Spring 2019 | Volume 33 | Issue 2

CorrectCare®

The magazine of the National Commission on Correctional Health Care

Busting the Myths Around Opioid Treatment in Jails

Partnering With OTPs: How One Jail Did It

Youth With a Terminal Diagnosis

Surviving Your Job With Style — Rule #2: You Will Be Sued for Doing the Right Thing

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Two New Position Statements Focus on Youth Well-Being

The NCCHC Board of Trustees has approved two position statements focused on juvenile health and well-being.

Adolescent Sleep Hygiene

A focus on rehabilitation remains at the core of all health care and correctional programming in juvenile correctional facilities. Adequate sleep is critical to juvenile rehabilitation. Moreover, reports of sleep disturbance and requests for "sleep meds" are a very common sick call request.

Adolescent insomnia is often related to medical comorbidities (including sleep apnea) and a number of risk factors common in incarcerated youth. In addition, many juveniles enter the justice system already taking psychotropic or over-the-counter medication that impacts sleep.

The position statement calls for all correctional facilities serving adolescents to take a comprehensive approach to sleep disorders. It makes recommendations concerning assessment, intervention, environmental factors and other considerations. See the complete position statement at **www.ncchc.org/adolescent-sleep-hygiene.**

Detention of Immigrant Children

The challenges presented by the increasing numbers of children and families being detained by U.S. Immigration and Customs Enforcement and the extended periods of confinement overwhelm the capacity of health care providers in these settings and surrounding communities, reduce the available resources to provide quality care, and pose potential health risks to these immigrant children and those caring for them.

NCCHC does not support the detention of any child due to immigration status and encourages full compliance with the Flores Settlement Agreement that establishes standards and licensing authority and limits the amount of time for which migrant and asylum-seeking children can be detained.

The position statement recommends that all people who are detained in confined settings receive developmentally appropriate physical and mental health care that also incorporates the social and life skill needs of the population being served. It specifies services and approaches essential to caring for immigrant children, adolescents and pregnant women, with discussion of medical and behavioral health care, housing, safe supervision, keeping family members together and transition to a nonsecure, licensed facility.

See the complete position statement at **www.ncchc.org/detention-of-immigrant-children.**

NCCHC's mission—to improve the quality of health care in jails, prisons and juvenile confinement facilities—can be achieved only through in partnership and by approaching challenges in new and innovative ways. In the 2018 Annual Report, you will learn how NCCHC and our partners are working together to address the biggest issues facing correctional health care. You'll also read about the past year's highlights.

www.ncchc.org/ncchc-2018-annual-report

Calendar of events

July 12	Accreditation Committee meeting
July 20	CCHP exams, Las Vegas
July 21-22	Correctional Mental Health Care Conference, Las Vegas
September 13	Accreditation Committee meeting
October 12-16	National Conference on Correctional Health Care, Fort Lauderdale
October 13	Accreditation Committee meeting
October 13-14	CCHP exams, Fort Lauderdale

See the list of all CCHP exams at www.ncchc.org/cchp.

Join Us in Las Vegas for the Correctional Mental Health Conference!

According to a 2017 Bureau of Justice Statistics survey, 37% of state and federal prisoners and 44% of jail inmates reported having been told by a mental health professional that they have a mental health disorder.

NCCHC's annual mental health conference is an extraordinary opportunity to delve into the complexities of providing mental health care in correctional facilities. Mental health care providers and other correctional health professionals are invited to spend two days learning and sharing, with more than 30 educational sessions and great networking opportunities built in.

The conference takes place July 21-22 at the Bally's Las Vegas Hotel & Casino. Earn up to 15 CE credit hours.

mental-health-conference.ncchc.org

Thoughts on Suicide in Corrections

by Thomas J. Fagan, PhD, CCHP-MH

At a recent conference that I attended, it was reported that suicide rates in prisons and jails were on the rise. Being the scientist/practitioner that I am, I went to the literature to verify this statement and, sure enough, 2014—the last year for which trend data is reported—was an especially bad year for both jail and prison suicide rates.

The Bureau of Justice Statistics reports that in 2014, 372 individuals died by suicide in local jails (a rate of 50/100,000), up from a low of 228 suicides (29/100,000) in 2008. In prisons, the number of suicides rose from 168 (14/100,000) in 2001 to 372 (20/100,000) in 2014. A closer look at the data found that the numbers and rates have fluctuated year over year, some years being lower than others.

These data collectively brought three thoughts to mind: even one suicide is tragic on many levels; how far we have come since the 1980s in identifying risk and preventing suicides in our prisons and jails; and how far we still need to go in our efforts to further reduce suicide rates. I'd like to talk briefly about each of these thoughts.

Even One Suicide Is Tragic on Many Levels

Each correctional suicide impacts any number of individuals. For the family of the victim, the event marks the loss of a loved one. For responding and treatment staff, it often triggers second-guessing about how they handled the event and grief over the loss of someone for whom they were responsible. For staff tasked with investigating the event, identifying missed cues for intervention or inadequate responses from staff may also produce conflicting emotions. For other inmates, the event may remind them of their own circumstances and generate feelings of loss, depression or anger.

In short, suicide is a tragic and traumatic event on many levels. How notifications are made to next of kin, how follow-up investigations are managed and how responding staff are counseled all matter. NCCHC standards offer some guidance on how these issues should be managed.

How Far We Have Come

In the 1980s, suicide rates were reported to be 129/100,000 in jails and 34/100,000 in prisons. By 2002, the rates had dropped to 47/100,000 in jails and 16/100,000 in prisons. What changed during that time period was the development and implementation of suicide prevention and intervention programs.

NCCHC standards define key components of an effective suicide prevention and intervention program: training, identification, referral, evaluation, treatment, housing, monitoring, communication, intervention, notification, review and debriefing. Collectively, these components point to key areas of importance.

1. All staff must be aware of the signs and symptoms of suicide; ongoing training is essential to increase awareness.
2. Effective assessment practices will help to ensure that potentially suicidal individuals are identified, monitored and treated as soon as possible.
3. Effective referral and communication procedures must be understood by all stakeholders (e.g., health and mental health staff, correctional officers, community health care agencies and providers), who also must know their role in the referral/treatment process.
4. Finally, when a suicide does occur, the precipitating factors must be investigated in an effort to avoid future suicides.

What is clear to me is that one program with clearly defined standards has had a significant impact on prison and jail suicide rates.

How Far We Still Need To Go

However, we still have a long way to go in lowering suicide rates. Toward that end, NCCHC has entered into a partnership with the American Foundation for Suicide Prevention to develop a national response plan for suicide prevention in corrections. AFSP has identified the correctional environment as one of four key areas with the highest potential for saving lives through suicide prevention efforts and it has set the ambitious goal of a 20% reduction in suicides by the year 2025.

Other partners in this effort include health and mental health experts and private vendors operating in correctional settings, as well as other leaders from the correctional and suicide prevention communities. Working collaboratively, these partners have identified three areas for further investigation: assessment, intervention and training/education. They have also set a series of short- and long-term goals, including development of a position statement and promising practices in the area of suicide prevention, multidisciplinary training curriculum guidelines and, perhaps most significant, corrections-specific assessment instruments and treatment protocols.

I commend these partners for their recognition that jail and prison suicide is a public health problem rather than just a corrections problem, and for their collaborative, multidisciplinary efforts. Let's hope that these efforts lead to another dramatic reduction in correctional suicide rates in the future.

Thomas J. Fagan, PhD, CCHP-MH, is the chair of the NCCHC board of directors. Look for the NCCHC–AFSP guidelines for suicide prevention later this year.

