase of any product or service from NCCHC). A new winner will be drawn every week through July 20.
- Each finalist will be featured in CorrectCare.
- The video contest winner will receive a free registration to the National Conference on Correctional Health Care, being held Oct. 15-19 in Baltimore. The winner will be announced during the Opening Ceremony and the video will be shown on the big screen for all to admire.
- Plus! Everyone who votes on the finalists will be entered into a raffle for a free National Conference registration.

In Other News ...

- Lucky New CCHPs. We want to see lots of certified professionals at our anniversary celebration in October, so everyone who passes the August regional exam will be entered into a raffle to win a free registration to the National Conference. Good luck!
- Call for Proctors! We have another big group of candidates from across the country sitting for the CCHP exam being held in August. We are seeking current CCHPs to proctor the exams in Jacksonville, FL, and Syracuse, NY. Please contact cchp@ncchc.org.
- Heads Up! Our annual call for nominations for the board of trustees will take place this summer. Do you know someone special (maybe yourself?) who would make a great addition to the board? Keep an eye on your CCHP email for information.
- Future Test Takers! With the new edition of the Juvenile Standards hot off the presses, the CCHP exam will be revised accordingly. This will apply to those taking the test in November or later. Need to pick up a new CCHP Study Package? See page 4 or visit www.ncchc.org.

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**CCHP Exam Dates**

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<thead>
<tr>
<th>Date</th>
<th>Location</th>
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<tr>
<td>May 22</td>
<td>Phoenix, AZ</td>
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<tr>
<td>June 18</td>
<td>Multiple regional sites</td>
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<tr>
<td>July 10</td>
<td>Las Vegas, NV</td>
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<tr>
<td>August 20</td>
<td>Multiple regional sites</td>
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<tr>
<td>October 16</td>
<td>Baltimore, MD</td>
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We are seeking additional sites for regional exams, as well as CCHPs to proctor the exams. If you would like to participate, contact the CCHP manager at 773-880-1460 or cchp@ncchc.org. Learn more at www.ncchc.org/cchp.
This department features news and information from NCCHC’s supporting organizations and other partners that share our goal of promoting quality health care in correctional institutions. If your organization has news to share, please contact editor@ncchc.org, 773-880-1460.

Break Free Alliance

With a mission of reducing tobacco use among populations of low socioeconomic status, the Break Free Alliance, a program of the Health Education Council, is strongly interested in the incarcerated, whose smoking rates are estimated to be as high as 70% (vs. 20% for all U.S. adults). Two years ago the Alliance issued a report, “Recommendations for Addressing Tobacco Use in Correctional Facilities Through Policy and Cessation Programming,” and now it is developing a webinar series to continue the discussion. The four 90-minute webinars will take place on select Tuesdays in July and August. Visit the web for dates, times, topics and registration. Or email Kristi Maryman at kmaryman@healthedcouncil.org.

Funded by the Centers for Disease Control and Prevention, Office on Smoking and Health, the Alliance also produced a tobacco cessation manual with assistance from NCCHC. Find the new edition at www.ncchc.org. Learn more: www.healthedcouncil.org/breakfreealliance

Society of Correctional Physicians

Correctional docs are a chatty bunch, and now they have their very own website for round-the-clock confab. The SCP Web Discussion Board has sections devoted to clinical and nonclinical topics, as well as a section for sharing documents. Guidance in using the site is offered via FAQs (frequently asked questions). Access is limited to SCP members only, and a username and password are required. Not a member? This resource is another great reason to join! Log in or join: www.corrdocs.org

Public Health Accreditation Board

After four years of preparation, a national voluntary accreditation program for public health departments is set to launch in Fall 2011. The initiative, believed to be the first of its kind, is being funded by the Robert Wood Johnson Foundation and the Centers for Disease Control and Prevention. Thirty health departments have tested the accreditation process and local officials report good results, according to the CDC. The program aims to improve the quality of services delivered by public health agencies as they work toward accreditation and, when they attain accreditation, reassure the public and officials that their health department is a peak performer. For a public health department to pass muster with the nonprofit Public Health Accreditation Board, it must meet stringent requirements for 10 essential areas of public health activities and demonstrate a commitment to constant improvement. Learn more: www.cdc.gov/ostlts/accreditation

Barbara A. Wakeen, MA, RD, CCHP

NCCHC board member Barbara Wakeen, MA, RD, CCHP, has won the election for chair-elect of Dietetics in Health Care Communities and begins her term on June 1. The oldest and one of the largest dietetic practice groups of the American Dietetic Association, DHCC has nearly 4,800 members and has a sub-unit focused on corrections. Wakeen represents the ADA on the board of directors and is the principal of Correctional Nutrition Consultants, LLC.

