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The magazine of the National Commission on Correctional Health Care

NCCHC

Assessment of Suicide Risk

*Highlights From
the Suicide Prevention
Resource Guide*



*NPs Can Add Value to
Your Medical Team*

*Common Psychotropic
Medication Classes: A
Refresher*

*2019 Award Winners
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National Commission on Correctional Health Care
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Revised Position Statements Address Juvenile Issues

NCCHC has revised two position statements in support of youth in juvenile detention and confinement facilities.

Suicide Prevention and Management in Juvenile Correctional Settings highlights the key components of a successful suicide prevention program. First issued in 2007, the position statement has been updated to reflect the most current understanding of trauma and adverse childhood events, suicide risk and the relationship between the two. While NCCHC's fundamental guidance has not changed, the statement has been streamlined for ease in understanding and implementation.

NCCHC recommends that all juvenile correctional facilities—including pre- and postadjudication, small and large, public and private—develop and implement a comprehensive suicide prevention program that takes into consideration the unique characteristics of adolescent suicide.

The program should have all of the following key components: staff training in suicide prevention, identification of risk, communication about suicide risk and behaviors, hous-

ing status, a monitoring level system, intervention strategies and a post-incident review process.

A more comprehensive description can be found in the *Standards for Health Services in Juvenile Detention and Confinement Facilities*, Y-G-05 Suicide Prevention Program.

Health Care Funding for Incarcerated Youth reiterates NCCHC's support for equality in access and funding for health care and recommends that all youth in public and private confinement and detention facilities remain eligible for all public (e.g., Medicaid) and private health care coverage consistent with state and local eligibility requirements. NCCHC advocates that youth apply for insurance enrollment and participate in prerelease coordination of care to ensure continuity of care upon release. It also calls for states to suspend, rather than terminate, Medicaid insurance following detention in order to facilitate quick reactivation upon release. See page 13 for the complete statement.

View all of NCCHC's statements at ncchc.org/position-statements.

A Warm Welcome to Two New Board Members



Alison O. Jordan, MSW, LCSW

Ms. Jordan is an internationally recognized public health professional with more than 20 years of senior government and health system management experience. For the past 15 years she has led the design, development and implementation of Reentry & Continuity Services for Correctional Health Services, a division of NYC Health + Hospitals, and linkages to community care after incarceration in New York City jails. She also is a governing councilor for the American Public Health Association's Medical Care section and coordinator of its Justice-Impacted and Incarcerated Health Committee. She replaces Joseph Goldenson, MD, as APA's liaison to the board.

Carol Cramer Brooks, MPA

Ms. Cramer Brooks' career focus includes training, technical assistance and program and curriculum development. Currently a consultant, her previous positions include director of training and confinement education for the National Juvenile Detention Association and director of the Office of Juvenile Justice and Delinquency Prevention's National Center for Youth in Custody. She is also a former director of program development and support services for the State of Michigan's Department of Human Services, Bureau of Juvenile Justice. Ms. Cramer Brooks serves as the National Partnership for Juvenile Services liaison to the NCCHC board, replacing David W. Roush, PhD, LPC.

Calendar of events

2020	Accreditation Committee meeting dates to be determined
March 21	CCHP exams, Phoenix
May 2-5	Spring Conference on Correctional Health Care, Atlanta
May 3	CCHP exams, Atlanta
July 18	CCHP exams, Denver
July 19-20	Correctional Mental Health Care Conference, Denver

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

It's Official! Deborah Ross Is Named CEO

After serving three months as interim chief executive officer, Deborah Ross, CCHP, has been named CEO by the NCCHC board of directors. The appointment became official Oct. 13 at the National Conference on Correctional Health Care in Fort Lauderdale. Ms. Ross has worked for the National Commission for 21 years, most recently as the vice president of education and meetings.

"The Board is excited about working with Deborah to pursue our mission of quality patient care in corrections," said Robert Morris, MD, CCHP-P, board chairman for 2019-2020. "She is a strong leader, focused on organizational excellence, and has a vision to achieve NCCHC's potential. She truly has the capabilities to push the organization forward."



Board Chair Robby Morris Wants the Kids to Be Alright

by Kim Sterling, MBA, CAE

Dr. Robert “Robby” Morris’ roots are deep with the National Commission on Correctional Health Care, which he has called his professional home since the late 1980s. On Oct. 14, he returned to duty as chair of the NCCHC board of directors for the second time; his first term was 2007-2008.

After graduating from Temple University Medical School, he served in the U.S. Army as a pediatrician. After the army, he began working at the Los Angeles juvenile halls as part of his academic career at the University of California Los Angeles Medical School.

