Inappropriate Medications in Jails and Prisons

Stroke: The Importance of Early Detection and Treatment

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Our Independence Matters

The National Commission on Correctional Health Care has no membership or dues. NCCCH is supported by the leading national organizations representing the fields of health, law and corrections.
New Initiatives Take Off!

**Live Learning Center Launches**
NCCHC is pleased to announce its Live Learning Center, an online resource that extends the reach of the premier educational programming offered at NCCHC conferences. The easy-to-use modules combine PowerPoint presentations with audio recordings in a format that enables learning at the user’s convenience.

Adding value to NCCHC’s Updates in Correctional Health Care conference, all attendees received complimentary access to the sessions recorded at the meeting. Now, these professionals can benefit from the speakers’ expertise by accessing sessions they could not attend in person. Free access will also be provided to attendees of the Leadership Institute and Correctional Mental Health Care meetings.

Concurrent sessions from Updates 2012 as well as the 2011 National Conference are now available for preview and purchase. Visit NCCHC’s Live Learning Center at http://ncchc.sclivelearningcenter.com.

**Leadership Institute Rebrands and Expands**
Building on the success of our two-day Boot Camps, NCCHC has established a Correctional Health Care Leadership Institute. Currently offering programming for medical directors and health administrators, these intensive events provide correctional health leaders with the specialized knowledge and expertise necessary in this unique and challenging field.

With separate tracks for those new to the role and for seasoned professionals, the events will enable participants to strengthen their understanding of the core elements of these demanding jobs.

Program features include:
- Two full days of both didactic and hands-on learning
- Designed by nationally recognized experts
- Structured networking sessions
- A mentor matching program
- Continuing education credit (approximately 15 hours)
- Online toolkit of seminar and supplemental materials

We highly recommend that correctional health care leaders and executives attend alongside their colleagues. Senior-level attendance signals the importance of partnership and enhances the opportunity to apply learning to facility goals and objectives.

**CHORDS Builds Momentum: 66 Sites Take Part in First Test**
NCCHC’s Correctional Health Outcomes and Resource Data Set project has devised its first nine performance measures, all related to diabetes, and has conducted its first test run of the system. Data were submitted by 66 participants—56 prisons and 10 jails; of these, 59 were single-site entities. Individualized reports will be sent to each of the participants.

Modeled after the National Committee for Quality Assurance’s Healthcare Effectiveness Data and Information Set, CHORDS is a quality improvement initiative that uses aggregate performance data and information to enable benchmarking among correctional health care providers. A CHORDS website will launch soon providing details about the project, listing the measures and inviting public comment. Stay tuned!

**Calendar of events**

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<th>Event Description</th>
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<tr>
<td>July 20-21</td>
<td>Leadership Institute: Medical Directors and Health Administrators, Chicago</td>
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For the complete list of CCHP exams, including regional exam sites, see ncchc.org/cchp.

**Correction**
In the Winter 2012 (issue 26-1) article on communicable disease and standard precautions, the table on page 23 has an error. In the bottom row (MRSA), the cells for “Signs and Symptoms” and “How It Spreads” should be reversed.

**Clarification**
The Winter 2012 (issue 26-1) cover story on crisis intervention teams indicates that the first CIT was the Memphis Model, established in 1988. Although this was the first use with regard to management of the mentally ill, according to the National Alliance on Mental Illness, reader Jeffrey Schwartz, PhD, informs us that crisis intervention teams used in law enforcement date to the 1960s in New York City. Schwartz is president of LETRA, Inc., a nonprofit criminal justice training, research and consultation organization in Campbell, CA.
An Ethical Conundrum in Correctional Health Care

by Carl C. Bell, MD, CCHP

As the chairman of NCCHC’s board of directors, I feel it is my duty to inform the field of an impending issue that is critical to the profession of correctional health care. American medicine is at a crossroads and correctional health care is going to be caught in the middle and will have to face ethical issues heretofore never experienced. Our nation is trying to decide if the practice of medicine will continue to focus on tertiary health care and expensive money-making procedures (e.g., triple bypass surgery, bariatric surgery) or whether we will move forward with the trend being advocated by both Republican and Democratic administrations that focuses on prevention, health promotion and public health.

Those of us who work in correctional health care are extremely aware of the problem of intellectual challenges in the inmates we serve. I vividly recall my experiences as a surveyor in 1985 when NCCHC was called to Texas to survey the state’s entire prison system, and I was surprised to learn that approximately 20% of the inmates were mentally retarded. More recently, in my conversations with the leadership of the Cook County Juvenile Detention Center in Chicago, I learned that approximately 66% to 75% of the youth incarcerated in that facility have problems with mild mental retardation, attention-deficit/hyperactivity disorder, specific learning disorders and various speech and language disorders. This problem, which I have seen for nearly 30 years in correctional health care, is not new. In fact, I recall seeing high rates of mild mental retardation in poor African-American youth around 40 years ago, when I was in training at Meharry Medical College, Nashville, TN, which primarily served poor African-Americans in the South.

Source of the Problem

After more than 40 years of trying to figure this out, I think I have finally identified the etiology of this problem: fetal alcohol exposure, which can be subcategorized as fetal alcohol syndrome and fetal alcohol spectrum disorders. For years we have known about the damage that FAE can cause to the developing fetus. In 2010, I was on “Tell Me More,” a National Public Radio show, discussing “Crack Babies: 20 Years Later” and I remember asserting that FAS was always a far larger problem in terms of physical damage to the fetus than crack cocaine.

However, it wasn’t until this past February at Manitoba’s Mental Health Summit—where I presented the keynote on “Prospects for the Prevention of Mental Illness” and was discussing America’s new, first-ever National Prevention Strategy—that I realized the probable source of the high levels of intellectual deficiencies we see in corrections was FAE. What drew my attention to the cause of the problem of mental retardation in corrections was Canada’s epidemiology of the prevalence of FAS among its First Nations populations. In the 1870s, Canada had a policy of forcibly removing First Nations children from their families and placing them in residential schools. In these schools, First Nations children were told that they should abandon their language, food and religion and dress to be good Canadians. The result? The First Nations culture that had protected both the children and adults was stripped, and their response to this cultural trauma was to drink (leading to the high rates of FAS and FASD, suicides, violent acts and generally self-destructive behaviors).

When I learned that FAE is the leading cause of mild mental retardation, ADHD, specific learning disorders and various speech and language disorders, it all finally made sense. Add that to the fact that, according to Canadian data, 19 of 20 youth in Canada’s juvenile detention centers have FASD, and it all makes perfect sense. Unfortunately, we do not have similar epidemiologic surveillance in the United States, but considering the prevalence rates of liquor stores in poor neighborhoods of people of color and based on my clinical experience of serving chronically, persistently mentally ill patients (many of whom are “mentally retarded”), I am convinced a major cause of the mental retardation and intellectual difficulties we see in inmates is fetal alcohol exposure.

From an international perspective, we know the problem that FAE is also causing in South Africa and Russia.

Ethical Implications

Now, here is the ethical rub: FAE (FAS and FASD) is completely preventable, so what is correctional health care’s responsibility in preventing this devastating problem in the U.S. population? Our ethics as health care professionals dictate that we not deny someone the inalienable right to what the United States has established as part of being human. The Declaration of Independence asserts, “We hold these truths to be self-evident, that all men are equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.” Maintaining that inextricable human right to life is at the core of health professionals’ purpose, quintessential to their vocational existence. This maintenance of life involves both intervention and prevention, and a health care professional’s neglect in applying the

continued on page 4
knowledge and ability to preclude a symptom or disease process is accepted as unethical and, in some cases, illegal.

Ethicists have argued that access to adequate medical care for diseases should be a right (i.e., an inherent, human allowance) and not a privilege (i.e., an earned and/or allocated allowance or advantage), and preventing the onset or progression of disease is a time-honored anchor of our profession. Regarding FAE, the dilemma for correctional health care, like most of U.S. medicine, is that we are on the tail end of addressing health problems from this completely preventable disorder. So what is a correctional health professional’s ethical responsibility for addressing this issue in a proactive manner?

From my perspective, despite being on the tail end of the FAE problem, correctional health care professions have a responsibility to advocate for the prevention of a medical disorder that increases the ranks of inmates in corrections. To this end, I propose educational programs that highlight the dangers of FAE for youth and adults in corrections.

Furthermore, evidence is mounting that omega-3 fatty acids can help with the symptoms of ADHD, which is most likely caused by FAE. Research on dietary differences in essential fatty acids status in six placebo-controlled randomized trials also illustrates that essential fatty acids can alter aggressive behavior. Thus, it is suggested that correctional diets be supplemented with foods that contain these fatty acids.