William C. Collins, JD

Twenty-two years after he and partner Fred Cohen, LLM, created Correctional Law Reporter, Bill Cohen is retiring from the bimonthly newsletter—or, as he says in the April/May issue, he will “slip some words in edgewise ... [but] step away from a major role.” A former assistant attorney general for Washington State, he envisioned CLR as “a unique resource for anyone working in corrections who is concerned about developments and changes in the law,” taking care to “translate legalese into plain English and to do so in a lively fashion.” The humble publication that was born in Collins’ kitchen led to the establishment of a publishing company, Civic Research Institute, Inc.

YOUR KEY TO Successful Recruitment

The #1 Career Resource for Professionals in the Correctional Health Community

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EMPLOYER Benefits
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http://careers.correctionalhealth.org
Charm City is the place to be this fall for savvy correctional health professionals and the companies that want to connect with them. NCCHC’s National Conference is the leading educational event in this field, attracting nearly 2,000 professionals who are ready to rev up their performance. The exhibit hall is a hot spot for your company to connect with these highly motivated individuals. Over three days of exhibit hall activities, these decision makers and influencers will come to explore new ideas and proven solutions for managing the complex operational and clinical demands of health care delivery to inmates. Your company’s presence will make an impact, both on site and in this market as a whole.

**Big Numbers, Big Opportunity**

With 2.3 million individuals incarcerated in the United States, serving their wide-ranging health care needs is a big business. In fact, the nation’s correctional facilities spend roughly $7 billion each year to provide this government-mandated care. Just as in the community, services span the spectrum, from acute care to chronic disease management to routine care, including dental and mental health, along with substance abuse treatment, prevention and health education. That’s a big challenge—and a big opportunity for companies that serve this market.

**Effective Outreach**

- Exhibitions are the #1 source for attendees who make purchasing decisions.
- Exhibition leads cost 56% less to close than field sales calls.
- Exhibitions allow you to reach an average of 88% of unknown prospects.

Source: The Center for Exhibition Industry Research (CEIR)

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- 75-word listing in the Final Program (deadline applies)
- Electronic attendee lists for pre- and post-show marketing
- Free basic listing in NCCHC’s online Buyers Guide
- Lead retrieval technology available for rental on site
- Opportunity to participate in raffle drawings
- Priority booth selection for the 2012 Updates conference

**Sponsorship Opportunities**

Enhance your presence and maximize marketing dollars through these outstanding opportunities.

- Premier programming: Educational sessions and breakfast/luncheon programs give attendees a fresh experience while giving your company exclusive exposure.
- Final proceedings: With your company’s name on the cover, the CD-ROM enables attendees to continue their learning with these PowerPoint presentations.
- Exhibit Hall reception/luncheon/breaks: Attendees will appreciate your contribution as they gather in this high-energy center to mingle and network throughout the day.
- Smaller opportunities with big impact: Promote your company name while enhancing the attendee experience by sponsoring the conference bags, lanyards, water bottles, badges, banners and more.
- Customize your contribution. NCCHC will work with you to develop a personalized package tailored to your needs and your budget.

**Registration Information**

The National Conference is the premier event where you can meet with important contacts and raise your profile in this specialty field, so reserve your space now. Standard booth sizes are 10’ x 10’; double-size and premium spaces are available. For details and a reservation form, please see the Exhibitor Prospectus, available online at www.ncchc.org, or contact Kim Simoni, exhibits and sales manager, at conference@ncchc.org or 773-880-1460.
Special Savings! 10% discounts are offered for Academy members (single copies) and bulk purchases of a single title. (Excludes already-discounted items.) To order or for a catalog, visit www.ncchc.org or call 773-880-1460.

NEW! The Legal Health Record: Regulations, Policies, and Guidance, 2nd Ed.
This important book explains, from a record manager’s perspective, how to create health records that are better organized and offer better legal defensibility, and how to lead teams through the processes necessary to clearly understand and organize strategies and work flows. As health records migrate to electronic environments, this book will assist in meeting the related challenges. The tools and strategies provided straddle the legal and record management/information technology arenas. Key features: expanded explanatory information; components of the legal health record; customizable forms and templates; litigation response and subpoenas; EHR system attributes that affect the legal health record; details about e-discovery, federal rules of civil procedure and uniform rules. By William Kelly McLendon, RHIA, and Michael R. Lowe, JD, technical editor. AHIMA Press (2011). Soft cover, includes CD-ROM, $59.95

NEW! Substance Abuse Treatment for Criminal Offenders: An Evidence-Based Guide for Practitioners
Part of the APAS Forensic Practice Guidebooks series, this book takes a comprehensive look at what interventions work in assessing and treating substance-abusing offenders. It is packed with practical information on traditional and cutting-edge approaches to treating offenders, including women, juveniles and those with the dual diagnoses of substance abuse and a mental disorder. Most substance abuse treatment today is provided to the criminal population so there is a pressing need for resources that bridge criminal justice and addictions treatment. From assessment and diagnosis through individual, family and group interventions and monitoring probationers, this is an essential resource for psychologists, psychiatrists, social workers, criminologists, sociologists, correctional officers and others working in institutional and community-based settings. By David Springer, PhD, C. Aaron McNeese, PhD, and Elizabeth Mayfield Arnold, PhD, LCSW. American Psychological Association (2003). Hardcover, 252 pages, $39.95