At UCLA, Morris developed a program to teach adolescent medicine. He became interested in juvenile justice after working on a study with the Centers for Disease Control and Prevention and NCCHC that found extremely high rates of sexually transmissible infections among detained juveniles.

A New Professional Focus

Morris’ life’s work came into focus when he took a sabbatical from UCLA in 2001 to serve as medical director for the Louisiana juvenile justice system to help it respond to a federal lawsuit. He noticed that signage and staff referred to the youth as “offenders.” He believed it was important for the language used to be neutral and not dehumanizing. He instituted the term “youth” and began to make a point of speaking of “children” in his publications and presentations.

Morris returned to Los Angeles in 2003, and in 2004 he was appointed health care director for the California Department of Corrections and Rehabilitation’s Juvenile Justice Division through 2009. In 2011, he became a professor emeritus at the UCLA Department of Pediatrics.

Morris is recognized as a national expert on health care for juveniles in the correctional system. He has served as a court-appointed expert for program evaluation and has published 15 peer-reviewed journal articles, eight additional articles, 26 book chapters and 43 abstracts, most of which involved juvenile justice.

In 2001, Morris joined the NCCHC board as the liaison of the Society for Adolescent Health and Medicine. He has served on the juvenile health committee continuously since 1992 and chaired it from 2003 to 2006 and from 2014 to 2016. He twice chaired the juvenile standards revision committee. He is proud of his role in innovations such as the juvenile health committee being the first within NCCHC to host an educational webinar.

Morris also chaired the education committee and has served on NCCHC committees for policy and standards,

At a Glance

Robert E. Morris, MD, CCHP-P



Professional Experience

- Lead physician, Sylmar Juvenile Detention Facility, Los Angeles, 1986-1990
- Senior physician, Central Juvenile Hall, Los Angeles, 1990-1998
- Director of pediatrics, Orthopedic Hospital, Los Angeles, 1998-2001 and 2003-2011
- Medical director, Louisiana Juvenile Justice System/ Louisiana Department of Public Health and Preventive Medicine, 2001-2003
- Medical director, Division of Juvenile Justice, California Dept. of Corrections and Rehabilitation, 2005-2009

Academia (selected appointments)

- UCLA Medical Center
 - Associate director, Adolescent Medicine Program, 1994-2011
 - Professor of clinical pediatrics, 1999-2011
 - Professor emeritus, 2011
- LSU Health Sciences Center, 2001-2004
 - Clinical professor of pediatrics

Leadership Activities (selected)

- American Academy of Pediatrics
 - Chapter 2 executive board, 1986-2001
- Society for Adolescent Health and Medicine
 - Fellow since 1998
 - President, local chapter, 1995-2001
- The Lloyd Society: Fellow since 2006

Education

- Temple University Medical School, Philadelphia

finance, personnel and CCHP-P certification. He has been a surveyor since 2012 and is the NCCHC liaison to the CDC Advisory Committee on the Elimination of TB.

An Advocate for Reform

Morris speaks passionately about the results of mass incarceration and the ripple effect that minor crimes have on children and families. He advocates for early intervention and cites studies showing the permanent damage to children when parents are incarcerated, rather than, for example, treated for substance abuse.

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NACo and NSA Tackle Inmate Exclusion Policy

On Oct. 17, U.S. senators introduced two bills to improve health care access for pretrial detainees. The bills address a policy known as the Medicaid inmate exclusion, which prohibits inmates of public institutions (including county jails) from accessing benefits under Medicaid, Medicare, the Children's Health Insurance Program and Veterans Affairs health services. This prohibition makes no distinction between pretrial detainees presumed innocent and convicted inmates.

The first piece of legislation, titled the Equity in Pretrial Medicaid Coverage Act (S. 2628) and sponsored by Sens. Ed Markey (D-MA), Jeff Merkley (D-OR), Sherrod Brown (D-OH) and Dick Durbin (D-IL), would amend the Social Security Act to remove limitations on Medicaid coverage for pretrial inmates of public institutions. The second piece of legislation, titled the Restoring Health Benefits for Justice-Involved Individuals Act (S.2626) and sponsored by Sen. Merkley, would take similar steps to remove inmate limitations on benefits under Medicare, the Children's Health Insurance Program and Veterans Affairs health services.

Restoring access to federal health benefits for pretrial

detainees is a key legislative priority for the Health Care and Jails Task Force between NACo and the National Sheriffs' Association. Over the past several months, task force members have worked closely with congressional offices to develop these proposals. Official introduction of the legislation followed a task force advocacy day on Capitol Hill in October, during which members met with congressional members to urge support for these measures.

Going forward, both bills must still be considered in the U.S. Senate committees of jurisdiction before being brought to a vote. The task force is working to identify potential sponsors for these bills in the U.S. House.