****

A Matter of Public Health

When I was installed as the chairman of NCCHC’s board of directors, I promised to focus on the issues of prevention, health promotion and public health. I hope the field will join me in this endeavor as our profession is a mainstay against diseases coming out of the correctional population we serve and ravaging communities in the “free world.” Accordingly, the inmate’s health we preserve is intimately involved with our own health and well-being outside corrections. We owe it to our inmates and families to provide everyone with the best prevention, health promotion and public health practices we can devise as we are all in this together.

Carl C. Bell, MD, CCHP, is president and chief executive officer, Community Mental Health Council Foundation, Chicago, as well as director, Institute for Juvenile Research, and clinical professor of psychiatry and public health, University of Illinois School of Medicine, Chicago. A founding member of the NCCHC board of directors, he now serves as its chair. For references, see this article online at ncchc.org/pubs.

Prevention can cost less than you think; treatment may cost more.

The average cost of treating a MRSA infection in the hospital has risen to over $60,000, and that cost does not include the staff time required to supervise a hospitalized inmate.

Correctional facilities are at high risk for the spread of skin infections due to the close quarters and crowding that is unavoidable in these environments.

Hibiclens® and Hibistat® wipes can help prevent bacterial infections and viral illnesses by providing an extra benefit on the skin. Both products contain Chlorhexidine Gluconate (CHG), which bonds to the skin and provides continuous killing action for up to 6 hours after use. It is simply not possible to wash and bathe after every potential contact with contaminants, but Hibiclens and Hibistat wipes can help provide lasting protection against contamination that may lead to illness or infection. Hibiclens has also been proven in a dermatological test to be non-irritating to the skin.

We can assist you with a plan to both reduce infection rates and to also fit within your budget. You can find your local representative by going to www.Hibiclens.com or by calling 800.849.0034.

Hibiclens and Hibistat wipes are available through your correctional distributor. They may also be purchased at CVS, Walgreens, Rite Aid, Target, Walmart, Stop & Shop, Giant, and SuperValu stores in the first aid section.
Segregation inmates are those who are isolated from the general population and who receive services and activities apart from other inmates. Whether you call it administrative segregation, protective custody, disciplinary segregation or even “the hole,” standard E-09 Segregated Inmates is about the conditions of living and confinement, not the reason for the segregation or what the area is called.

First, let’s define the degrees of isolation as set forth in this standard’s compliance indicators.

- Extreme isolation refers to situations where inmates are seen by other staff or other inmates fewer than three times a day. Compliance indicator 2a addresses this category.
- The middle degree of isolation, which we find to be the most common, refers to inmates who are segregated and have limited contact with staff or other inmates. These conditions are addressed in compliance indicator 2b.
- The least restrictive category refers to inmates who are allowed periods of recreation or other routine social contact among themselves while segregated from the general population. This is addressed by compliance indicator 2c.

In supermax or lockdown facilities or tiers all inmates are in a segregated status and, therefore, all should be monitored under the auspices of this standard.

**Review and Monitoring**

The intent of the standard is to ensure that inmates placed in segregation maintain their medical and mental health while physically and socially isolated from the rest of the inmate population. To ensure this, appropriate monitoring and health record review procedures should be in place.

The first step is the health record review. Compliance indicator 1 states: “Upon notification that an inmate is placed in segregation, a qualified health care professional reviews the inmate’s health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation. Such review is documented in the health record.”

Custody and health staff should have an effective system to communicate when an inmate is about to be, or has just been, placed in segregation. It is important for health staff to quickly determine whether there are contraindications or necessary accommodations to the segregation to minimize the risk of harm to the inmate’s health. Documentation of this review (in the health record) prior to, or soon after, the placement is vital. NCCHC recommends that the responsible health authority be involved in the development of segregation policies and procedures so that appropriate accommodations for health conditions can be addressed.

Due to the complex conditions of segregation, health staff should review the health status of their patients prior to their placement into segregation to ensure continuity of care and services. Take care when reviewing health records of inmates with serious mental illnesses to assess the risk of exacerbation of the mental illness. Medical staff reviewing the record should notify mental health staff when the inmate is currently under the care of mental health services.

Next, frequent monitoring based on the degree of isolation should be initiated. Inmates under extreme isolation should be monitored daily by medical staff and at least once a week by mental health staff (category 2a). Segregated inmates who have limited contact with staff or other inmates should be monitored three days a week by medical or mental health staff (category 2b). Inmates in category 2c should be checked weekly by medical or mental health staff.

The quality of the health round in segregation is key. Checks by health staff ensure that each inmate has the opportunity to request care for medical, dental or mental health problems. These individual visits also enable health staff to ascertain the inmate’s general medical and mental health status. Inmates often experience irritability, anxiety or a dysphoric mood within weeks of placement in social isolation. Special attention should always be given to vulnerable populations, such as adolescents and the mentally ill. Due to the possibility of injury and depression during isolation, the evaluations by health staff should include notation of bruises or other trauma markings, comments regarding the inmate’s attitude and outlook (particularly as they might relate to suicidal ideation) and any health complaints.

Inmates with serious mental disorders often experience an exacerbation of their underlying illness when segregated. NCCHC recommends that the health rounds on patients with serious mental illness in segregation take place at the beginning, middle and end of each week to decrease the likelihood of problems during weekend hours.

Simply initialing a housing roster upon entering the unit is not enough. Segregation rounds should be documented on individual logs or cell cards (and when filled should be filed in the inmate’s health record) or in the health record, and include date and time of contact and the signature or initials of the health staff member making the rounds. Significant findings should be documented in the health record.

Health staff should note every time they make rounds, whether or not there is a health-related interaction or observation. However, necessary clinical encounters should not take place cellside but in an appropriate clinical setting and noted in the patient’s health record. When a segregated inmate requests health care, arrangements should be made for triage, examination and treatment in an appropriate clinical setting. Note that the segregation rounds are required in addition to whatever mechanism is in place for inmates to request health services daily (see E-07 Nonemergency Health Care Requests and Services).

Notably, this standard is considered essential for prisons and important for jails with regard to accreditation due to the extended lengths of stay in prisons versus jails.

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

Nine years after passage of the Prison Rape Elimination Act, the U.S. Department of Justice has released a final rule to prevent, detect and respond to sexual abuse in confinement facilities. The rule sets national standards for four categories of facilities: adult prisons and jails, lockups, community confinement facilities and juvenile facilities. The standards do not focus on outcomes but rather on policies and procedures. An objective was to craft standards that will yield the maximum desired effect while minimizing the financial impact on jurisdictions. The average estimated annual cost of compliance is $55,000 per prison, $50,000 per jail, $16,000 per lockup, $24,000 per community confinement facility and $54,000 per juvenile facility.

The standards apply to facilities operated by, or on behalf of, state and local governments and the DOJ. Initially the standards are binding on the Federal Bureau of Prisons. At the state level, those that do not comply with the standards are subject to a 5% reduction in DOJ funds received for prison purposes unless the governor certifies that 5% of such funds will be used to enable compliance in future years. The rule also provides for audits of correctional facilities every three years. PREA also applies to federal confinement facilities other than those operated by the DOJ, and separate rules will be developed for those agencies.

To help with compliance, the DOJ has funded the National Resource Center for the Elimination of Prison Rape to serve as a resource for online and direct support, training, technical assistance and research to assist adult and juvenile corrections, detention and law enforcement professionals in combating sexual abuse in confinement. NCCHC is one of the collaborating organizations lending its expertise in developing programs and training curricula for the resource center.

WHO Warns of Antibiotic-Resistant Gonorrhea

The World Health Organization is calling for greater vigilance on the correct use of antibiotics and more research into alternative treatment regimens for gonococcal infections. This comes in response to cases reports of resistance to cephalosporin antibiotics—the last treatment option against gonorrhea—from several countries, including Australia, France, Japan, Norway, Sweden and the UK.

Gonorrhea makes up one-fourth of the four major curable sexually transmitted infections. Untreated gonococcal infection can cause health problems such as infection of the urethra, cervix and rectum; a significantly increased risk of HIV infection and transmission; infertility in both men and women; and pregnancy complications. “The available data only shows the tip of the iceberg,” said a WHO representative. “Without adequate surveillance we won’t know the extent of resistance, and without research into new antimicrobial agents, there could soon be no effective treatment for patients.”

ACLU: Cost of Mass Incarceration of the Elderly

In 1981, there were 8,853 state and federal prisoners age 55 and older. Today, that number is 124,900, and the number is projected to exceed 400,000 by 2030, according to a new report from the American Civil Liberties Union. Titled At America’s Expense, the report provides a comprehensive 50-state and federal analysis of the incarceration of aging prisoners, with a fiscal analysis showing how much money states would save by releasing elderly prisoners.