Spotlight on the standards

by Tracey Titus, RN, CCHP-RN

E-02 Receiving Screening (essential)

Screening is performed on all inmates upon arrival at the intake facility to ensure that emergent and urgent health needs are met.

– 2018 *Standards for Health Services* for jails and prisons

Perhaps one of the most important processes of a correctional health system, receiving screening (standard E-02) is meant to fulfill four purposes:

- Identify and meet any urgent health needs of those being admitted
- Identify and meet any known or easily identifiable health needs that require medical intervention
- Identify and isolate inmates who may be potentially contagious
- Obtain a medical clearance when necessary

Fulfilling these purposes is a multistep process.

Step 1: Medical Clearance

Medical clearance should happen as soon as the individual arrives at the facility. Reception personnel need to ensure that people who are unconscious, semiconscious, bleeding, mentally unstable, severely intoxicated, exhibiting symptoms of alcohol or drug withdrawal, or otherwise urgently in need of medical attention are referred immediately for care and a medical clearance into the facility.

This documented clinical assessment of medical, dental and/or mental status may come from on-site qualified health care professionals or may require sending the individual to the hospital emergency room. If the patient is sent to the emergency room for a medical clearance, it is imperative that reception personnel and the emergency room staff communicate about the potential health concern so that the patient is examined appropriately. Admission to the facility should be predicated on written medical clearance from the hospital for the identified condition.

Step 2: The Actual Screening

The receiving screening is a process of structured inquiry and observation intended to identify potential emergency situations among new arrivals and to ensure that patients with known illnesses and those on medications are identified for further assessment and continued treatment.

In jails and juvenile facilities, the screening may be conducted by health-trained correctional personnel or qualified health care professionals. In prisons, only qualified health care professionals should conduct the screening. A qualified health care professional must also be able to respond in a timely manner.

Standard E-02 requires that the receiving screening take place "as soon as possible." It does not define a concrete time frame but the intent is for the screening to be conducted promptly, without delay. Administrators should consider the risks of not knowing an inmate's medical condition (e.g., suicidal ideation, prescription medications, communicable illness symptoms, drug and alcohol use and/or withdrawal symptoms) when designing the intake and receiving screening process. Generally, it is not acceptable to wait to start the screening until correctional staff complete the admission process, which may take many hours.

Ideally, the receiving screening is conducted within minutes of an inmate's arrival. However, a good rule of thumb is that it should occur no more than two to four hours after admission. Staff need to get an idea of inmates' urgent health needs, identify and meet any known or easily identifiable needs that require medical intervention, and identify and isolate inmates who may be contagious. For example, we do not want a person in need of insulin sitting in a holding cell for hours on end.

The standard recognizes that sometimes inmates arrive in large groups, making it impossible to conduct a receiving screening immediately. In such cases, reception personnel should quickly perform a medical clearance to determine who may be too ill to wait for a screening or be admitted.

However, another requirement is for health staff to regularly monitor the receiving screenings to determine the safety and effectiveness of the process. If the norm is to receive inmates in large groups and receiving screening times are delayed, then staffing should be adjusted to meet the intent of the standard. The timeliness of screening should be monitored regularly through the continuous quality improvement program (see standard A-06) to ensure that the screening is conducted as soon as possible but no later than the two to four hour time frame.

Another important concept is that all inmates are to be screened. This means that, as soon as possible, all inmates are to receive all elements of the screening, including every inquiry and observation noted in compliance indicators #3, #4, #5 and #6. It is not acceptable to conduct an abridged version right away with the remaining questions being asked several hours later or the next day, nor to ask only some of the questions, with a "yes" to certain questions triggering a complete screening.

For facilities that do not routinely function as intake/receiving facilities, a receiving screening must be performed on all newly arrived probation and/or parole violators.

Lastly, reception personnel should make accommodations for people who have difficulty communicating (e.g., non-English speaking, intellectually or developmentally disabled, deaf, mentally ill, under the influence) to ensure a thorough screening is conducted. People with mental disorders are often unable to give complete or accurate information in response to health status inquiries. Therefore, it is a good practice for mental health staff to be involved in training staff who do the intake screening.

Areas of Inquiry

For jails and prisons, the receiving screening inquiries are mostly the same. They include current and past illnesses, health conditions or special requirements (e.g., hearing aids, visual aids, wheelchair, walker, sleep apnea machine); past infectious disease; recent communicable illness symptoms (e.g., chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever); current or past mental

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illness, including hospitalizations; current or past suicidal ideation; dental problems (e.g., decay, gum disease, abscess); allergies; dietary needs; prescription medications as well as legal and illegal drug use (type, amount, time of last use); current or prior withdrawal symptoms; possible, current or recent pregnancy; and other health problems as specified by the responsible physician.

In prisons, a screening test for latent tuberculosis should be done (e.g., skin test, chest X-ray, laboratory test).

Observations to document include appearance (e.g., sweating, tremors, anxious, disheveled), behavior (e.g., disorderly, inappropriate, insensible), state of consciousness (e.g., alert, responsive, lethargic), ease of movement (e.g., body deformities, gait), breathing (e.g., persistent cough, hyperventilation) and skin (including lesions, jaundice, infestations, bruises, scars, tattoo, needle marks or other indications of drug abuse). It is good practice to not only observe but also ask additional questions. For example, when an individual has a rash that's not visible to the screener, asking questions will yield the best possible screening.

Staff who work in juvenile detention and confinement facilities should also inquire whether there are children under the juvenile's care; the type and time of the most recent sexual encounter and use of contraception and condoms in order to screen for emergency contraception eligibility; and victimization by recent sexual assault in order to screen for emergency contraception eligibility.

All pregnant females should be asked about opioid history. In all types of facilities, females who report opioid use should immediately be offered a pregnancy test to avoid withdrawal risks to the fetus. In juvenile facilities, all females should be offered a pregnancy test upon arrival and referred to health staff within 48 hours for testing. In addition, sexually transmitted disease testing should be offered to all juveniles upon arrival or at least within the first 24 to 48 hours.

Step Three: Documentation and Follow-Up

Based on the findings from the screening, the disposition of the inmate should be documented (e.g., referred to the appropriate health care service, placed in general population). The forms should be dated and timed immediately upon completion and include the name, signature and title of the person completing the form.

If the screening revealed recent communicable illness symptoms, the potentially infectious patient should be isolated from the general inmate population.

All immediate health needs identified through the screening process should be properly addressed by qualified health care professionals. When inmates indicate they are under treatment for a medical, dental, mental health or substance use problem, health staff should initiate a request for a health summary from the community prescribers after obtaining a signed release from the patient.

However, health staff should be cautious with this practice: Community providers may take days or weeks to provide records (or sometimes not at all), and waiting for them before proceeding with treatment plans may be detrimental to patient care. Depending on the nature of the problem, patients may need to be monitored and/or referred to the facility's providers to initiate a treatment plan prior to receiving records.

Additional Screening Tips

Screeners should fully explore the potential for suicide for incoming inmates. This includes reviewing any history of suicidal behavior and visually observing their behavior (delusions, hallucinations, difficulty communicating, speech, posture, impaired level of consciousness, disorganization, memory defects, depression or evidence of self-mutilation).

Screeners should also investigate the potential for individuals to exhibit symptoms of withdrawal from alcohol and other drugs. These approaches, coupled with training in aspects of mental health and chemical dependency, enable staff to intervene early to treat withdrawal and to help prevent suicides (see B-05 Suicide Prevention and Intervention and F-04 Medically Supervised Withdrawal and Treatment).

Inmates arriving with signs of recent trauma should be referred immediately for medical observation and treatment. A history of trauma may also warrant follow-up care by mental health professionals.

Patients enrolled in a community substance abuse program should be considered for ongoing medication-assisted treatment.