To learn more about the most recent submitted legislation, see the Pretrial Detainee Health Care and Recidivism tool kit at naco.org/resources/featured/healthcareinjails.

Blair Bryant, MPH
Associate Legislative Director, Health
National Association of Counties

Editor's note: NACo and the NSA are supporting organizations of NCCHC. This letter has been lightly edited in accordance with the CorrectCare stylebook.

Board Chair (continued from page 3)

"Corrections and health are in flux," Morris says. "The federal sentencing reform guidelines passed in 2018 and changes in California about a decade ago are making great progress in removing kids from the system. In California alone, the state has made tremendous changes from the mid-1990s when 10,000 children were incarcerated to fewer than 1,200 today. Plus, the 1,200 are no longer supervised by the corrections department, but by health and human services."

Morris is concerned that "the United States continues to incarcerate more children than anywhere else in the world, by a factor of 3 to 5 times." He highlights the disproportionate incarceration of youth of color and those who are LGBTQ. It's a situation that he feels must be addressed by

raising awareness of the lack of equity in the justice system.

Looking ahead, Morris notes, "NCCHC can make a real difference in people's lives. Our mission of education is directly tied to better health outcomes for those incarcerated. The best facilities commit to resources for supporting staff and providing continuing education. In turn, those facilities will have the best results for children and adults."

Turning Mission Into Movement

Morris would like to use his one-year term as chair to:

- Increase federal and state advocacy for improved health care resources and effectiveness
- Leverage the board members to get more visibility for correctional health care within each board member's sponsoring organization
- Continue to drive for organizational excellence in NCCHC's day-to-day functions
- Examine the NCCHC strategic plan and develop a shared vision for what's next

Above all, Morris continues to advocate for patients in the correctional system. He says, "No group of patients is more grateful. If we treat the children in our care with respect, they will respond positively. If we help them, we can make a permanent difference in their lives and the lives of their entire families."

Kim Sterling, MBA, CAE, is director of professional services for NCCHC.

Dr. Joseph Penn Becomes Chair-Elect

Joseph Penn, MD, CCHP-MH, clinical professor in the department of psychiatry at the University of Texas Medical Branch and director of mental health services at UTMB Correctional Managed Care, was elected chair-elect. He is the American Academy of Psychiatry and the Law liaison to the board.

Dr. Penn served as board chair in 2008-2009 and has chaired the accreditation and juvenile health committees. He is a physician surveyor and served on multiple task forces to revise NCCHC standards. Dr. Penn is triple board certified in general, child and adolescent, and forensic psychiatry.



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Assessment of Suicide Risk

Highlights From the Suicide Prevention Resource Guide



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Preventing suicide requires ongoing assessment to identify patients who are at heightened risk and need intervention. Only by identifying those individuals can resources be appropriately directed to target interventions and save lives.

In correctional settings, however, valid and reliable suicide risk assessment has remained elusive for a number of reasons. There is no magic formula or definitive approach to suicide risk assessment, as understanding of this complex behavior among a complex patient population continues to evolve. What follows are state-of-the-art recommendations based on advancements in the science and consensus among experts.

Assessment: More Thorough Than Screening

Screening and assessment, while both important to identifying individuals at risk for suicide, are not the same thing. That is an important distinction, as the terms are often mistakenly interchanged.

Screening is generally a one-time event used at intake for the early identification of individuals at potentially high risk for suicide. Screenings are usually brief, use simple “yes/no” questions, and can be administered by health care professionals or trained custody staff. Screening results do not definitively diagnose a specific condition or disorder, but can indicate a need for further evaluation or preliminary intervention.

Screening tools for suicide risk that have been validated in the community are available that can be used in correctional settings with modification. [See *the Resource Guide* for a list of screening tools.] They can be used during the admission process to help identify immediate needs and in special situations, such as placement in restrictive housing/segregation, following a court hearing, proximate to a transfer or a change in security status.

Assessment, on the other hand, is an in-depth process involving a comprehensive examination conducted by a

qualified mental health professional (QMHP). Assessment is not a one-time event, but a process that should be ongoing throughout the at-risk patient’s incarceration.

An assessment includes a thorough evaluation of the individual’s history and functioning across multiple domains, providing a more complete clinical picture. Assessments assist in identifying key risk factors, including mental health conditions or psychological problems and their severity, and aid in treatment planning. Assessments typically integrate results from multiple sources, including psychological tests, clinical interviews, behavioral observations, clinical records, and collateral information.

A comprehensive assessment of suicide risk includes sufficient description of the current behavior and justification for the interventions being provided to mitigate risk and move the individual away from suicidal thoughts and behaviors.