SAMHSA Issues New Treatment Improvement Protocols

Latest in the series of TIPS from the Substance Abuse and Mental Health Services Administration are two that will be useful in a correctional health care setting:

- **TIP 53**: Addressing Viral Hepatitis in People With Substance Use Disorders
- **TIP 54**: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders
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Texas’ Prison Dental Policy Linking BMI to Need to Provide Dentures at Issue

by Fred Cohen, LL.M.

In Marquez v. Woody (440 Fed. Appx. 318, 5th Cir. 2011), the court dealt with some highly dubious policy and decisions involving dental care for a Texas prisoner. It is undisputed that inmate Marquez does not have any teeth; none. He has been repeatedly denied dentures because his body mass index was in the normal range of 18.5 to 25.

In the appeal under review here, the issue focuses on an allegation that despite his having a prescription for soft food, the food manager refused to provide it. Instead, a “veggie” diet was offered and now Marquez claims he has suffered severe gastrointestinal problems because he has no dentures and is not being provided with the prescribed, soft diet he needs.

On review of summary judgment for the food services provider and Thaler, director of the Texas Department of Criminal Justice, the court of appeals reinstates the complaint and allows the case to move forward.

The food service provider had been granted summary judgment on a finding that, among other things, Marquez failed to exhaust his administrative remedies. In fact, Marquez did name the proper party and did exhaust his administrative remedies.

Further, the magistrate erred in concluding that there was no evidence in the record that food services employee Lemaster was deliberately indifferent to Marquez’s serious medical need for a soft food diet. In his grievance, which was attached to his verified complaint and which was also sworn, Marquez stated that Lemaster ignored Marquez’s prescription for a soft food diet by taking Marquez’s diet pass, crossing out the portion describing the soft food requirement and writing “veggie” on it. Marquez alleged that Lemaster ignored him when he explained that he could not eat a veggie tray because he had no teeth. In his verified complaint, Marquez also stated that Lemaster actually had thrown the plaintiff out of the chow hall, refusing to provide any sustenance whatsoever. Thus, there clearly is a fact issue that Lemaster knew Marquez had a soft food prescription and deliberately denied him the prescribed diet.

Accepting Marquez’s competent summary judgment evidence as true, as the reviewing court must at this stage, Lemaster’s actions clearly violated the Eighth Amendment because she refused to provide Marquez with soft food despite the fact that a doctor prescribed him such a diet. It would be difficult to argue that Marquez did not need to eat soft food when it is apparent that Marquez has no teeth and since Marquez presented a prescription for a soft food diet to Lemaster that indicated that such a diet was medically necessary. Lemaster’s qualified immunity defense is rejected at this stage based on the competent summary judgment evidence before the court, recognizing that the facts actually proven may be different from those sworn to by Marquez.

As for Thaler, the claim is that Thaler may be liable if he implemented a policy that caused constitutional violation. The magistrate judge should have considered whether Thaler could have modified or contravened the policy that denied dentures and instead implemented a policy of providing soft food.

Reversed and remanded.

Comment

At a policy level, the most important issue in this case relates to the provision of dentures to an inmate wholly without teeth based on the BMI. This is a fundamentally flawed approach. In Ohio, the following agreement derives from the lawsuit styled Fussell v. Wilkinson, Case No. C-1-03-704 (S.D. Ohio). The Fussell Dental Stipulation has now
Agreement on Dental Care

Level Four
Level 4 care is to generally be reserved for the longer-term population; inmates who will likely be in ODRC custody for more than three (3) years.

Endodontics. Root canal therapy is considered to be Level 4 care once the infection and pain are controlled. Root canal therapy will be limited to those cases with compelling reasons for saving a particular tooth. In those very limited instances where the dentist performing the service feels that endodontics is warranted, this service may be provided in accordance with the following criteria: a) The dentist must evaluate the total oral health of the inmate and there must be excellent oral hygiene and periodontal health, b) the tooth must be in occlusion, c) low caries risk is noted, and d) there is sufficient clinical crown, such that a full-coverage, cast restoration is not anticipated.

Prosthodontic Treatment. If the inmate does not have occlusion of at least the maxillary and mandibular second bicuspids as well as the anterior teeth, some type of partial or full denture should be considered. Prosthodontic (denture) treatment is Level 4 care. Thus, the inmate’s length of sentence must be considered. Full and partial dentures are Level 4 care. While these treatments are desirable for all who fit the diagnosis, they are often not necessary to prevent pain or significantly improve chewing function. A soft diet shall be made available for inmates whose difficulty chewing interferes with proper nutrition.

Partially edentulous inmates must have their mouths fully prepared prior to fabrication of a removable partial denture. This preparation may require a surgical procedure to ensure that the maxillary and mandibular ridges on which the dentures will rest have a physiologic shape. This would mandate eligibility for Level 3 care to be able to progress to Level 4. For dental prostheses to be wearable there must be supporting structures that can keep them stable under the forces of chewing and speaking. The occlusion (bite) must be carefully recorded to keep the finished denture in harmony with the patient’s jaw position and chewing cycle.

Removable Prosthetics. P & P shall provide criteria for a dentist to decide whether and when an inmate qualifies for removable partial dentures. These criteria shall be based on inmate need, sentence length, and the condition of the inmate’s supporting structures and commitment to good oral self care. The P & P shall address:

- Fabrication of temporary partial dentures
- Fabrication of cast framework partial dentures
- Fabrication of complete dentures and immediate dentures
- Denture repairs
- Denture remakes
- Dental review board
- Quality of impressions, casts and interocclusal records

Fred Cohen, LLM, is the coeditor of the Correctional Law Reporter. This article is in press for a future issue of CLR, ©2012 Civic Research Institute, Inc., and is reprinted here in slightly abridged form with permission of the publisher. All rights reserved.

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Traumatic Brain Injury: How to Assess and Manage an Often-Hidden Condition

by Barbara Burchell Curtis, MSN, RN

A traumatic brain injury may have debilitating effects, yet its presence is not always obvious. According to the Centers for Disease Control and Prevention, at least 5.3 million people in the United States are living with TBI-related disabilities. In the free world, typical causes of TBI are falls, motor vehicle accidents, being struck by objects and assaults.

Compared to prevalence in the general population, about 8.5%, TBI among incarcerated populations is far more widespread, with estimates ranging from 25% to 87%. In the correctional setting, a common cause is assault, as well as being struck by an object and falling.

Among inmates who report a history of brain injury, the effects of that injury could have contributed to behavior that led to arrest and incarceration. Inmates with prior TBI are known to have more disciplinary problems and substance abuse problems.

Those behavioral problems persist behind bars, of course. Behavioral lapses that may become disciplinary issues include forgetting when one needs to be somewhere or that one can’t go somewhere in particular, inability to focus on instructions, forgetting the rules, poor impulse control and inability to control anger or irritability. These behaviors can lead to additional injury to the brain, as well.

Identifying TBI

It is important to identify inmates with TBI for the benefit of the patient, who then can be treated, and for the institution, which can take the disability into account when managing the inmate.

Ideally, initial intake would include a screening evaluation for TBI. It also could be addressed during subsequent physical examinations or clinic visits. In addition to asking the right questions, the clinician should look for physical signs such as scars on the face or head, any physical disability like one-sided weakness and difficulty with speech or action. It can also be useful to ask about infraction history to assess the nature of behavioral problems.

Being able to differentiate the effects of a TBI from potential malingering can be very helpful when developing a management plan. Maybe the best test for differentiation is whether the symptoms occur when the patient needs to do something he doesn’t really want to do—but not when he does want to do it.

Brain injuries can be classified as mild, moderate or severe. These categories correspond with scores on the Glasgow Coma Scale, a tool used by medical practitioners to diagnose the symptoms of TBI.

Mild brain injury (GCS 13-15) manifests as a change in mental status at the time of injury and may include mild headache, fatigue and sleep disturbance. Other symptoms...
might include depression, anxiety, nausea, poor balance and emotional moods swings. Three-quarters of all diagnosed brain injuries are in this category. Many people who experience a mild brain injury do not seek medical help.

In moderate brain injury (GCS 9-12), the person experiences loss of consciousness lasting from a few minutes to hours, and confusion lasting longer. Physical, cognitive and behavioral impairments may last for months or forever.

Finally, severe brain injury (GCS 3-8) results in a prolonged unconscious state or coma lasting days, or longer. The patient may be in a vegetative state, have locked-in syndrome (being awake and aware but not able to move any voluntary muscles except for the eyes) or suffer from akinetic mutism (retaining cognitive awareness but unable to speak or move due to a frontal lobe injury).