COs Performing Receiving Screening

The training given to correctional officers who conduct the receiving screening in jails and juvenile facilities depends on the role they are expected to play in the process. The responsible physician or designee needs to provide documented training in early recognition of medical, dental and mental health conditions that require clinical attention. At a minimum, this includes how to take a medical history; how to make the medical, dental and mental health observations; how to determine the appropriate disposition based on responses to questions and observations; and how to document their findings on the receiving screening form.

Facilities that use correctional officers to perform receiving screening should not depend on this screening alone to meet the mental health and oral screening requirements (see standards E-05 Mental Health Screening and Evaluation and E-06 Oral Care). The screenings required by those two standards must be done, at a minimum, by trained qualified health care professionals.

In Summary

Regardless of the term used in your facility—receiving screening, intake screening or booking questions—standard E-02 Receiving Screening is the first step in establishing a quality correctional health care system. Identifying medical, dental and mental health needs as soon as possible upon arrival and referral to appropriate health services promotes the continuity that is required for quality patient care.

Tracey Titus, RN, CCHP-RN, is NCCHC's vice president of accreditation.

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Transgender Inmate/Parolee Prevails in Claims of Denial of Treatment

by Fred Cohen, LLM

In *Mitchell v. Kallas* (7th Cir. 2018), Lisa Mitchell, a transgender person who identified her entire life as a woman, prevailed on her denial of treatment claims as a Wisconsin prisoner and the later interference with treatment when she was on parole. The intrepid Ms. Mitchell filed the initial complaint *pro se* then had the excellent legal assistance of Nicole Jakubowski of the Chicago law firm of Skadden, Arps (the fifth largest law firm in the country).

Mitchell's basic claim is that Wisconsin officials repeatedly prevented her from obtaining access to the treatments needed to express her identity. It took the Department of Corrections more than a year simply to assess her for the needed hormone therapy and it then refused the hormones on the grounds that she was within six months of release.

Once released on parole, she actually was forbidden from taking the hormones she might obtain on her own or dressing as a woman as she always had. The lower court granted the doctors' motion for summary judgment and dismissed the parole officers from the action.

Chief Judge Wood of the Seventh Circuit composed a relatively brief opinion in favor of Mitchell that is of exemplary clarity and humanity. The lower court, then, was reversed as to the failure of treatment while Mitchell was in prison and as to the parole officials' efforts to block her from hormones she obtained and from dressing as a woman.

Clearly, Wisconsin officials were simply hostile to Mitchell as transgender and obstructive to her modest claims as to dress and hormones.

Discussion

Prison

Mitchell presented at the Wisconsin DOC as one who had functioned as a woman her entire life. She was not asking for surgery, just to continue with her hormones. That is the easiest, least expensive request for a DOC to comply with once an inmate's "TG" status is authenticated.

Her request for hormone treatment engendered layers of assessment, including one by an outside consultant who took six months to conduct an interview and about a year to submit what was an extremely supportive report. The report came in about a month before Mitchell's scheduled release, and the DOC's mental health director then rejected the treatment because of a policy requiring at least six months of supervised care in the use of the hormones.

There was some supportive counseling provided but not treatment of the gender dysphoria.

Judge Wood finds there is a total denial of treatment in prison responsive to Mitchell's serious medical condition. Prisons have limited resources, and delays in assessment and treatment seem almost inevitable. Delays in receiving an evaluation for hormone treatment have been countenanced by other courts. Here, the 13-month delay provided the mental health director with the cover of qualified immunity.

However, his total denial of responsive treatment when the serious condition and need was not in dispute would allow a jury to find deliberate indifference in that respect. Judge Wood wondered if psychological support might be urged as proper treatment for a broken leg. His answer is, "No!"

The "six months to go" limitation is not an acceptable reason for not launching care that could be continued on the outside.

Parole

Parole officers have no duty to provide health care to those they supervise. The constitutional right of an inmate to medical care ends with her first step outside the prison on parole. (There is a duty to provide some medications on release to maintain a releasee until a prescription may be obtained.)

However, officials may be constitutionally obligated to not block a parolee who is trying to arrange for care. Thus,

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Busting the Myths Around Opioid Treatment in Jails

by Carolyn Sufrin, MD, PhD, and Kevin Fiscella, MD, MPH, CCHP

The committee is firm: Not offering these treatment options represents denial of appropriate treatment and is unethical

The National Academies of Science, Engineering and Medicine (previously named the Institute of Medicine) is the most prestigious scientific organization in the world. When the federal government wants an unbiased, science-based report on a national issue, they typically ask the National Academies to assemble a national committee of the country's best and brightest scientists to review the science and issue a report.

At the request of the National Institute of Drug Abuse of the National Institutes of Health, together with the Substance Abuse and Mental Health Services Administration, the National Academies convened an expert committee to examine the evidence base for medications to treat opioid use disorder and to identify barriers that prevent people from accessing these medications. In March the committee issued its report, Medications for Opioid Use Disorder Save Lives.

With more than 47,000 deaths from opioid overdoses in 2017, this report is timely. It provides crucial information for correctional health providers, as jails and prisons are being confronted firsthand with the consequences of the opioid epidemic. Every day, thousands of individuals with opioid use disorder are in our nation's jails and prisons. When people with OUD enter a correctional facility, health care and custody staff must have systems in place to ensure that they get safe and effective treatment.

The committee reached seven important conclusions based scientific evidence (see box on page 11). Each conclusion is discussed more fully in the report.

The Core Philosophy

These conclusions are particularly relevant to treatment of OUD in corrections, underscoring the core philosophy that OUD is a chronic illness and therefore warrants long-term treatment. Collectively, the report's conclusions dispel common myths about opioid use disorder, including how it is managed in jails and prisons.

Myth 1. Opioid use disorder is not a real disease.

Many people believe that opioid use disorder results from a failure of will or weakness of character. The first conclusion directly challenges those folk beliefs and reaffirms opioid use disorder as a chronic disease. As a chronic and, unfortunately, often relapsing disease, it merits the same compassion and use of medications as other chronic diseases widely treated in jails and prisons.

Myth 2. Medications to treat opioid use disorder don't work.

The second conclusion refutes this myth. The committee concludes that approved medications are effective and that two, methadone and buprenorphine, save lives. This conclusion provides an opportunity for jails and prisons to save lives, particularly during the first few weeks postrelease when the risk of death from opioid overdose is greatest. Indeed, Rhode Island was able to reduce statewide overdose deaths by one-third when by providing methadone to all incarcerated people with OUD in the state.

Conclusions From the National Academies Report: Medications for OUD Save Lives

1. Opioid use disorder is a treatable chronic brain disease.
2. FDA-approved medications to treat opioid use disorder are effective and save lives.
3. Long-term retention on medication for opioid use disorder is associated with improved outcomes.
4. A lack of availability or utilization of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder.
5. Most people who could benefit from medication-based treatment for opioid use disorder do not receive it, and access is inequitable across subgroups of the population.
6. Medication-based treatment is effective across all treatment settings studied to date. Withholding or failing to have available all classes of FDA-approved medication for the treatment of opioid use disorder in any care or criminal justice setting is denying appropriate medical treatment.
7. Confronting the major barriers to the use of medications to treat opioid use disorder is critical to addressing the opioid crisis.

The full report and a highlights document are available for free online at nationalacademies.org/OUDtreatment

Myth 3. Medications should be used short term only.
The reports states the opposite. Longer treatment with addiction medications improves outcomes, including lower recidivism and fewer overdoses. Jails and prisons should reinforce continuity of care by ensuring that people who are receiving treatment in the community be allowed to continue in custody and those not receiving treatment be offered a choice of buprenorphine (Suboxone), methadone (Methadose) and extended-release naltrexone (Vivitrol). Solid scientific evidence shows that when treatment is continued during incarceration, people are much more likely to reengage in community-based treatment postrelease as compared to when their medications are stopped.