A Process, Not an Event

At present, there are no known validated suicide risk assessment instruments designed specifically for use in correctional settings. The principles and approaches described below are based on a general population in the community.

As such, they are a useful starting point for risk assessment of incarcerated individuals, while not addressing the unique challenges discussed.

While each method provides a foundation for conducting suicide risk assessment, additional information is needed to develop an assessment process appropriate for incarcerated populations and correctional settings. Until a validated corrections-specific assessment instrument is developed, these principles are to be used as guidelines.

Each of these methods highlights that suicide risk assessment is a process, not an event; is multifaceted; and requires information from multiple sources. These methods also rely heavily on patient self-report, which can present challenges with correctional populations. [See the *Resource Guide* for a summary of these methods.]

- Zero Suicide
- Collaborative Assessment and Management of Suicidality (CAMS)
- Chronological Assessment of Suicide Events (CASE)
- The H.E.L.P.E.R. system
- National Suicide Prevention Lifeline

Approaches to Assessing Suicide Risk

Clearly, the process of assessing suicide risk involves more than completing a simple questionnaire with the patient.

Be collaborative, confident and compassionate. The Zero Suicide initiative emphasizes that screening and assessment of suicide risk must attend to more than just the instrument being used or the questions being asked. The qualified health care professional (QHCP) conducting a clinical interview is encouraged to:

- Adopt a collaborative stance, reflecting empathy and genuineness.
- Convey confidence that pain can be alleviated by alternative means and that the patient can be empowered to use care and services to do so.
- Treat the interview as an exploration of what has happened to the patient, not as a task to complete or an examination of what is wrong with the patient.
- Indicate that when people move beyond a suicidal crisis or attempt, they typically find ways to engage in their lives. More than 90% of people who make a suicide attempt do not die by suicide even upon long-term follow-up.
- Express an understanding of the ambivalence in the patient's desire to die to relieve pain.

Ensure reasonable privacy and confidentiality during the screening and assessment processes. Experience has demonstrated that it is not unusual for an otherwise suicidal inmate to deny suicidal ideation when questioned in a physical environment that lacks privacy and confidentiality. The intake or reception area of any jail or prison is traditionally chaotic and noisy, an environment where staff feel pressure to process a high number of inmates in a short period of time. Two key ingredients for identifying suicidal behavior—time and privacy—are at a minimum. The ability to carefully assess the potential for suicide by asking the inmate a series of questions, interpreting their response

(including gauging the truthfulness of their denial of suicide risk), and observing their behavior is grossly compromised by an impersonal environment that lends itself to something quite the opposite.

Efforts should be made to ensure privacy and confidentiality (from other inmates and non-health care personnel) when conducting suicide risk screening and assessments.

Maximize rapport and self-disclosure. In *The Practical Art of Suicide Prevention*, C.S. Shea identified the following approaches to help establish rapport and encourage self-disclosure on the part of the patient:

- Ask for specific descriptions of behavioral incidents, not the patient's opinions.
- Avoid judgmental or shame-inducing questions by framing questions in a manner that is consistent with the patient's experience.
- Assume the existence of suicidal impulses and ask about them directly, in a matter-of-fact tone.
- Frame questions regarding frequency of behavior and ideation in a manner that may overestimate their true frequency, so that the patient will respond with a more accurate estimation of their frequency, rather than minimizing them.
- Avoid blanket questions. Instead, ask about specific types of suicidal behavior and ideation separately.

But don't rely solely on self-report. It is extremely important for a QHCP to balance patient self-report with the collection of objective data related to the patient's suicide risk using all information available to them. Whenever possible, previous treatment information should be reviewed, along with objective data from staff observations and incident reports, and direct observation of the patient during the clinical interview. Include family members, if possible, as people may convey their distress more directly to family.

Include discussion of coping strategies and other protective factors during the assessment interview. A critical ingredient to the suicide risk assessment process (as well as clinical rationale for discharging the patient from suicide precautions) is the development of a safety plan. A safety plan includes warning signs, ways the person can distract themselves, who they can be with to distract themselves, people they can discuss their distress with, professionals and how to contact them, how to limit access to lethal means, and reasons for living. While this is an intervention, the development of the plan provides a wealth of information to support the assessment. A suicidal crisis is not a good time to develop a plan.

The Suicide Prevention Resource Guide

The National Commission on Correctional Health Care and the American Foundation for Suicide Prevention have teamed up to create an authoritative guide to preventing inmate suicide in jails and prisons.

Based on both organizations' expertise, with input from national experts in the field of correctional mental health and suicide prevention, this resource provides a road map for navigating the complexities of suicide prevention behind bars—and can help save lives. Sections address the following topics:

- Suicide risk assessment principles
- Approaches to intervention and treatment
- Training curriculum guide
- Real-life case studies
- Facility design considerations

This article abridges the section on suicide risk assessment. The guide is available as a free download at www.ncchc.org/suicide-prevention-plan.