On-Site Injury
Inmates sometimes sustain brain trauma while incarcerated. In serious cases, this may produce acute symptoms such as seizures, neurological deficits, unilateral weakness or paralysis, poor pupillary response, vomiting, altered equilibrium, changes in consciousness, visual or hearing impairments, alterations in vital signs and changes in baseline personality and behavior.

Although little can be done to reverse the initial damage caused by trauma, the goal is to prevent further injury. The immediate treatment may require supplemental oxygen, adequate perfusion, controlling intracranial pressure or surgical intervention. It also is important to identify other injuries, such as spinal cord injury.

Over time, depending on the nature and degree of impairment, the patient may need physical and occupational therapies as well as psychological and social supports, such as those outlined below.

Managing Inmates With TBI
A treatment plan should be developed for each patient with TBI. The treatment goal is to improve independent function to the best level possible, and the focus should be on managing symptoms, teaching compensatory strategies and making environmental modifications.

The effects of TBI depend not only on severity of the injury but also what aspect of the brain was involved (see table on page 12). The type of symptoms and specific deficits will dictate individual treatment plans, which may involve counseling, education, adaptive assistance and pharmacology. It also is important to reduce the risk of further trauma. If balance has been affected, using walkers or canes might prevent falls. Always using hand rails or walking with someone will also help. If falls continue, wearing a helmet may prevent repeat brain trauma.

Because some TBIs cause seizures, some patients will be placed on antiseizure medications. Other pharmacology treatment may include use of psychotropic agents to reduce symptoms; this must be monitored very closely.

Custody staff play a key role in managing of inmates with TBI. They must be informed about these inmates so they understand the relationship between the injury and behavioral problems and can help address the inmates’ special needs. They also should be trained on effective management strategies and ways to communicate with inmates with various types of brain injuries. All staff should be on the alert for impulsive behavior, including violence, sexual activity and suicide risk.

Improving Daily Functioning
Ongoing physical and occupational therapies along with both psychological and social support will enhance the patient’s ongoing treatment. This approach is multidisciplinary in nature and can be accomplished through the support of the people who interact with the inmate.

Many simple yet effective tools can help inmates with TBI to cope better in the correctional environment. These include planning calendars, memory diaries and maps of inmate-accessible areas of the facility. Designated “helpers” could be paired with these inmates to assist with daily challenges. Some tools can be taught in group settings, such as training on topics like building essential skills, setting goals, solving problems and finding resources. Additionally, mental exercises are useful in conditioning the mind to stay focused, calm and free of distractions.

All staff could benefit from learning communication strategies for dealing with inmates with mental deficits. For example, when giving rules or directions to a person with poor memory, the information should be relayed slowly, step by step, and/or provided in writing. Provide examples, ask the inmate to provide examples and encourage questions. If the inmate is prone to irritability or anger, don’t let yourself get into an argument. Instead, try rephrasing the problem or breaking it down into smaller parts, and reinforce positive behavior. If uninhibited or impulsive behavior erupts, tell the inmate calmly that the behavior is not acceptable and redirect the behavior. If necessary, seek assistance from mental health professionals.

Special Considerations on Release
The inmate with TBI may have a difficult time adapting to the free world upon release. Thus, reentry and community staff should be trained to identify a history of TBI and have resources that can be consulted. Any transition services provided should be capable of accommodating the effects of TBI. Finally, the individual should be connected with local resources that can provide assistance with mental health and substance abuse issues and, optimally, with TBI.

continued on page 12
Effects of Brain Injury

**Parietal Lobe**
- Difficulty naming objects or writing words
- Can’t do more than one thing at a time
- Can’t focus visual attention
- Reading difficulty
- Poor hand–eye coordination
- Confusing right and left
- Simple math difficulty
- Difficulty with drawing and visual perception
- Loss of awareness of certain body parts

**Temporal Lobe**
- Difficulty remembering names and faces
- Difficulty understanding words
- Difficulty verbalizing about objects
- Short-term memory loss
- Aggressive or inappropriate behavior
- Change in sexual interest
- Visual limitations

**Frontal Lobe**
- Sequencing
- Perseveration
- Loss of spontaneity
- Loss of flexible thinking
- Distractibility
- Attention deficits
- Concentration difficulties
- Mood swings

**Occipital Lobe**
- Visual limitations
- Loss of color recognition
- Hallucinations
- Word blindness
- Difficulty recognizing written words or drawn objects
- Loss of reading and writing skills

**Chemical Transmission Dysfunction**
- Changes in memory or cognitive function
- Changes in personality
- Attention deficits

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Barbara Burchell Curtis, MSN, RN, is the director of nursing for the Washington State Department of Corrections, Olympia, WA. She presented a session on this topic at the 2011 National Conference on Correctional Health Care in Baltimore, MD. For resources, see this article online at www.ncchc.org/pubs.

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Inappropriate Medications in Jails and Prisons

by Jeffrey E. Keller, MD

All medications have side effects and potential complications. Of course we all know this. Whether to prescribe and what to prescribe should involve a careful weighing of the expected benefits vs. the potential harm for each individual patient. This math—risks vs. benefits—can change for many reasons. For example, drug X may be great for most people but this patient has kidney disease and should not take drug X. This patient does well on drug Y but that patient has no health insurance and cannot afford drug Y.

Being incarcerated changes the risk-benefit equation for many drugs. This is especially true for drugs that are addictive or have the potential to be abused. Some medications may be inappropriately used by inmates to continue or maintain their drug addiction while incarcerated. Such medications have value in the jail system and are commonly shared and sold. Individuals taking these medications may be at risk from other inmates, who may coerce patients to “cheek” and share. This additional extraordinary risk must be considered when prescribing medications in a correctional setting and for many drugs, the risks always (or almost always) outweigh any benefit a patient may derive from them.

In this essay, I present five drugs (and allude to several more) that, in my opinion, should not be allowed in correctional settings. This is an opinion piece. Feel free to disagree! For each medication, I will summarize the potential benefits, the potential for harm and the availability of substitute medications that do not carry this risk. While all of these medications are commonly prescribed on the outside, in a jail or prison setting their risks far outweigh any potential benefit patients may derive from them.

Dextromethorphan

Dextromethorphan is a common ingredient in over-the-counter cough medications. OTC cough medications, including DM, probably do not work well. Multiple studies have failed to find any meaningful difference between DM and placebo in the treatment of cough. If there is benefit, it is slight. On the other hand, DM has a significant abuse potential. When taken in high enough doses (which are only 5 to 10 times the normal dose), DM blocks the excitatory brain receptor NMDA (N-methyl-D-aspartate), producing a “high” similar to that of PCP. It is commonly abused on the outside, and 6.9% of high school seniors reported ingesting DM to get high in a recent survey.

Are there substitutes? Yes, there are other cough medications, although no OTC cough suppressant has ever been shown to be very effective, including antihistamines, decongestants and guaifenesin. The evidence-based guidelines issued by the American College of Chest Physicians recommend NSAIDs for coughs due to viral upper respiratory infection and albuterol inhalers for wheezy coughs due to bronchitis. No treatment is absolutely necessary in most cases. If you feel like you must have a cough medicine available, I would recommend putting something like menthol cough drops on the commissary. It doesn’t work either, but at least it is cheap and benign.

Tramadol

Tramadol is a particularly ineffective pain reliever. Many studies have shown it to work no better than placebo and much worse than other narcotics. It simply does not work well. And although there seems to be a widely held misconception that Tramadol is not addictive and has few side effects, in fact it has a fairly high adverse effect profile (nausea, drowsiness, etc.) and is dangerous in overdose (seizures, serotonin syndrome). Also, as any of us who have practiced in correctional medicine know, Tramadol is, in fact, quite addictive. In my experience, Tramadol addicts go through a particularly painful withdrawal process.

The bottom line is that Tramadol is less effective and just as addictive as is hydrocodone. The misconception that Tramadol is not a narcotic and is not addictive is dangerous. When narcotic treatment for acute pain is indicated, hydrocodone is a superior drug all the way around. By the way, codeine also is inferior to hydrocodone as a pain reliever and has a worse side effect profile, so I personally would not ever use codeine in correctional settings, either.