CCHP Items
As the Certified Correctional Health Professional program celebrates its 20th year, be sure to stock up on these professional items adorned with the CCHP logo. Find product descriptions and order online via the publications catalog at www.ncchc.org.
- CCHP Pin Enhancer to mark 5, 10 or 15 years of participation in the program. (20-year pins will be available in the fall.) $10
- CCHP Business Card Case, a stylish way to tote your business cards. $8
- CCHP Cup and Coaster, 11 oz. white porcelain cup with coaster that can serve as a lid to keep beverages warm. $7.50 for one, $6 for two
- CCHP Executive Organizer with mini binder, calendar, address book and more. $20

SIMPLIFIND
Tap into the incredible network of the National Commission on Correctional Health Care with the NCCHC Buyers Guide. Powered by MultiView, the Guide is the premier search tool for correctional healthcare practitioners. Find the suppliers and services you need, within the network of the association you trust.
Simplifind your search today at www.ncchc.org.

About CorrectCare™
CorrectCare is the quarterly magazine of the National Commission on Correctional Health Care. Its mission is to publish news, articles and commentary of relevance to professionals in the field of correctional health care.

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Editorial Submissions: Submitted articles may be published at our discretion. Manuscripts must be original and unpublished elsewhere. For guidelines, contact Jaime Shimkus at editor@ncchc.org or 773-880-1460. We also invite letters or correction of facts, which will be printed as space allows.

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Expert Advice on NCCHC Standards

by Jennifer E. Snow, MPH, CCHP, and Scott Chavez, PhD, MPA, CCHP-A

Nursing Coverage

Q  We are interested in becoming accredited, but our small work camp doesn’t have 24x7 nursing staff. Does that mean we can’t be accredited?

A  Not at all. NCCHC standards do not require 24x7 nursing coverage for accreditation. When health staff are not on site, a health care liaison can coordinate a number of health services activities, such as triaging non-emergency sick-call requests every 24 hours, facilitating sick call by having inmates and records available for the health care professional, and helping to carry out clinicians’ orders regarding such matters as diet, housing and work assignments. The health care liaison may be a correctional officer or other person without a health care license who is trained by the responsible physician in limited aspects of health care coordination. Note that if infirmary care is provided on site, then 24x7 coverage would be required as infirmary patients should always be within sight or hearing of a qualified health care professional.

Right to Refuse Treatment

Q  We understand that patients have the right to refuse treatment (standard I-05) and we always have them sign a refusal form when they do. Are we also required to have them sign a refusal form for refusing a single dose of medication?

A  No. A form does not need to be signed for every no-show at pill line or for every time a patient refuses a medication. However, if the patient is repeatedly refusing, the responsible health authority would do well to have a policy to address follow-up such as provider notification and patient counseling.

New Juvenile Standards

Q  We are ready to jump into the new standards for juvenile facilities, but where do we begin? What’s new? Are there any major changes?

A  NCCHC is proud of the 2011 Standards for Health Services in Juvenile Detention and Confinement Facilities, the result of the hard work and collaboration of national experts in juvenile justice and health care. Some of the most significant changes are discussed in the Spotlight column on page 3, but here’s a quick rundown. We also will discuss the changes, both significant and subtle, in greater detail in upcoming columns.

Standards Y-B-03 Patient Safety and Y-B-04 Staff Safety are new; both are classified as important. Y-G-01 Chronic Disease Services was classified as important in the previous edition but it is now an essential standard, which means that it must be met in order to achieve accreditation. Please note that Y-G-01 was also updated for 2011.

Be sure to carefully review standards where major changes were made. These include (but are not limited to) Y-A-04 Administrative Meetings and Reports; Y-A-06 Continuous Quality Improvement Program; Y-A-10 Procedure in the Event of a Juvenile Death; Y-G-01 Credentialing; Y-D-01 Pharmaceutical Operations; Y-D-03 Clinic Space, Equipment, and Supplies; Y-E-12 Continuity of Care During Incarceration; Y-G-01 Chronic Disease Services; and Y-G-05 Suicide Prevention Program.

Update: Please note the revised time line for compliance:

- June 1: All juvenile facilities seeking initial accreditation will be surveyed under the 2011 edition of the Standards.
- June 1 through September 30: All currently accredited juvenile facilities will be surveyed under the 2004 edition.
- October 1: All juvenile facilities will be surveyed under the 2011 edition.

Jennifer E. Snow, MPH, CCHP, is NCCHC’s director of accreditation. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president and liaison to the policy and standards committee.
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