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One helpful instrument is the Reasons for Living Inventory, which assesses life-maintaining beliefs. Areas of potential inquiry include the patient's:

- In-cell activities
- Distress tolerance skills
- Emotion regulation skills
- Long-term goal orientation
- Relationships with cellmates or others on the tier
- Relationships with supports in the community
- Ability to ward off suicidal/self-injurious impulses
- Ability to ask for help
- How the patient has handled similar situations in the past

Conduct comprehensive training for health and custody staff. All staff members who work with inmates should receive both initial and recurring suicide prevention training that includes, but is not limited to, the following topics: avoiding negative attitudes to suicide prevention, why correctional environments are conducive to suicidal behavior, risk factors to suicide, high-risk suicide periods, warning signs and symptoms (verbal and behavioral cues) and identifying suicidal inmates despite the denial of risk.

Provide adequate staffing. Many correctional facilities function with staff vacancies. Shortages in mental health staffing do not support thoughtful, attentive, and comprehensive suicide risk assessments. Instead, cursory screenings may be conducted just to ensure that at least some evaluation of risk is completed. Vacancies in custody staff can result in systemic and dangerous barriers to patients' access to care.

Without sufficient staff, the risk for inmate suicide will remain high in correctional settings, exacerbated by inmate isolation, lack of access to mental health staff, and decreased monitoring by custody staff.

Take time to establish rapport and trust. Conversations about suicidal thoughts, despair, and hopelessness are difficult even in the best therapeutic contexts. Correctional settings are far from therapeutic and are challenging with respect to privacy and confidentiality. Effective suicide risk assessment requires that the assessment be conducted in a private and confidential setting, not cell-front.

Health staff can feel pressure to be efficient and may feel rushed to complete an assessment rather than to connect with a patient experiencing distress. Despite good intentions, health staff may "signal" to the patient that there is insufficient time to dive in to his or her experience. Suicidal individuals can be sensitive to these dynamics and shut down in the midst of an assessment.

Communicate with family members and supports, especially when they convey concern. It is important for any incarcerated individual at risk for suicide to be able to access social supports. Early on in the evaluation of these patients, it is important to work with them to identify individuals who can be relied upon for support. Whenever possible, health care staff should obtain releases of information to be able to contact family and friends to discuss patient needs.

Open communication allows for the patient to experi-

ence support from multiple relationships. It also allows for health care staff to alert family and friends to high-risk times, warning signs and other factors that may be identified by those social supports but may not be shared with clinical staff. Family and friends should be encouraged to contact facility staff whenever they have concerns.

Balance safety and autonomy. Most models of health care and wellness share the foundational assumption that patient health is maximized when patients are autonomous, engaged, and able to make informed decisions about their care. In correctional settings, health staff must balance support for patient autonomy with support for patient (and often institutional) safety. Often there are two choices for patients experiencing suicidal thoughts: return to general population with a plan for follow-up, or be placed in a single cell under observation on suicide watch. Both options are far from ideal.

Typically, suicide watch is highly restrictive and very uncomfortable. Patients are placed alone in a cell, clothed in a tear-proof smock, with a tear-proof mat, and observed continuously by another individual. Finger food is provided without utensils.

While that approach can often support safety, it removes the patient's ability to develop or practice the skills necessary to cope with distress. For many patients, it intensifies feelings of shame, triggers traumatic memories, increases feelings of hopelessness, and erodes therapeutic connections with health staff. The underlying message is that the patient is incapable of keeping safe. Understandably, patients may be hesitant to reveal suicidal thoughts when they know the result of doing so.

Decisions about whether or not to place a patient on "suicide watch" need to be made based on a thorough evaluation of risks, protective factors, contexts, and patient characteristics. There is no one formula that will work for every patient. Qualified health care professionals need to weigh all factors to determine how best to support patient safety while also providing care in the least restrictive environment possible to maintain that safety.

Conduct suicide reviews/psychological autopsies under protection from litigation. In some facilities, clinical mortality reviews and psychological autopsies—critical quality improvement processes—can be hindered or diluted by litigation fears.

In NCCHC's 2018 *Standards for Health Services* for jails and prisons, standard A-09 Procedure in the Event of an Inmate Death requires the following:

- A clinical mortality review is conducted within 30 days
- An administrative review is conducted in conjunction with custody staff
- A psychological autopsy is performed on all deaths by suicide within 30 days

The purpose of these reviews is "to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study." The intent is to improve care and prevent future deaths.