Amphetamines

Amphetamines like methylphenidate (Ritalin) are commonly prescribed for juveniles diagnosed with attention-deficit/hyperactivity disorder. I will not comment on amphetamine use in juvenile correctional facilities. However, in my opinion, the risk of amphetamine use in adult correctional facilities far outweighs the benefits that adults may get from it. First of all, only 10% of children with ADHD carry this diagnosis into adulthood. In adults, amphetamines, atomoxetine, bupropion and desipramine have similar efficacy. The risk of using amphetamines in correctional facilities is extraordinarily large. Inmates may use prescribed amphetamines to maintain their addiction or to sell to other inmates, and other inmates may coerce patients into sharing. In my experience, sending one patient on amphetamines into a dorm filled with metham-

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All candidates must be able to pass background investigation, drug screen, and medical evaluation.
As correctional health professionals, we must have a good knowledge base when dealing with patients who may be having symptoms of a stroke. The symptoms may be overtly obvious or very subtle, and early recognition is the key to treatment and better outcomes.

The National Stroke Association reports the following statistics:

- Stroke is one of the top five leading causes of death in the United States.
- There are an estimated 7,000,000 stroke survivors in the United States.
- African-Americans have almost twice the risk of first-ever stroke compared with Whites.
- Two million brain cells die every minute during a stroke.
- Up to 40% of all people who have a transient ischemic attack (TIA), known as "mini-stroke," will later have a stroke.
- The estimated direct and indirect cost of stroke in the United States in 2010 was $73.7 billion.

In the past, a person who suffered a stroke had to live with the sometimes devastating results from the loss of blood flow to the brain. There was little the medical field could do to stop the progression of the stroke. Today, there are many treatments and interventions that can be provided to patients experiencing stroke symptoms, thereby reducing the negative outcomes that may follow.

The most important concept to understand is that "time is brain." Similar to the concept of the "golden hour" that applies when dealing with trauma patients, with stroke patients the "three-hour rule" states that stroke is an emergency that is treatable within three hours of symptom onset.

Types and Symptoms

First, let us discuss some important definitions. A stroke/cerebrovascular accident (CVA) occurs when blood supply to part of the brain is disrupted, causing brain cells to die. When blood flow to the brain is impaired, oxygen and glucose, both imperative to brain cell life, cannot be delivered to the brain.

There are different types of strokes, and the type of stroke dictates the treatment and interventions that may be given. In a thrombotic stroke, the most common type, an artery in the brain is blocked by a clot that forms in a small blood vessel within the brain that has been narrowed. An embolic stroke is when a clot or a piece of atherosclerotic plaque breaks loose, travels through the arteries and lodges in an artery of the brain.

A cerebral hemorrhage occurs when a blood vessel in the brain ruptures and bleeds into the surrounding brain tissue. Edema and the accumulation of blood from cerebral hemorrhage increase pressure within the skull and cause further damage by "squeezing" the brain against the bony skull.

A TIA occurs when a blood clot blocks an artery for a short time. Typically, symptoms, which are the same as those for stroke, last less than 24 hours and do not cause permanent brain damage.

Controllable risk factors for TIA and CVA include hypertension, cigarette smoking, heart disease, diabetes, atrial fibrillation and previous TIAs.

The signs and symptoms of TIA and stroke include the following:

- Sudden numbness or weakness of the face (facial droop)
- Unequal or lessened extremity strength or movement
- Sudden confusion, inappropriate or slurred speech, or aphasia
- Sudden vision disturbances
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden severe headache with no known cause

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- Unequal or lessened extremity strength or movement
- Sudden confusion, inappropriate or slurred speech, or aphasia
- Sudden vision disturbances
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden severe headache with no known cause

The signs and symptoms may present in any combination. A key point to remember is that they may be subtle signs, yet they must not be ignored.

Assessment and Treatment

There are several basic steps to follow when determining possible TIA/CVA:

- Evaluate and monitor the ABCs (airway, breathing and circulation)
- Measure and monitor blood pressure
- Perform a glucose finger-stick test (if available)
- Perform an EKG (if available)
- Administer oxygen therapy
- Perform a prehospital stroke scale/screen
- Obtain medical history
- Determine time that the patient was last seen “normal”
- Minimize transport time
- Transport patient to the nearest appropriate hospital
- Notify the receiving hospital

The correctional health care provider will have a key role in the outcome of these patients by the early recognition and provision of appropriate interventions. Remember that the stroke clock is ticking and every minutes counts. Do not delay in getting these patients to the appropriate higher level of care.

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Correctional Nursing Practice: What You Need to Know (Part 10)

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/cchprn, where you can also view the entire test outline (see downloads).

Health Promotion and Maintenance
Corrections nurses have more opportunity than nurses working in other settings to influence patients’ health beliefs and behavior for several reasons:

- Every inmate sees a nurse at least once while in jail, prison or a detention facility.
- A nurse sees every inmate who makes a request for health care attention.
- Over the term of incarceration, nurses have more contact with every inmate than any other health professional.
- Nurses provide care in many of the same areas where inmates are held and so they are familiar with the living conditions and constraints of self-care.

Among the basic principles established by the American Nurses Association for correctional nursing is to “encourage each individual through patient and family education to take responsibility for disease prevention and health promotion.” Correctional nurses teach, promote healthy behaviors, assess risk factors and facilitate discharge planning. Health teaching and promotion is not limited to individual patients and can include families, health care colleagues and correctional personnel. Correctional nurses often oversee preventive health and safety measures for the benefit of inmates, correctional personnel and their families (e.g., vaccinations, standard precautions, postexposure prophylaxis and counseling, exposure control plans). The effectiveness of health promotion and teaching is evaluated and the nurse incorporates this feedback to improve the appropriateness and specificity of content, strategies and methods used, according to the ANA’s Scope and Standards of Practice for corrections nursing.

The NCCHC Standards for Health Services emphasize health promotion in standard F-01, particularly individualized education and instruction in self-care, preventing disease and healthy lifestyle choices. Several other standards include elements of health promotion, as well. Self-care instruction and preventive education is emphasized in E-06 Oral Care. B-01 Infection Control Program requires environmental inspections, exposure control plans, disease surveillance and an immunization program. E-12 Continuity of Care During Incarceration requires that periodic health assessments be offered to inmates consistent with recommendations of professional organizations. Finally, E-13 Discharge Planning requires that medications and referrals be provided to support continuation of inmates’ health care during transition to the community. Nurses are responsible for establishing and maintaining programs and practices consistent with each of these standards.

An Individualized Approach
Health promotion and education is more effective when it is targeted to specific health risks, appropriate to the situation and responsive to the patient’s interest. Information collected at intake and during the initial health appraisal (see table) addresses a patient’s health behaviors and family history of disease that create risk for disease or disability.

Other information collected during initial evaluation and assessment—screening for infectious disease, diagnostic procedures to identify age- or gender-related diseases and checking the immunization history—also contributes to development of an individualized health promotion plan. The content of patient assessment and screening should be based on guidelines established by the facility physician and consistent with recommendations from organizations such as the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention.

These guidelines also help determine the frequency for follow-up and routine preventive care. For example, a juvenile who was a sex worker should receive rapid testing and follow-up to treat communicable disease as well as education and counseling to reduce risk of STDs. Effort should be made to update the juvenile’s vaccine record and provide any recommended vaccinations. In another example, a 40-year-old male with a family history of hypertension and cardiac disease who has a 25-year history of heavy smoking and is obese will need follow-up for cardiac disease. He should also receive at least some information on tobacco cessation and weight control. If he is to remain incarcerated for some time, he should also be offered education in self-care and behavioral counseling to make lifestyle changes.

Nurses should validate and summarize the results of the initial screening and health assessment with the inmate and then explain the recommendations for ongoing care. The ANA calls for actively involving the patient in validation of clinical findings and identifying outcomes for subsequent intervention. For many inmates, the health assessment may be the first time they have received information about their health risks and preventive care. Knowing what is recommended, when it should take place and its relative importance will assist the inmate in following up even if transferred or discharged. It is best to provide this information both orally and in written form for later reference.
Changing Behavior

Behaviors that contribute to significant morbidity and mortality include tobacco use, poor eating habits, inactivity, alcohol misuse, illicit drug use and risky sexual practices. The U.S. Department of Health and Human Services’ “Healthy People” initiative has targeted these areas for improvements for almost 30 years. There is increasing evidence that brief interventions during routine health care encounters to promote healthier lifestyles are effective in changing risk behaviors. Nurses have the opportunity during every patient encounter to provide health information, education and counseling that improves health and well-being.

The goals are to help inmates develop and maintain healthy behavior during incarceration and to increase their knowledge of self-care and appropriate use of the health care system. The ANA Scope and Standards of Practice gives more guidance on the correctional nurse’s role in health teaching and promotion. The teaching addresses topics such as “healthy lifestyles, risk-reducing behaviors, developmental needs, activities of daily living and preventive self-care.” Teaching methods should be “appropriate to the situation and the patient’s developmental level, learning needs, readiness, ability to learn, language preference and culture.”