Myth 4. Medications work only when coupled with behavioral treatment.
Scientific evidence is clear that medications are effective even in the absence of behavioral treatment. This finding is less surprising than it may seem. Medications to treat diabetes and hypertension are effective in the absence of behavioral treatment. We don't withhold these treatments when dieticians and health educators are not available to counsel the patient. Behavioral treatment is desirable, but its absence should not be a barrier to treatment.

Myth 5. Treatment is accessible to all people who want it.
Lack of insurance, treatment costs and stigma are significant barriers to treatment. Jails and prisons can help by linking people with Medicaid, insurance exchanges and sites that offer discounted fees (such as Federally Qualified Health Centers.) We also must reassure people that opioid use disorder is a chronic disease that requires treatment—not a shameful behavior.

Myth 6. It is acceptable for jails and prisons to not offer all three treatment options.
The committee is firm in its conclusion that not offering these treatment options—buprenorphine, methadone and extended-release naltrexone—represents denial of appropriate treatment and is unethical.

Myth 7. Stigma and punishment are effective.
The committee refutes this myth, stating that there is tremendous misunderstanding and stigma surrounding opioid use and these beliefs discourage people from obtaining lifesaving treatment. Treating people with dignity and respect while adopting the medical model for treating OUD can reduce stigma and engage more people in treatment.

Myth 8. Pregnant women should be treated the same as nonpregnant people with OUD.
Medication treatment in pregnancy is the standard of care. The harms of detoxification in people with OUD are more pronounced in pregnancy and include potential fetal effects, especially with the risks of overdose and infectious diseases from relapse. Both methadone and buprenorphine are safe and have well-established benefits for pregnant and postpartum women, including those who are breastfeeding. Naltrexone is not approved for use in pregnancy. Correctional facilities have an important role to play in ensuring adequate treatment for pregnant women with OUD to optimize their health and the health of their babies.

Our Important Role

The National Academies' report provides a rigorous base of evidence to support medication treatment for all people with OUD. A substantial proportion of people entering jails and prisons today have OUD. Correctional facilities have an important role to play in continuing and initiating medication treatment, and making an impact on individual lives, public health and the communities to which people return.

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Kevin Fiscella, MD, MPH, CCHP, is dean's professor, Family Medicine and professor, Public Health Sciences and Community Health at the University of Rochester Medical Center. He serves on the board as liaison of the American Society of Addiction Medicine.

Partnering With OTPs to Provide MAT: How One Jail Did It

by Carl Anderson, BSN, RN, CCHP

At the Arapahoe County Sheriff's Office in Centennial, CO, we are committed to protecting public safety and public health—and this includes making a difference for individuals suffering from opioid use disorder. Jails across the country are on the front lines in responding to the OUD epidemic, and we were obligated to do our part.

Although our region was not hit nearly as hard as other parts of the county, we had to be prepared. In 2016, we partnered with Colorado's Office of Behavioral Health to provide one dose of intranasal naloxone—a medication designed to rapidly reverse opioid overdose—to high-risk individuals upon release. We identify these people at booking and offer training on how to use the drug. Those who complete the training receive the dose at release. This program has generated positive feedback from returning inmate-patients, some of whom reported that the drug saved their life because they taught their family or friends how to use it.

We also implemented the use of this life-saving medication throughout our agency. Our deputies often are the first on scene for medical assist calls, and we were committed to giving them access to naloxone. We first trained them efficiently through use of videos that demonstrate the signs and symptoms of opioid overdose and how to administer the medication. Within one week of providing naloxone to each of our patrol vehicles, our deputies saved two lives.

Naloxone can also prove life-saving in the event of an accidental exposure to an opioid injection or inhalation, such during a routine pat-down or traffic stop, or even a child finding a syringe on a playground.

Arapahoe County Detention Facility has been accredited by NCCHC since 1989 and holds accreditations by four other agencies. Average annual intake is about 18,000.

Continuity of Care via MAT

As a floor nurse, for years I found myself asking this question: How is it that we continue insulin for a person with diabetes, but don't continue methadone for someone with opioid use disorder? This presented an ethical dilemma for me.

As the OUD crisis grew worse, the ACSO's efforts to address it continued to evolve, and our next big step was to implement a medication-assisted treatment program. We understood the importance of developing strong community support for this decision. To be successful, it was critical that we collaborate with county and local officials and partner with community-based opioid treatment programs.

A variety of models exist for MAT programs; the ACSO decided to start with inmate-patients already enrolled in a community OTP. Instead of having to "go cold turkey," they can continue to receive their medications, thus ensuring continuity of care and reducing their risk of relapse and overdose after release. We have partnered with three community opioid treatment programs to deliver and administer the medication. Medications provided are methadone, buprenorphine and naltrexone. The cost of this program is ultimately paid by the county, but it is a pass-through cost with our medical vendor.

Other models also offer induction to MAT for those with OUD who are not yet receiving treatment. Some jails will provide only one opioid treatment medication, but this approach is not recommended because different patients require different medications. Models also differ in where and how the medications are administered.

How Our Program Works

To help ensure success, we started by creating a team to champion the program, define expectations and ensure regular communication among all stakeholders.

The team is composed of our health services administrator and director of nursing, the medical providers (MD, NP, PA) and community partners (the OTPs). The HSA and DON have a crucial role in getting the providers' buy-in and sharing information about the program, such as criteria for participation, verification of treatment in the community, and clinical issues related to the medications, side effects, drug–drug interactions and more. The community OTPs must be involved at the outset to support the process and to assist in creating the optimal structure for the program.

In developing our model, we assessed the need for additional staffing (whether clinical or security) but determined that our program could be managed with current staffing. Naturally, there was a learning curve as the staff members involved took on additional tasks, but we prepared for that with early and frequent communication before the program began, and overall it has gone smoothly.

We identify potential participants at intake. A nurse then contacts the community OTP to verify their treatment plan and arranges for the OTP to deliver the patient's medication to the detention facility. We designated a safe and secure spot in the administrative area that provides privacy for the receiving staff and OTP courier.

Nurses who have received training from the OTPs deliver and administer the medications to the patients. This is done separately from routine med pass using a cart that has been designated for MAT medications only.

Other MAT-related tasks for ACSO staff include documenting receipt of the medication, securing it in the cart and documenting the dosing on the medication administration record. The medical team ensures that the proper dosing is taking place. The nurses and providers also evaluate each MAT participant for signs and symptoms of adverse reactions. If abnormal findings are identified, the medical team communicates with the proper provider and the OTP to determine whether the treatment plan/dosing needs to be changed.

It took a while to become accustomed to the separate med pass and, in particular, the time it takes for absorption of sublingual buprenorphine. Another change was the occasional need to transport inmate-patients to their respective OTP, which requires timely notification to the

transporting deputies. However, frequent communication eased the transition to these new workflows and the deputies embraced the opportunity to learn and assist.

The risk of diversion is a concern with any medication, and the MAT program is no different. A deputy and nurse are present for each administration, and for MAT, having the separate cart has proven beneficial. The deputy observes while the nurse prepares and administers the medication, and both of them remain with the patient until they confirm that it has been taken.

Typically, MAT programs include psychotherapy. The psychotherapeutic element is outlined in our agreement with our medical vendor and the OTPs so that we can be confident that we are able to provide both components of a successful MAT program. Typically, if a participant displays symptoms requiring additional counseling support, the medical team arranges for a counselor from the OTP to meet with the patient at our facility, although sometimes the patient is taken to the OTP if that type of intervention is deemed most appropriate.