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EOE

A Nurse Practitioner Can Add Value to Your Correctional Medical Team

by Jennifer Clifton, DNP, FNP-BC, CCHP, Chase Roberts, MBA, CCHP, Leissa Roberts, DNP, CNM, & Tom Rowley, DNP, FNP-BC

This article is the second of a three-part series on NPs.

The United States has 270,000 nurse practitioners and that number is growing. NPs are vital to our health care system and are key providers of accessible, evidence-based care. NPs can be found in a variety of settings, with 73% delivering primary care in outpatient

settings, according to the American Association of Nurse Practitioners. AANP estimates that 1% of all NPs, about 2,700, provide care within correctional systems.

As correctional system health administrators seek to provide value without sacrificing quality, the number of correctional NPs will increase. This article will help correctional administrators

to understand the education and certification processes that NPs undergo to ensure quality care for patients.

NP Education Explained

To become an NP, one must first earn a bachelor's degree in nursing and then earn either a master's or a doctoral degree. After a degree is conferred, the individual must pass a national certification exam with a specific practice focus and obtain a state advanced practice registered nurse license. The APRN license encompasses NPs along with clinical nurse specialists, certified nurse midwives and nurse anesthetists.

To provide uniformity and expertise in NP education throughout the United States, national standards require that every educational program be accredited by one of the major nursing education accrediting bodies. Only graduates from an accredited program are eligible to sit for national board certification. For an educational system to be accredited, specific essentials must be met in the curriculum.

In the publication *Health Professions Education: A Bridge to Quality*, the Institute of Medicine listed a set of core competencies that all health professionals, regardless of discipline, should demonstrate:

1. The provision of patient-centered care
2. Working in interprofessional teams
3. Employing evidence-based practice
4. Applying quality improvement approaches
5. Using informatics

Each of the IOM core competencies is addressed within both the master's and doctoral education described in the American Association of Colleges of Nursing *Essentials*, aimed at meeting the needs of the patient and those of the 21st century United States health system.

In addition to curriculum, accrediting bodies sets standards for program admission, faculty credentials and clinical sites. NP programs are practice-focused and designed to prepare experts in advanced nursing practice in specialized fields such as family, pediatrics, obstetrics, geriatrics, acute care and psychiatry. NP education is based on achievement of competency rather than a specified duration of time. Students must demonstrate integration of the knowledge and skills required to provide safe patient care.

Upon graduation from an accredited program, the NP must meet eligibility requirements to take a board certification examination. Exams are competency-based and provide a valid and reliable assessment of the entry-level clinical knowledge and skills of nurse practitioners. State licensure requires both a degree from an accredited educational program and national certification. Licensure is generally governed by state nursing boards. State boards establish education and certification criteria to assure the public and employers that licensed individuals are competent to provide care.

NPs Add Value in Correctional Health Care

In *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine made many recommendations for an action-oriented design for the future of nursing and nursing education. First among the key messages: "Nurses should practice to the full extent of their education and training." This means "eliminating barriers such as structural flaws in the U.S. health care system, (and) limitations in the present work environment.... Regulatory barriers are particularly problematic." Nurse practitioners, with their doctorate or master's-level education, play significant roles in implementing this vision.

NPs are educated to practice well beyond direct patient care. Corrections offers multiple opportunities for NPs to practice "to the full extent of their education."

- With an educational background in systems leadership and quality improvement, NPs can lead organizational teams conducting needs assessments and quality improvement projects.
- Given their education in health policy and advocacy, NPs can collaborate with elected officials and correctional administrators to speak for the health needs of their clients.
- NPs are educated to manage both individual patient and population health, allowing them to work closely with state and local health departments to manage infectious disease trends.
- NPs are educated to be innovators and critical thinkers and can be involved in all aspects of health care, from planning disaster drills to designing clinics and managing patient health care.

Nurse practitioners can add significant value to a correctional health care system. Value is particularly important when operating a tight medical budget. The University of Utah identifies value with the following equation. This



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equation can be applied to NPs to gauge the value of their services in a health care delivery system.

$$\text{Value} = \frac{\text{Quality} + \text{Service}}{\text{Cost}}$$

University of Utah Health

- **Quality:** Researchers who published a Cochrane Data Base Systematic Review stated, "The quality of care provided by advanced practice registered nurses was as high as that of the physicians." (Laurant et al., 2006)

- **Service:** In a 2004 study comparing the patient outcomes of NPs and physicians, the researchers concluded, "No differences were identified in health status, physiologic measures, satisfaction or use of specialist, emergency room or inpatient services." (Lenz et al.)

- **Cost:** An NP's average annual wage is \$107,030 (\$51.46/hour); for a family practice physician it is \$201,100 (\$96.68/hour), according to Bureau of Labor Statistics data published in 2018.