Simplicity and reinforcement are the two most important principles to remember in providing patient education. Present the simplest topic first, followed by progressively more complex material. Avoid use of medical terminology; instead, use words the general public would know. Provide the material in the language the patient best understands. Be concrete and explicit by telling the patient what you want them to do. To reinforce the information, teach the most important concept first and repeat it at the end of the encounter. Ask the patient to state what they understand and then use their description to emphasize key points, correct misunderstanding and answer questions. Provide information in auditory, visual, tactile ways to increase learning, understanding and skill acquisition.

Counseling for behavior change builds on the assessment of health status and advice or information given to promote health. The focus of counseling is for the patient to develop behaviors or skills that improve health. Effective behavioral counseling requires patient involvement; the health care team provides professional support for changes the patient elects to make. Readiness to change is assessed by asking the patient to describe how important the change is for them and how much confidence he or she has in mastering the skills and situations encountered in making the change.

Having the patient describe a typical day will identify barriers to change. Listening to the patient’s perspective may reveal barriers that are not apparent; it also helps build the rapport needed for a collaborative change relationship. The nurse should also work with the patient to identify environmental and interpersonal factors that support behavior change. Have the patient select a realistic therapeutic goal and assist them to resolve or avoid barriers. It also is important for the patient to identify reinforcements and support needed to initiate and maintain the change. Follow-up is most effective when it takes place relatively soon after counseling with follow-up at longer intervals. Follow-up provides support by acknowledging effort and success, modifying goals and interventions based on the patient’s experience and addressing relapse and its prevention.

At the follow-up encounter, the nurse should ask how the patient is doing in changing behavior and what they need help with. Provide additional information or assistance in a neutral, objective manner, then ask the patient to explain how they can use this information. Resistance to change can be reduced or avoided by not taking away control; instead, emphasize personal choice and control over one’s health. It may be that the patient is not ready for change but instead is thinking about or preparing for it. Support the patient’s need for information and consideration of lifestyle change; do not insist on it. If the patient verbalizes reluctance, avoid arguing for a specific change or action. Use of a relaxed posture and reflective listening or understanding of the patient’s perspective reduces resistance and can open up other avenues of discussion.

Correctional Challenges

Nurses must address counterproductive aspects of the correctional setting such as fat-laden menus with few healthy alternatives, intimidating exercise yards, isolation from those who support lifestyle change and limitations on rewards or reinforcements for new behavior. Some inmates engage in health promotion activity for secondary gain such as better housing, preferred place in the meal line or to ingratiate themselves to a staff member. Finally, health information and education must be delivered during very brief encounters such as sick call and medication administration.

Many health education and promotion resources are available, including material or programs used at other correctional facilities. The local or state health department is an excellent source of resources linked to the inmates’ community. Finally, nonprofit and government organizations such as NCCHC, the American Heart Association and Healthy People 2020 have information for clinicians and patients that support adoption of healthy lifestyles.

Catherine M. Knox, RN, MN, CCHP-RN, is an independent consultant with correctional health care administrative and clinical expertise. This column is coordinated by Lorry Schoenly, PhD, RN, CCHP-RN, an independent consultant specializing in correctional health care and social media. For correspondence, write to editor@ncchc.org. For references and resources, see this article online at ncchc.org/pubs.
Jail Suicide Study Finds Changing Patterns

The good news: The rate of suicide in detention facilities decreased significantly over a 20-year period, from 107 suicides per 100,000 inmates in 1986 to 38 per 100,000 inmates in 2006. This time frame coincides with national efforts to study the phenomenon, raise awareness and use findings to improve suicide prevention efforts in jails.

The not-so-good news: Characteristics of jail suicides have changed, which means that correctional facility efforts at prevention also must change and expand accordingly. These findings and conclusions come from an article written by Lindsay Hayes, MS, project director at the National Center on Institutions and Alternatives, Mansfield, MA, and published in the July 2012 issue of the Journal of Correctional Health Care.

A foremost expert on jail suicide, Hayes first conducted a study on the issue in 1983 and again in 1989. This third national study (like the others, funded by the U.S. Justice Department’s National Institute of Corrections) sought to update the data on the scope and extent of jail suicide in the United States. All 15,978 jail facilities—3,173 county jails and 12,805 short-term lockups—were surveyed to determine if they sustained one or more suicides in 2005 and/or 2006. The study identified 696 jail suicides and the researchers were able to analyze data on 464 of the deaths. Analysis examined descriptive data on demographic characteristics of each victim, incident and facility.

Results point to substantial changes in the characteristics of the suicides in 2005-2006 compared to 20 years earlier.

• The most serious offense among suicide victims was “personal and/or violent” (43%), whereas in the previous study the offense categories were fairly evenly distributed.
• Intoxication was identified in 60% of inmate suicides in the 1989 study, but now it was found in only 20% of cases.
• Previously, 51% of suicide victims were dead within the first 24 hours of confinement; now only 23% of suicides occurred during this time period, with an equal number taking place between 2 and 14 days of confinement.
• Only 38% of suicides happened while the inmate was housed in isolation as compared to 67% in the 1989 study.
• Only 21% of the victims were found within 15 minutes of the last observation by staff. In 1989, the figure was 42%.
• In contrast to the 1989 study, many suicides occurred during waking hours, and many suicides occurred in close proximity to a court hearing.
• Most facilities that experienced inmate suicides had a written suicide prevention policy (85%) and an intake screening process (77%) to identify suicide risk. In the earlier study, the rates were 51% and 30%, respectively.

Demographic victim profiles cannot predict suicide risk, Hayes warns. Rather, the profiles should be used only to help correctional and health care personnel understand the general risk of suicide for those in custody. Furthermore, findings related to inadequacy of suicide prevention protocols and staff training suggest that significant challenges remain in ensuring a continuum of comprehensive suicide prevention programming in jails.
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The Importance of Repairing the Family

One of the reasons that Ronald Schneider, LMSW, went into social work is because of his belief that it does take a village to raise a child. His commitment to this belief takes him regularly into the jails at Riker’s Island, NY, where he works primarily with adolescents aged 16 to 20 to help them repair their lives and ready themselves for healthy reintegration into their families and communities. He does this work as an employee of the Legal Aid Society, a not-for-profit agency in New York City that provides free legal and other services for low-income clients in the criminal justice system.

At NCCHC’s 2012 Updates in Correctional Health Care conference, Schneider gave a talk on therapeutic work with youth offenders and their families. It is not always easy for facility-based corrections staff to connect with families, he acknowledged, but in his role he has multiple opportunities to reach out and he finds this family involvement to be critical to achieving better outcomes for youth. “Family involvement empowers families, based on their strengths, to have an active role in their child’s disposition and treatment.”

After outlining risk factors for delinquent behavior (including a dysfunctional family unit) and defining various types of families, he elaborated on the benefits of family participation. It can reduce anxiety in the youth and caretaker, provide an advocate who can articulate the youth’s needs and desires, allow the caretaker to retain some influence over what happens to the child and provide information that is critical to keeping the child safe and stable.

Although a family member’s response when called into a juvenile justice situation can be unpredictable, depending on the family dynamic, this engagement is crucial. A key principle is that all families will act in the child’s best interest and fulfill their role when they have the necessary skills and support. Thus, positive engagement involves providing families with a discrete set of approaches and services that can assist in meeting their family’s needs.

Family Therapy

In dealing with youth and their families, it is important not to assign blame for the youth’s behavior, and particularly not to blame other family members. Schneider uses a method of supportive inquiry that gathers information through open-ended, nonjudgmental questions. The questions do not focus on deficits, such as substance abuse, but instead promote insights into the youth’s and family’s strengths, productive behaviors and healthful coping mechanisms. This exchange also helps them to identify goals and ways to achieve them.

Schneider also described several psychotherapeutic approaches that can be used with families. These include multisystemic therapy, functional family therapy, brief strategic family therapy, intensive preventive services and, most common in correctional settings, aggression replacement therapy and trauma-focused cognitive behavioral therapy.

Supporting families to enable effective involvement includes flexibility with meeting times, facilitating access to financial support for transportation and dependent care, and regular communication using channels that are readily available and comfortable for the families.

Healthy Relationships

Schneider says that the youths he works with often don’t understand what their families mean to them until they are in a stressful situation. “Many of these kids never imagined they’d be in jail. And the parents, nine times out of 10, are surprised at what their kids are involved in.” By counseling both sides, a healthy relationship can be nurtured that will lead to a positive juvenile justice disposition and reduced likelihood of continued offending. And, Schneider adds, “Ultimately, it is the community that benefits.”