Finally, the local hospitals are informal but important partners in our efforts to help people with OUD. In Colorado, induction of MAT medication in emergency departments is becoming quite common. We have received support from the hospitals with regard to our naloxone and MAT programs.

Measuring Success

Overall, we have found that the MAT program has enhanced efficiencies and quality of care. To gauge the efficacy, we routinely collect and analyze numerous data points and discuss it at our team's monthly meetings. This information enables us to determine whether the program is meeting the needs of its participants and whether any logistical or operational adjustments are needed.

- Number of participants
- Specific MAT medications being administered
- Number of deliveries and doses from each partnering OTP
- Number of bridge dosings via other health care entities that are not formally part of our program
- Number of instances of relapse postrelease
- Number of OTP physician encounters (at ACSO or OTP clinic)
- Number of counseling encounters by an OTP counselor (at ACSO or OTP clinic)

Launched in June 2018, the program had 146 participants in its first 11 months. We are aware of one patient who did not return to their community-based OTP upon release from custody.

These 146 individuals did not:

- Experience withdrawal
- Require the use of opioid withdrawal protocols, which can be labor intensive and in some cases incur overtime costs (for security and/or medical personnel)
- Require additional resources (e.g., extensive medical or mental health assessments, extensive interventions by security staff)

> The MAT program at Arapahoe County saved me. I did not relapse when I got out this time. I was able to return to my treatment program, and I did not have to go through withdrawal.
> *– program participant*

Additionally, without MAT, some of these patients might have required a higher level of outside care for withdrawal-related treatment. Preventing this has an impact on safety and security as well as costs related to transport, security, staffing and medical and mental health care.

We are hoping that this program will decrease recidivism, but ultimately this program will:

- Enhance continuity of care
- Decrease the risk of withdrawal while incarcerated
- Decrease the risk of relapse postrelease
- Decrease the risk of accidental overdose postrelease

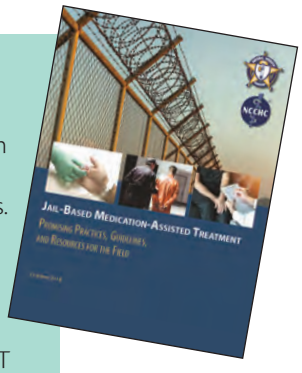
With the success of these efforts, the ACSO is exploring adding induction services to offer individuals with OUD the chance to initiate MAT while incarcerated.

You Can Do It, Too!

While it may feel overwhelming to implement a MAT program, you are not alone. Collaborating with your internal leadership team, community OTPs, medical services provider and local public health department will prove greatly beneficial. Your commitment to implementing a MAT program will allow your facility to provide a much-needed service to a high-risk population by enhancing continuity of care for individuals who are incarcerated or reentering their communities, while simultaneously decreasing liability for your agency.

Carl Anderson, BSN, RN, CCHP, is the administrative manager for detention administration at the Arapahoe County Sheriff's Office, Centennial, CO.

Promising Practices, Guidelines and Resources for MAT Programs in Jails



In November 2018, the National Sheriffs' Association teamed up with NCCHC to produce a comprehensive, practical guide to opioid treatment behind bars. The result of a nearly two-year collaboration among a group of federal, national and private partners, the guide reflects the state of the art in MAT. It is based on the most current research with real-life guidance from facilities that have implemented MAT programs. Included are concrete guidelines and best practices, an overview of various medications, case studies and tips. It is a highly useful guide for any jail considering MAT, working on implementation or hoping to improve an existing program.

www.ncchc.org/jail-based-MAT

Youth With a Terminal Diagnosis: Tips for Appropriate Management and Care

by Michelle Staples-Horne, MD, MPH, CCHP, and Jennifer Maehr, MD

This article is a precursor to a position statement that is in development.

Youth involved in the justice system often come to us with diabetes, hypertension, sickle cell anemia, cardiac conditions and other morbidities, mirroring their prevalence in the community. For the most part, with adequate care and education, these chronic medical conditions can be managed within the correctional facility, with the youth transitioned to the community for care upon release.

On very rare occasions, youth are diagnosed with a terminal illness, such as end-stage cancer. This situation presents a challenge as to how these youth should be managed by all involved. In the community, these youth are treated with kindness and compassion and are provided with optimal care. There should be no difference for youth confined to secure juvenile facilities.

To ensure we meet the community standard of care for youth with a terminal diagnosis, correctional staff must take additional measures to address their specific needs and requirements. However, facilities may not have experience in providing care for youth in this situation. This article seeks to provide guidance from two long-standing state juvenile justice medical directors. The recommendations apply to both juvenile and adult confinement settings.

Key Issues

Parental or Guardian Notification

Once the terminal diagnosis is confirmed, medical and behavioral health care staff, in collaboration with security, must be available to explain the diagnosis and answer any questions. Ideally this would be a face-to-face interaction. The decision as to when to inform the youth—before, during or after the parental/guardian discussion—is based on the youth's age, developmental stage and psychosocial factors.

The parent/guardian should not be informed of the diagnosis directly by the youth or security staff. Time should be allotted for counseling and support by behavioral health care staff. A community resource for support should be identified and made available to the youth's family.

Legal Issues

Youth aged 18 or older must provide consent for treatment and for the release of health information to anyone. Depending on the youth's legal status, court notification may or may not require consent. Your legal office should be involved early in the process, not only for the facility, but also for the hospital and other treating facilities. Hospitals generally require their own consent documents signed by the parent or guardian if the youth is a minor regardless of legal status. Advance directives should be discussed and included in the health record.

If court notification is required, medical staff may request a compassionate release back to the community for care and treatment. The court could also consider alternatives to detention or even home electronic monitoring.

In cases like this, the juvenile justice agency needs to provide a medical presence during court proceedings to explain the medical situation accurately and answer the court's questions. Juvenile justice health care staff also need to provide timely updates to the case management team on the youth's medical status. If the court agrees to release, health care staff must facilitate a smooth transition of care from the facility and local provider to the youth's home community of health care providers.

Hospital Care

Hospital policies vary concerning admission of youth confined to a secure facility. Hospitals often have a blanket "do not admit" policy for corrections-involved individuals for nonurgent care. Hospital agreements should already be in place to prevent unnecessary delays in care. Hospital and juvenile justice legal staff must come to the table with health care staff to reach agreement on how to handle these situations. The discussions should also address payment sources and insurance coverage, access to Medicaid after a 24-hour hospital stay and billing responsibility.

Restraint policies for youth in the hospital should consider the youth's medical condition and ability to escape. Youth should never be restrained to an inanimate object like a hospital bed. Room assignment, security staff, clothing and visitation policies should also be discussed and included in the agreement. Juvenile justice systems may need to modify visitation lists and hours under these circumstances.

Interdisciplinary Treatment Teams

These teams should include not only the hospital health care team taking care of the youth but also security, risk management, social work, billing/other administrative staff, specialty division heads (such as pediatrics or oncology), judge/magistrate, public defender, state attorney, juvenile justice case manager and juvenile justice health care staff. The team should meet prior to any court proceedings to review the youth's medical status.

Ideally, a health care staff member—such as a physician, advanced practice provider or nursing supervisor—who is knowledgeable and up to date on the youth's medical status will be present during the court proceedings. Treating providers in the community/hospital may also need to be called into court or patched in via telephone.

Mental and Behavioral Health

A terminal diagnosis will impact the youth's mental and behavioral health. Always be aware of the increased risk of suicide ideations and attempts and plan accordingly. Address these needs as soon as possible to provide support. Share past psychosocial or psychiatric evaluations with the hospital team and social workers. Youth may already have underlying mental health or developmental issues that will

affect their coping skills and ability to deal with a terminal diagnosis.