In summary, NPs are educated to provide high-quality individual and population health care and can easily be employed in correctional systems at a cost in line with realistic operating budgets. Health care administrators in correctional systems should consider the use of NPs as part of their provider workforce to provide value and quality care in a system that demands maximizing resources.

ION KEY MESSAGES

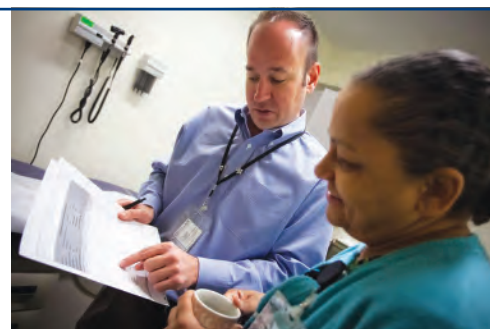
- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States.
- Effective workforce planning and policy making require better data collection and an improved information infrastructure.

Institute of Medicine. (2010). The Future of Nursing: Leading Change, Advancing Health.

The authors are affiliated with the University of Utah College of Nursing. Jennifer Clifton, DNP, FNP-BC, CCHP, is a clinical director and associate professor; Chase Roberts, MBA, CCHP, is outpatient clinic manager/juvenile justice services contract; Leissa Roberts, DNP, CNM, is a professor and associate dean of faculty practice; and Tom Rowley, DNP, FNP-BC, is an assistant professor. Clifton also serves on the NCCHC board of directors as liaison of the American Association of Nurse Practitioners and is a member of the juvenile health committee.

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Common Psychotropic Medication Classes: A Refresher

by Nicole Walker, MSN, RN, CCHP

Correctional settings are home to more individuals diagnosed with mental illness than are inpatient psychiatric facilities in the United States. Therefore, correctional health professionals must possess knowledge of psychotropic medications. This article will review the five classes of psychotropic medications, indications for use and common side effects.

Psychotropic medications are used to treat symptoms of mental and psychiatric disorders. Common examples are anxiety, depression, schizophrenia, bipolar disorder and attention-deficit/hyperactivity disorder. These medications work by increasing the amount of neurotransmitters in the brain. It is important to note that psychotropic medication will not cure the disorder, but it may assist the patient in managing it.

Antidepressants

Antidepressants are primarily used to treat depression. They may also be used to treat symptoms of anxiety disorders such as post-traumatic stress disorder, generalized anxiety disorder, panic disorder and social phobias. The common classes of medications are selective serotonin reuptake inhibitors, serotonin/norepinephrine reuptake inhibitors, monoamine oxidase inhibitors and tricyclic antidepressants.

Common symptoms for which antidepressants may be prescribed are persistent feelings of sadness and hopelessness, loss of interest or pleasure in activities, mood swings, disruption in sleep patterns and thoughts of suicide or self-harm. Common side effects are dry mouth, nausea and vomiting, diarrhea, weight gain or loss, sleep disturbances and sexual dysfunction.

MAOIs and tricyclics have not been commonly prescribed for depression since the discovery of SSRIs and SNRIs, and they are associated with more side effects than their counterparts.

Anxiolytics

Anxiolytics are used to treat anxiety disorders and as a bridge to control anxiety while patients are starting an antidepressant. Common anxiety disorders are obsessive-compulsive disorder, PTSD, generalized anxiety disorder and social anxiety disorders. The most common class of anxiolytics is benzodiazepines. Beta blockers may also be prescribed to help control the symptoms of anxiety.

Common symptoms in anxiety disorders are rapid heart-beat, trembling, sweating and overwhelming feelings of fear. Common side effects are fatigue, trouble sleeping, light-headedness, nausea and vomiting, headache and confusion. Anxiolytics carry the risk of dependence and addiction.

Antipsychotics

Antipsychotic medications are used to treat schizophrenia, schizoaffective disorder, schizophreniform disorder, delu-

sional disorders and substance abuse-induced psychosis.

The two classes of antipsychotic medications are typical and atypical. The typical antipsychotics were developed first and include chlorpromazine, haloperidol, perphenazine and fluphenazine. Examples of atypical antipsychotics are risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole and paliperidone.

Psychotic disorders are characterized by abnormal thought processes and perceptions; hallucinations are a common presenting symptom. Common side effects of typical antipsychotics are dry mouth, tremors, bradykinesia, akathisia, dystonia, orthostatic hypotension, tardive dyskinesia (may be permanent) and neuroleptic malignant syndrome (life threatening and requires immediate intervention). With atypical antipsychotics, side effects include weight gain, lipid abnormalities, hyperglycemia and potential development of diabetes mellitus.