Schneider’s presentation is available for a fee at NCCHC’s Live Learning Center. Visit http://ncchc.sclivelearningcenter.com, click on the Updates logo and select session 121.
Meet Your New Trustees

by Matissa Sammons

Each year, the NCCHC board of directors appoints one board member and one member of the public to the CCHP board of trustees. A third seat is filled through a peer election. The CCHP board welcomes three trustees to serve a three-year term through 2014.

Pauline Marcussen, MS, RHIA, CCHP (vice-chair)
Pauline Marcussen, who represents the American Health Information Management Association on the NCCHC board of directors, has worked at the Rhode Island Department of Corrections for more than 14 years. Serving as interdepartmental project manager/medical records, she oversees all aspects of medical records and medical claims processing, including implementing an electronic system a few years ago. Of her transition to correctional health care, Marcussen says, “It was the best decision of my career.”

Marcussen became interested in certification while serving on a committee, using NCCHC Standards to draft health care policies. It seemed a natural progression for her to pursue certification and in 2004 she did just that. She finds certification rewarding due, in part, to the networking and camaraderie among certificants. She recounts having access to no shortage of subject matter experts that she has called upon when the need arose. Marcussen also feels that certification has fostered professional opportunities, opening doors to speak at local and national levels.

Carol Shepard, RN, CCHP
In August 2011, an online election was held for trustee nominees nationwide and Carol Shepard emerged the winner. Shepard is the regional vice president for Armor Correctional Health Services in West Palm Beach, FL, and has been CCHP certified for 20 years. Her work in corrections began 23 years ago at a county jail but she has since worked in both jails and prisons of all sizes in 22 states. One of the reasons she “fell in love with corrections,” she says, is the unique opportunities and autonomy.

Certification is key, says Shepard, in providing continued educational and professional opportunities. Most importantly, she wants people outside of the correctional industry to recognize that correctional health care is an established field with professional certification and standards that professionals choose, not a last resort for employment.

Esmaeil Porsa, MD, CCHP
The third new addition to the board of trustees is Esmaeil Porsa. He began working at Harris County Jail as a second year internal medicine resident 17 years ago. Soon afterward, he made a decision that correctional health care would be his career and source of professional and personal growth rather than a mere stepping stone. Believing that his work is more than a job—that it is a mission—Porsa finds the most rewarding aspect “the pure joy of being able to care for a segment of our population that is sicker, less served and less represented.”

Porsa became a CCHP in 2009 and views certification as being in a professional affiliation like no other. He found value in certification “to be associated with a first-class organization such as NCCHC, with a reputation of being a trendsetter and a guardian of the values that we as health care professionals keep in the highest regard.”

About the CCHP Board of Trustees
The board of trustees is a subcommittee of the NCCHC board of directors that oversees the program for the certification of correctional health professionals who apply for such recognition and meet the program’s criteria. The board of trustees has sole responsibility in matters relating to basic, specialty and advanced certification, including preparing and grading exam materials, establishing grade levels for passing, determining who has qualified and making decisions regarding applicant eligibility for participation.

Matissa Sammons is the certification manager for NCCHC.

Online Certification a Hit, Survey Says
Shortly after launching the new online recertification system, we conducted a survey to assess user satisfaction and to identify any problems. We are pleased to report great results! Three-fourths of the 134 CCHPs who responded said it was easy to use; only 2 reported having some trouble. Also, by a vast majority (98%), CCHPs liked receiving confirmation of recertification by email (the actual certificate follows in the mail).

To use the system, which also enables you to update your contact information, visit the Continuing Certification page at www.ncchc.org/cchp.

CCHP Exam Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 22</td>
<td>Chicago, IL</td>
</tr>
<tr>
<td>August 18</td>
<td>Multiple regional sites</td>
</tr>
<tr>
<td>August 25</td>
<td>Toms River, NJ, &amp; Harrisburg, PA</td>
</tr>
<tr>
<td>October 21</td>
<td>Las Vegas, NV</td>
</tr>
</tbody>
</table>

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 ncchc.org/cchp.
Drugs (continued from page 14)

Jeffrey E. Keller, MD, is medical director of the Ada County Jail in Boise, ID, and the Bonneville County Jail in Idaho Falls, ID. He writes a correctional medicine blog at http://jailmedicine.com. Contact him at jkeller@badgermedicine.com. For references, see this article online at ncchc.org/pubs.

Pseudoephedrine and Ephedrine
These decongestants are able to dry up runny noses to a degree. However, they are the precursor drugs to methamphetamine production and inmates know this. They also can cause a high when large amounts are ingested. Alternatives include antihistamines, which probably dry mucous membranes even better than decongestants. I prefer topical therapy like nasal sprays or, if I truly think an oral agent is needed, I would use the second-generation antihistamines like loratadine (Claritin). Since nasal sprays and loratadine are OTC, I recommend putting them on the commissary.

Carisoprodol (Soma)
Soma is an interesting drug. Soma itself is not an FDA-controlled substance, but its major metabolite, meprobamate, is. Also, Soma is marketed as a “muscle relaxant,” but meprobamate is considered a sedative—and addictive. That is why meprobamate is a schedule IV drug. Soma is commonly used in the drug community to enhance the effect of narcotics, or just on its own as a sedative to get high. Patients absolutely do get addicted to Soma, in my experience. There are several other muscle relaxers that can be substituted for Soma, such as cyclobenzaprine (Flexeril). However, all so-called muscle relaxers probably work via sedation, not because they directly relax muscles. And all have some degree of abuse potential. In my opinion, all muscle relaxers should be used sparingly in correctional facilities, but Soma?—not at all.

Individual Consideration
I have limited my discussion here to these five drugs, but there are several other drugs I could have included due to their high “value” in the jail and prison economies and the ready availability of less risky alternatives. The risk-benefit math is not quite as lopsided as for the drugs listed above, but many other drugs can cause big problems in correctional facilities, as well, and this must be taken into consideration. Two notable exceptions are trazodone and quetiapine (Seroquel).

I think it is important to emphasize that patients must be considered individually, and based on individual consideration I have indeed prescribed some of these medications—but this is rare. Most of the time—in fact, almost always—the risks of these five medications outweighs their potential benefits and less risky alternative exist.

Stoke (continued from page 16)

Stroke Rapid Response
The National Stroke Association has established Stroke Rapid Response™, an educational program for emergency medical services and prehospital providers. Program goals include the following:

• Increase and maintain prehospital providers’ knowledge of stroke
• Increase recognition of stroke signs and symptoms on scene
• Increase the occurrence of EMS calls identifying symptoms as “possible stroke/CVA”
• Facilitate delivery of stroke patients to the nearest appropriate hospitals/stroke centers
• Reduce en-route time and time to treatment

When the patient with presenting signs of stroke or TIA arrives at the hospital emergency department, there will be an immediate evaluation by the physician. This is why notifying the hospital that this patient is coming is so important. Your phone call will set the stage for the ED staff so that evaluation and diagnostic testing can be done immediately. The patient requires an immediate CT scan of the head to determine if there has been a stroke, what type of stroke and if there has been any other brain injury. A clot-busting drug can be used only within a small window of time provided there are no contraindications and there is no evidence of hemorrhage on the CT scan.

Hospitals can be classified into two different types of stroke centers, primary and comprehensive. Primary stroke centers are set up for diagnostic testing and recognition of stroke. Once a stroke is identified, the primary stroke center may provide some treatment options (such as medication) but may transfer a patient to a comprehensive stroke center for more in-depth treatment and intervention.

A comprehensive stroke center can provide treatment modalities such as medication therapy and/or surgical intervention. You should inquire about the emergency departments near your facility to determine what hospitals would be best for your patient’s outcome. Remember, delays in transporting a patient from the correctional facility to a hospital, or from a primary stroke center ED to a comprehensive stroke center, can directly affect the patient’s outcome.

Correctional health care providers must understand the importance of early recognition of stroke signs and symptoms, and must make every effort to quickly transfer the patient to the most appropriate hospital.

Learn More
• National Stroke Association: www.stroke.org
• American Stroke Association: www.strokeassociation.org
• The Stroke Network: www.strokeeducation.info

Susan Laffan, RN, CCHP-RN, CCHP-A, is co-owner of Specialized Medical Consultants and is based in New Jersey. Contact her at njjailnurse@aol.com.
Alvin J. Thompson, MD, MACP
Longtime NCCHC board member Alvin J. Thompson, MD, MACP, died on May 21 at age 88. Thompson retired from the board in 2011 after serving for 24 year as the liaison to the American Medical Association. As evidenced by a lengthy list of professional activities and honors, Dr. Thompson had a stellar career that was a testament to his unwavering commitment to patient care. Key strengths included health policy, quality improvement, community and organizational leadership, and teaching and mentoring, not to mention clinical care.