If the youth is still confined to the juvenile facility, provide programming that keeps the youth involved, busy, distracted and at the level at which they can safely participate. Ideas for downtime are journaling, card games with staff or other youth, reading books and other low-stress activities. Ask the youth where he or she may feel the most comfortable in detention—it may be the infirmary, or on the unit, or at a different detention center (if this is an option).

Pain Management
Youth with a terminal diagnosis may be on controlled drugs for pain management. Security procedures for controlled substances and medication inventory measures should be continued as usual. Medications that treat and prevent side effects such as constipation should be available. Train youth and family on the administration of Narcan if sending the youth home on narcotics.

Attempt to use alternatives to narcotics whenever possible. These may include topicals (e.g., lidocaine patches), gabapentin, NSAIDs, acetaminophen and others. These youth may develop opioid dependence and even withdrawal. Address these issues with the youth and family. Involve pain specialists and palliative care.

Immunizations
Based on their medical status some youth may benefit from additional immunizations, so this should be addressed.

Reproductive Health Care
The youth may be sexually active, may desire increased intimacy in sexual relationships and/or want children of their own before they die. Addressing their reproductive health and providing counseling is critical for both males and females.

Laboratory or Other Diagnostic Studies
Work with the hospital and specialists to determine if hospital, specialist or facility health care staff should order and obtain laboratory and other diagnostic studies.

Communication With Specialists
When possible, consider telemedicine to enable the youth and/or parents or guardians to talk to providers by telephone or by screen if questions or concerns arise before scheduled visits. Also arrange for communication between specialists and facility health care providers in between appointments to discuss the case and update each other on the youth's status.

Nutrition
The youth's medical condition, mental health status, medications and treatments may affect appetite, oral intake, weight and/or nutrient absorption. A nutritional consult by a registered dietitian may be necessary, as well as supplements and/or special diets.

Ambulatory Needs
Provisions for occupational or physical therapy must be made available. Address security issues for access to walkers and wheelchairs and other adaptive devices.

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Staff Coverage and Housing
Nursing staff coverage may need to be increased to care for a youth with a terminal diagnosis and not interrupt the facility's normal health care operations. Increased residential staff coverage may also be necessary since youth may need assistance with showering, moving, eating, dressing and other activities of daily living.

Although admission to an infirmary may be necessary, also considered the youth's opinion on where they feel most comfortable. The youth may wish to maintain social interaction and activity. Hospital beds, special bedding and additional pillows or padding may help with pain and improve sleep.

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Surviving Your Job With Style

Rule #2: You Will Be Sued for Doing the Right Thing

by Susan M. Tiona, MD, CCHP

In her upcoming book, "Correctional Health Care: Twenty Rules for Surviving With Style," Dr. Tiona offers sage and practical advice on forging your way through a smart, successful and satisfying career in correctional health care. Applicable to a range of health care disciplines and experiences, these rules encapsulate the emotional, professional and cognitive complexities of the worst job you'll ever love.

It probably goes without saying that if you do something terribly wrong, you are likely to have to answer for it in a courtroom. But being sued for doing the *right* thing? What's that all about?

In Rule #1: Refuse to Be a Victim, we talked about standing your ground and acquiescing to inmate requests only when those requests are medically necessary (or at least medically justifiable). That is doing the right thing.

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Unfortunately, inmates will initiate a lawsuit because they didn't get what they wanted from you—an extra mattress, an MRI or a particular pain medication, for example. On occasion, they will sue for actual lack of (or deficient) care, but even that usually goes back to their perception of not getting care to which they felt entitled, rather than care that was actually substandard.

We've all heard the words, "I'll be talking to my lawyer" as the inmate dramatically exits the exam room. So, what transpires between the threat and the courtroom?

Most of the time, the threat never materializes into anything. People get upset and spout off without real intent, and inmates are no exception. The ones who tend to follow through are the same folks we talked about in Rule #1—the manipulator who fails to manipulate you. So, in spite of your best efforts to do the right thing, you might end up lamenting your integrity when it results in the dreaded *Summons in a Civil Action*.

Eighth Amendment Claim

The basis for inmate litigation is typically not malpractice. In theory, leveling a malpractice claim could be done, but it is not the norm—you would have had to truly do the wrong thing, and the burden of proof for that is quite substantial. Rather, the vast majority of inmate litigation is based on the perception that you (and usually an entire litany of defendants) are responsible for violating his Eighth Amendment rights: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments afflicted." So, if you decline to order a knee MRI in lieu of six weeks of physical therapy, you may find yourself on the receiving end of civil litigation.

Before filing a civil action against you, the inmate first has to exhaust all of his administrative options by going through the grievance process. Your first hint of possible impending litigation is that step 3 grievance wherein you reiterate, again, that your treatment decisions are sound and appropriate. This argument will fall on deaf ears, as the inmate has already made up his mind that he has been wronged, and he's just going through the requisite steps so that he can proceed with his lawsuit.

Sometime in the ensuing two years (the statute of limitations), and long after you've forgotten the "I'll be talking to my lawyer" rant, the inmate files a civil action in federal court. Very often, the inmate will file *pro se*, which means he is acting as his own lawyer; less often, he will retain the services of a lawyer.

You will find out about the lawsuit in one of two ways: Either you will be served personally (usually at your home by your friendly neighborhood marshal—I recognize mine by his SUV as he pulls into my driveway) or, with much less fanfare, your lawyer will call asking for more information. Upon being presented with a summons, be sure to notify your lawyer, as time is of the essence in making your initial response to the complaint.

If you work for a state DOC, you are most likely represented by the state attorney general's office (the corrections unit or something similar). If you are employed by a private prison company or a staffing agency, and you're not sure who represents you, check with your health services administrator. This begs a word of caution: When you start working in a correctional setting, regardless of your employment or contract status, be sure that your arrangement entitles you to representation in the (almost certain) event of litigation. You do not want to be figuring this out *ex post facto*.

What Happens Next?

At the risk of offending fans of the TV series "Bull," the next step in the process is not the trial. Assuming your lawyer does not respond with a motion to dismiss, the discovery phase will begin. Most of the time, this assumes the form of written *interrogatories* or *requests for admission*, the latter being used by the inmate when he really wants to be a thorn in your side..

Occasionally, you may be targeted for a deposition. This is a nerve-wracking affair. You will be asked seemingly ridiculous, inconsequential and immaterial questions, but you are required to answer them (even if your lawyer *objects to form and function*). As a deponent, never start your response with "yes, but …" or "no, but …" As soon as you say "yes" or "no," your deposer will try to cut you off,

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Photo: Maricopa County (AZ) Jail Systems

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even if you have much more to explain. Instead, finish your response with "… so, yes" or "… so, no." In so doing, you maintain control of the deposition, and redirect the angst back to the plaintiff's lawyer—tag, you're *not* it!

When the discovery phase is done, and if your lawyer is pretty convinced that the inmate doesn't have a case, a motion for summary judgment will be submitted on your behalf. If the judge rules in your favor, all is done! If not, it just means that the judge doesn't have a legal basis to award a unilateral judgment.

So, time marches on, often months and months. Eventually, after additional legal banterings and filings, a trial date will be set and you will finally have your day in court. You will probably have some angst about testifying, but a few tips can perhaps take the sting out of it.

Plaintiff attorneys can be tricky. They want you to be uncomfortable, and they want you to say what they want you to say. They'll bait you with a line of questioning that, when strung together, ends up saying something you didn't really intend.

Refuse to be a victim! Stay focused and think about every response before it leaves your lips. You'll often be asked the same question from multiple angles, because the lawyer is trying to get you to contradict yourself. And don't guess or add information that you really don't know. If you don't recall, or if your notes aren't clear, then just say that. As with depositions, if your response calls for an explanation, then start and end with "… so, yes" or "… so, no."