An emeritus clinical professor of medicine at the University of Washington, Dr. Thompson in 2008 was honored by the American College of Physicians with a prestigious award given to an outstanding practitioner of internal medicine who has devoted his career to patient care, is highly respected for his clinical skills and has been a role model as a member of a clinical faculty or department of medicine. He was elected to the Institute of Medicine in 1978. Other honors include the John Geyman Health Justice Advocate Award, in recognition of tireless commitment to justice in health care, and the AMA’s Dr. Benjamin Rush Award for Citizenship and Community. In 2011, the AMA commended him for his work to improve correctional health care through his service to NCCHC.

“Dr. Thompson was a great advocate for patient care,” says NCCHC president Edward Harrison. “Despite his tenacity, he was always a gentleman and highly respected by all who knew him.”


American Osteopathic Association
In March the AOA passed a resolution that will enable development of a medical fellowship program in correctional health care and subsequent certification. This move came in recognition of the fact that correctional medicine is an area of osteopathic medical practice not currently fulfilled by AOA certifications. Now, the AOA’s Council on Postdoctoral Training has issued proposed standards for fellowship training. Developed by the American College of Osteopathic Family Physicians, the American College of Osteopathic Internists and the American Osteopathic College of Occupational and Preventive Medicine, the standards are designed to provide osteopathic physicians with advanced and concentrated training in correctional medicine and to prepare the physician for an examination of Certificate of Added Qualifications in Osteopathic Correctional Medicine.

To develop the CAQ, the AOA polled a large number of practicing correctional physicians to determine areas of specific competencies that will be included in the table of specifications, which determines the content of the certification exam. The period to comment on the Basic Standards for Fellowship Training in Correctional Medicine ends Aug. 3. The program will be officially announced at the AOAs annual meeting in October, with the first exam expected to take place in October 2013.

- Proposed standards www.osteopathic.org/inside-aoa/Education/postdoctoral-training/Pages/proposed-changes-public-comments.aspxp

American Medical Association
A new AMA policy encourages the establishment of drug courts at the state and local level as an alternative to incarceration and a means of overcoming addiction for individuals with addictive disease convicted of nonviolent crimes. According to the AMA, citing the National Association of Drug Court Professionals, drug courts are an alternative for individuals with addictive disease, providing them with intensive treatment and regular drug testing. Furthermore, the AMA policy notes, a 2009 National Institute of Justice study found that drug court participants had significantly fewer positive drug tests and reported better improvements in their family relationships.


Academy of Correctional Health Professionals
The Academy’s education committee is now accepting applications for scholarships to attend the National Conference on Correctional Health Care, being held Oct. 20-24 in Las Vegas, NV. Valued at $730, the scholarship includes the following:

- $400 travel stipend, paid to the recipient upon check-in at the conference
- $330 registration fee (excludes preconference seminar fees) paid directly to the National Commission on Correctional Health Care
- $380 housing costs
- $50 food, incidentals and other personal expenses

To meet the scholarship criteria, the applicant must have been an Academy member for at least two years, must not have previously attended a national conference sponsored by the Academy, and must write a 500-word essay explaining how he or she will gain significant professional benefit from attending the conference.

For complete details and an online application, visit the Academy website. The application deadline is Aug. 1.

- www.correctionalhealth.org/education/scholarships/scholarship_app.html
Big Numbers, Big Opportunity

With 2.3 million people incarcerated in the United States on any given day, it is a huge, costly endeavor to provide constitutionally mandated health care to these individuals. And as inmate populations grow older, their health care needs—and related expenditures—are rising. 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)

Exhibitor Benefits

- Three days of exhibit hall activities
- Two full conference registrations per 10’ x 10’ booth
- Discounted full registration for up to 5 additional personnel
- 75-word listing in the Final Program (deadline applies)
- Electronic attendee lists for pre- and post-show marketing
- Free basic listing in the online NCCHC Buyers Guide
- Lead retrieval technology available for rental on site
- Opportunity to participate in raffle drawings
- Priority booth selection for the 2013 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: Marked with your company’s name, the digital proceedings enables attendees to continue their learning with the speakers’ 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. To obtain an Exhibitor Prospectus with details and a reservation form, email NCCHCexhibits@ncchc.org or call 773-880-1460.

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sions and combinations to use for chronic pain; essential information on safe prescribing and screening tools such as the opioid risk tool and screening tools for aberrant behaviors; nontra-
ditional treatment options such as acupuncture, energy therapies and psychological and coping strategies. By Yvonne D’Arcy, MS, CRNP, CNS. Springer Publishing Co. (2011). Softcover, 368 pages, $45

CCHP and NCCHC Logo Items
If you are a certified correctional health profes-
sional, show off your accomplishment with professional items adorned with the CCHP logo, such as a business card case, executive organizer and coffee cup and coaster set. Or display the NCCHC logo on a deluxe writing pad portfolio, denim shirt and accreditation pin (shown below). For product descriptions and prices, visit the online catalog at www. ncchc.org/pubs.

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.

Subscriptions: CorrectCare is mailed free of charge to members of the Academy of Correctional Health Professionals, key personnel at accredited facilities and other recipients at our discretion. To see if you qualify for a subscription, submit a request online at ncchc.org or by email to info@ncchc.org. The magazine is also posted at ncchc.org.

Change of Address: Send notification four weeks in advance, including both old and new addresses and, if possible, the mailing label from the most recent issue. See page 1 for contact information.

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

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

Mental Health Screening and Evaluation

Q In standard J-E-05 Mental Health Screening and Evaluation, compliance indicator 1 says that within 14 days qualified health professionals or mental health staff conduct initial mental health screening. On intake our nursing staff do an initial screening, and will refer to mental health for a positive screen, but do all inmates need an additional mental health evaluation by the mental health staff?

A To clarify, the mental health questions described in standard E-02 for receiving screening are not part of the initial mental health screening. Specially trained nursing staff may, during intake, include each inquiry noted in the E-05 mental health screening standard in order to fulfill the “initial mental health screening within 14 days” requirement. If all elements of the E-05 screening are completed at that time by health staff trained in identifying and interacting with individuals in need of mental health services, the screening does not need to be repeated.

The mental health evaluation, which is performed by qualified mental health professionals such as psychiatrists, psychologists, psychiatric social workers, etc., is completed only for inmates who screen positive on aspects of the initial mental health screening.

Written Agreements for Off-Site Care

Q My question is about the Hospital and Specialty Care standard (D-05). We have had an MOU in place with our hospital for years. Since we routinely receive discharge summaries when our patients return from the hospital, does it matter that the MOU doesn’t specifically mention that this paperwork should come back to our jail as required in compliance indicator 2?

A For each community hospital or off-site specialty service used regularly for medical and mental health care, there needs to be a written agreement that outlines the terms of the care to be provided. Written agreements include a contract, letter of agreement or memorandum of understanding between the facility and the hospital, clinic or specialist. Agreements should require that the off-site facilities or health professionals give the inmate a summary of the treatment given and any follow-up instructions. In other words, those treatment summaries and discharge instructions should accompany the inmate back to the facility. This provision should be in writing, even if it happens in practice. A written agreement with this language will help to ensure that the practice continues, regardless of leadership or procedural changes. Keep in mind that this is an “important” standard, so if your MOU isn’t being revised soon, it is possible to not meet this standard and still achieve accreditation.

Oral Exams for Intrasytem Transfers

Q I work for a prison that accepts transfers from the state intake facility. Since the inmates are already in our system, we assume they do not need to have an oral exam within 30 days. At the intake facility, the oral screenings are done well within seven days.

A It’s great that your oral screenings are done in a timely fashion, but standard P-E-06 Oral Care also requires an examination. If the health records document that an oral exam has been done within 30 days of the inmate’s admission to the intake facility/system, we would not expect your facility to repeat that exam. If an oral exam by a dentist is not being completed elsewhere (or there is no documentation that it was done), then your facility should be doing it within 30 days of inmates’ admission to your site.

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. Send your question to accreditation@ncchc.org.
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Ethan Gill
Sr. Vice President, Human Resources
MHM Services

Healthcare professionals working in correctional settings face unique challenges that require special skills and training. Ethan Gill heads up MHM’s Human Resources Department, which includes a comprehensive employee orientation, training, and continuing education program - MHM University - to ensure clinical staff receive ongoing job skills training and continuing clinical education relevant to the correctional environment. Using web applications and guided self-study programs, we are able to provide training programs that do not disrupt staff schedules or service delivery. As a value-added service to our clients, we extend our training curriculum to facility administrators and security personnel.

MHM is the leading national provider of mental health and specialty medical services to correctional systems. Delivering healthcare the right way costs less. Find out how by contacting Ethan Gill at 800-416-3649 or egill@mhmservices.com.