If you are being attacked, it's OK to fight back—with decorum, of course. "That's not what I said, sir." "Please don't put words into my mouth." "I do not agree with that statement." These are all perfectly acceptable responses.

Take every opportunity to gain a little bit of control over the situation. I once had a particularly contentious lawyer read a statement, then ask me if I agreed with it. I responded that I did not. He then said, "But Dr. Tiona, that's a statement you made in deposition. Are you saying you disagree with yourself?"

"Well," I responded, "why don't you read the complete sentence, because I'm pretty sure that's not what I said." When he read my entire statement (instead of only the dependent clause that he had pulled out of my otherwise complex sentence), it made perfect sense, and I was able to affirm: "And *that* I agree with." Juries like it when witnesses catch lawyers being sneaky. I've come up against this lawyer a few times since then, and he thinks twice before he misquotes me!

Write Defensibly

It all comes down to this: If you work in the correctional setting long enough, you will be sued, and it will often be for doing the right thing. It will be tempting to try to mitigate the potential damage by throwing someone else under the documentation bus, but resist the urge. You've heard it said, "Speak sweetly, for tomorrow you may have to eat your words." In correctional health care, "Write defensibly, for tomorrow you may hear your words read in court."

After all, you are what you write—the next rule for surviving with style.

Susan M. Tiona, MD, CCHP, has practiced medicine in the correctional setting since 2004. She is the former chief medical officer for the Colorado Department of Corrections and is currently a telemedicine provider for CoreCivc, as well as providing expert witness services and pursuing a master's degree in forensic psychology.

Study: Many Women in Prison Would Accept HPV Vaccination if Offered

Women in correctional settings have cervical cancer at a disproportionately high rate, with one study finding it to be nearly 5 times higher than found in the community. These women also have high rates of human papillomavirus infection, the most common sexually transmitted infection and the cause of up to 90% of all diagnosed cases of cervical cancer. Furthermore, when in the community these women have limited access to Pap smears and other health care services.

A pilot study conducted by Alia Moore and colleagues found that most young women in prison had not received the HPV vaccine but would be willing to get it if offered in the prison. The study results were published in the July issue of the *Journal of Correctional Health Care*.

The researchers surveyed 97 English-speaking women aged 19-26 at a women's state prison that does not offer the HPV vaccine. The purpose was to assess attitudes and knowledge about HPV and the vaccine, acceptability of receiving the vaccine in prison, barriers to in-prison vaccination and self-reported vaccination rates. Study investigators typically administered the 10-minute survey verbally, although participants in a high-security unit completed a paper survey. In all cases, study procedures took place in a private room.

Low Knowledge, High Acceptance

Overall, 34% of the participants reported ever receiving the HPV vaccine, and 57% of those women said they completed the full vaccine series.

Most (85%) participants had heard of HPV and 57% had heard of the HPV vaccine. The average knowledge score on all HPV and vaccine questions was 41% (±22%). Scores were highest for the question "the HPV vaccine works in women who are already sexually active" (76% correct) and lowest for "HPV infection usually goes away on its own" (0%).

Nearly two-thirds (64%) of women somewhat or strongly agreed that vaccines do more good than harm. Attitudes toward the HPV vaccine in particular were largely positive, with 66% somewhat or strongly agreeing that it could save their lives. More than half (53%) somewhat or strongly agreed that the HPV vaccine is safe, while only 12% agreed that it has dangerous side effects.

Most women (78%) somewhat or strongly agreed that cervical cancer would have negative consequences for them, potentially including death. However, the majority felt they had no increased risk of HPV infection (58%) or cervical cancer (64%) compared to women who had never been incarcerated. Furthermore, only 40% somewhat or strongly believed that the HPV vaccine is effective at preventing cervical cancer, although this was higher than the 25% of women who somewhat or strongly believed that the vaccine can prevent genital warts.

As to acceptability, 75% of the 63 women who reported never receiving the HPV vaccine said they would be somewhat or very likely to get the vaccine in prison if it was offered; 11% were neutral. Neither awareness nor knowledge was found to be associated with acceptability.

Lower acceptance was associated with identifying as LGBT, low perception of HPV infection risk and low interest in obtaining information about the virus and vaccine.

Cited barriers to in-prison vaccination include uncertainty about how to obtain more information about the vaccine (56%), concern that they would not receive help in the event of an adverse reaction (37%) and wariness about prison employees administering the vaccine (27%).

Groundbreaking 'Pregnancy in Prison' Statistics

Until now, there have been no systematic collection of data on pregnancies in correctional settings in the United States or what happens to those pregnancies. The Pregnancy in Prison Statistics project has validated data that will better inform policy and research aimed at improving health care and outcomes for pregnant people behind bars and their newborns.

The PIPS project collected data for one year from 22 state prison systems, the Federal Bureau of Prisons, 6 jails and 3 juvenile justice systems. This sample represented 57% of females in prison and 5% of females in jail.

An article reporting findings from the prison participants was published in the May issue of the *American Journal of Public Health*. Overall, 1,396 pregnant women were admitted to prisons during the study period. As of December 2016, 3.8% of newly admitted women and 0.6% of all women were pregnant. There were 753 live births (92% of outcomes), 46 miscarriages (6%), 11 abortions (1%), 4 stillbirths (0.5%), 3 newborn deaths and no maternal deaths. Of the live births, 6% were preterm and 30% were cesarean deliveries. Distributions of outcomes varied by state.

PIPS is headed by Carolyn Sufrin, MD, PhD, assistant professor of gynecology and obstetrics at the Johns Hopkins University School of Medicine. Sufrin serves on NCCHC's board of directors as liaison of the American College of Obstetricians and Gynecologists.

- www.pipsdata.org/
- ajph.aphapublications.org/doi/10.2105/AJPH.2019.305006

Likely Shortage of Aplisol PPD for TB Skin Testing

The Centers for Disease Control and Prevention is expecting a 3- to 10-month nationwide shortage of Aplisol, which is one of two PPD tuberculin antigens licensed by the Food and Drug Administration for use in performing tuberculin skin tests. The manufacturer, Par Pharmaceuticals, said it anticipates supply interruptions of Aplisol 5 mL (50 tests) beginning in June and Aplisol 1 mL (10 tests) in November. However, the 1 mL shortage could occur earlier if demand increases. The 3-10 month time frame is Par's estimate and is subject to change.

The CDC recommends three approaches to prevent a decrease in TB testing capability because of the shortage:

- Substitute IGRA blood tests for TSTs, but be aware that the criteria for test interpretation differ from those for TSTs.
- Substitute Tubersol for Aplisol for skin testing. In cross-sectional studies, the two products give similar results for most patients.
- Prioritize allocation of TSTs, in consultation with state and local public health authorities. This might require deferring the testing of some people..

To monitor the status of this supply interruption, see the FDA's Center for Biologics Evaluation and Research–Regulated Products: Current Shortages webpage.

Transgender *(continued from page 8)*

the lawsuit is allowed to proceed to determine if their action was deliberately indifferent to Mitchell's gender dysphoria.

Comment

This is a novel holding with regard to the parole officers, although rather mainstream, but important, as to treatment in prison. The constitutional right to medical care begins and ends with incarceration.

The decision here is not a right to treatment while on parole. Rather, it is a right not to be blocked from appropriate care as a transgender individual, including gender-appropriate dress.

Fred Cohen, LLM, is editor of the Correctional Law Reporter. *This article is reprinted (with minor modifications) from CLR with permission of the publisher.*

For subscription information, contact the Civic Research Institute, 4478 U.S. Route 27, P.O. Box 585, Kingston, NJ 08528; 609-683-4450; www.civicresearchinstitute.com.

Terminal Diagnosis *(continued from page 15)*

Preparing for Discharge

Set up follow-up appointments with community providers: specialists, a primary care provider and a behavioral health provider. Ensure that youth will be able to get to the appointments. This may involve the juvenile justice agency arranging for transportation to appointments or enlisting other agencies to assist. Provide an adequate supply of medications/prescriptions at discharge, but do not give too many narcotic pills. Discuss who (e.g., family member, home health nurse) will help to administer and safeguard medications at home. Consider providing a Narcan kit.

End of Life

It is essential to empower the youth with as much decision making and autonomy as possible. Before they are in the end stage of illness, they should be encouraged to communicate how they want to be comforted, supported, treated and remembered. Finally, the family may need assistance with hospice care and final expenses. The agency may not be able to provide these resources, but juvenile justice case managers should have access to community resources and be able to make appropriate referrals.

Michelle Staples-Horne, MD, MPH, CCHP, is medical director for the Georgia Department of Juvenile Justice, Decatur. Jennifer Maehr, MD, is medical director for the Maryland Department of Juvenile Services, Baltimore.

Medical Officer and CCHP Exam Proctor Leads by Example

by Katie Przychodzen, MA, CCHP

For the past three years, Alsan Bellard, Jr., MD, MBA, CCHP-P, has organized and proctored the CCHP exam at the District of Columbia's Department of Youth Rehabilitation Services, where he serves as health services medical officer. On average about 10 employees sit for the annual exam at DC DYRS, although 25 people took it the first year it was offered.

"Staff members typically form a study group to prepare for the exam, meeting weekly for several months prior to the test. After one year of employment, our agency pays for staff members to take the exam," says Bellard. RNs and NPs who pass the CCHP exam even receive a financial incentive.

A Template for Optimal Care

Earlier in his career, Bellard worked in underserved rural and inner city areas, and he says his move into corrections made sense, as there he would be able to help yet another underserved population. "Most of the adolescents in our system are talented, creative individuals who simply have gone off course for a myriad of reasons," says Bellard, a pediatrician by trade. "I feel that my presence alone is a powerful statement as to what they can achieve."

When Bellard joined DC DYRS six years ago, it was his first-ever job in correctional health care. Right away he purchased the *Standards for Health Services in Juvenile Detention and Confinement Facilities*. "I needed a template on how to organize our services to ensure that we were providing the best level of care based on national guidelines and best practices, instead of on instincts," he says.

To be effective in this role, Bellard wanted to have a thorough understanding of the standards. That led him to achieve CCHP certification in 2016. At that time, he was both the health services administrator and the responsible physician at DC DYRS, overseeing all medical and behavioral health services at the agency's two secure facilities.

Champion of Certification

Bellard has been a champion of the CCHP program at his facility ever since. "It was important that I set an example to my direct reports to encourage them to pursue certification of their own," says Bellard. He has since also earned specialty certification for physicians, or CCHP-P.

When Bellard addresses new staff, he incorporates the value of CCHP certification into his introductions. Because most health care professionals have never before entered a secure facility, he starts by explaining the distinctiveness of the environment: "There are both unique challenges and unique opportunities in corrections, and it is imperative that we understand those issues in our efforts to provide good care."

Bellard describes the CCHP program as a great opportunity for correctional health professionals to learn about the requirements for maintaining quality health services and to acquire the confidence necessary to work in this environment. Staff earning certification has "without a doubt" helped improve the quality of health services at DC DYRS, and has led to both facilities achieving accreditation, he says.

"As the leader of our department, I believe that I set the tone for how important the work that we do is, as perceived by not only my direct reports but also by our peers on the custody side," he adds. "By constantly promoting both the CCHP program and NCCHC accreditation, I have made quality health care part of the mission of our entire agency."

Alsan Bellard

Katie Przychodzen, MA, CCHP, is marketing and communications manager for NCCHC. To learn more about the CCHP-A credential and to apply, visit www.ncchc.org/cchp-a.

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Standards for Opioid Treatment Programs
These standards present the requirements for OTPs seeking NCCHC accreditation. This second edition adheres to the Substance Abuse and Mental Health Services Administration's 2015 Federal Guidelines for Opioid Treatment Programs and takes into account the issues unique to correctional settings. The OTP Standards address the general areas of patient care and treatment, clinical records, governance and administration, personnel and legal issues. 2015. Softcover, 141 pages. $69.95. Order at www.ncchc.org/ncchc-store or call 773-880-1460.

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ADVERTISER INDEX

Expert Advice on NCCHC Standards

by Tracey Titus, RN, CCHP-RN

Psychologists Prescribing Psychotropic Meds

Q *Idaho has passed legislation that permits psychologists to prescribe psychotropic medication if they have certain training. Does NCCHC have a position on whether it is appropriate to have a psychologist in a correctional setting prescribing, if properly licensed?*

A NCCHC has no position on that specific issue, except to the extent that the facility is complying with the laws applicable in the jurisdiction.

For example, in the 2018 *Standards for Health Services*, standard C-01 Credentials states that "The facility's qualified health care professionals are legally eligible to perform their clinical duties." Compliance indicator #4 requires that qualified health care professionals not perform tasks beyond those permitted by their credentials. In standard D-02 Medication Services, compliance indicator #2 states that "Prescription medications are given only by the order of a physician, dentist, or other legally authorized individual."

Therefore, if the psychologist is appropriately licensed and has documented proof of required training to prescribe medications per state law, this would be in compliance with the NCCHC standards.

Weekly RHA Visits at Multiple Sites

Q *Our jail system has three facilities, and one of them is 40 miles away from the others. Standard A-02 requires that the responsible health authority be on-site at least weekly. Our designated RHA is busy at our main jail 40 hours a week and couldn't possibly make it to all three facilities. Does the standard require that the RHA be on-site weekly at each facility?*

A The RHA should designate someone to be on-site at least once a week for each facility. In a system such as yours, that person may work under the supervision of the system's health authority. If your outlying facility is large, it probably has a physician who visits at least weekly. Such a person, or an on-site administrator, is often the one who is designated as the facility's responsible health authority.

Annual Health Assessments

Q *Our facility is preparing for NCCHC accreditation and we have a question about Standard E-04 Initial Health Assessment. We thought there was a requirement that all inmates are to receive an annual health assessment but cannot find that in the standard.*

A The standard gives jails two options. (1) "Full population assessment" requires that the initial health assessment be completed as soon as possible but no later than 14 calendar days after admission. (2) The "individual assessment when clinically indicated" must be completed within two working days after admission, and other stipulations must be met in order to qualify for this option. For prisons and juvenile facilities, the full population assessment must be completed as soon as possible but no later than seven calendar days after admission; the individual assessment when clinically indicated is not an option.

In addition, periodic health assessments should be considered an important part of ongoing disease prevention. The responsible physician should determine the frequency and content of these exams for various groups based on age and risk factors. In the 2018 *Standards* for jails and prisons, this requirements appears in B-03 Clinical Preventive Services, compliance indicator #2. For juvenile facilities, see E-04 Health Assessment, compliance indicator #3.

Tracey Titus, RN, CCHP-RN, is NCCHC's vice president of accreditation. If you have a question about the standards, write to accreditation@ncchc.org or call 773-880-1460. For an archive of Q&A topics as well as the Spotlight on the Standards column, visit www.ncchc.org/standards-explained.

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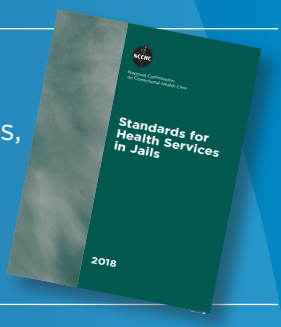

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