Mood Stabilizers

Mood stabilizers are typically used to treat bipolar disorder. They may also be used as an adjunct therapy to augment the therapeutic effects of medications used to treat depression. Lithium was the first mood stabilizer approved by the Food and Drug Administration. Anticonvulsant medications may also be used as mood stabilizers. Common anticonvulsants are valproic acid, carbamazepine, lamotrigine, topiramate, olanzapine and aripiprazole. When lithium is prescribed, a special consideration is that it has a narrow therapeutic window and blood levels of the drug need to be monitored regularly.

Common side effects of mood stabilizers are thirst, polyuria, weight gain, tremor, nausea, vomiting, slurred speech, blackouts and itching. Stevens-Johnson Syndrome, characterized by the formation of a rash, is a life-threatening side effect. Patients who develop a rash need immediate medical evaluation and treatment. Mood stabilizers are contraindicated in pregnancy.

Stimulants

Stimulants are commonly used to treat ADHD. ADHD can occur in both children and adults. Stimulants help patients to focus by increasing alertness, attention and energy. Common stimulants are methylphenidate, amphetamine and dextroamphetamine. Atomoxetine is a nonstimulant medication used to treat ADHD.

Common side effects of stimulants are loss of appetite, stomach pain, headache, tics and difficulty falling asleep. Stimulant medications increase heart rate, respiratory rate and blood pressure. Therefore, patients with a history of heart disease need to be monitored closely and may be at risk for sudden death.

Nicole Walker, MSN, RN, CCHP, is the nurse educator/supervisor at Taycheedah Correctional Institution, Fond Du Lac, WI.

Practice resources for reference are the National Institute of Mental Health website, drug reference books and correctional health textbooks

Position Statement Calls for Equitable Health Care Funding for Incarcerated Youth

The following position statement was adopted by the NCCHC board of directors on Oct. 13. It is the latest revision of a statement that was first adopted in 1993. For more guidance from NCCHC, see www.ncchc.org/position.statements.

"Adolescents involved in the juvenile justice system represent a unique pediatric patient population, often hidden from public view. For a multitude of reasons including socioeconomic disparities and poor access to health care, these children have a disproportionate number of physical and mental health needs. Many of these conditions are first identified upon entering the juvenile justice system, addressed while youth are incarcerated, and require continued care long after release."

— Gergelis, K., Kole, J., & Lowenhaupt, E. (2016). *Health care needs of incarcerated adolescents*. Rhode Island Medical Journal, 99(9), 24-26.

Health Insurance in Juvenile Detention and Confinement Facilities

When youth incarcerated in juvenile detention and confinement facilities return to their communities, it is important that they receive support to help them live productive and healthy lives. This support includes needed health care services, such as early diagnosis and treatment for communicable and chronic diseases. The likelihood that needed health care will be provided is contingent upon the availability of funding for these services. Justice-involved youth who are placed in foster homes, private residential facilities, or group homes remain eligible for Medicaid, ensuring that the federal and local governments share in the cost of required health care.

However, federal regulations disallow any federal reimbursement for health services to incarcerated individuals, including youth. Instead, local governments (e.g., states, counties, cities) are responsible for financing needed health care, which often results in inequities in the quality of care available to youth. Justice-involved youth housed in public facilities are disproportionately poor, minority, and from socially disadvantaged families. Medicaid may be the only source of insurance coverage while in the community. Eligibility is lost while detained and often difficult to initiate or reinstate upon release.

The Affordable Care Act (ACA) expands insurance coverage, providing opportunities for many youth in correctional settings. The ACA led to the expansion of Medicaid in many states, establishment of health insurance exchanges with subsidies for low-income families, coverage under parents' insurance to age 26, and removal of exclusions for pre-existing conditions. Pediatric dental coverage is an ACA Essential Health Benefit that must be offered to families buying health insurance in the state- and federally-facilitated marketplaces. Most youth and their parents/guardians require assistance in enrolling in these programs.

Position Statement

America's future depends on the health of all of our children. Incarcerated youth represent an especially vulnerable population at high risk for illness and disability. Early diagnosis and treatment and continuity of care are essential. All of America's youth deserve the opportunity for equal access to health care regardless of placement in public or private facilities.

NCCHC supports equality in access and funding for health care and recommends that all youth in public and private confinement and detention facilities remain eligible for all public (e.g., Medicaid) and private health care coverage consistent with state and local eligibility requirements. NCCHC advocates that youth apply for insurance enrollment and participate in prerelease coordination of care to ensure continuity of care upon release into the community. NCCHC also recommends that states suspend rather than terminate Medicaid insurance following detention in order to facilitate quick reactivation upon release.

Revised OTP Standards Will Offer New Options for Treatment Delivery

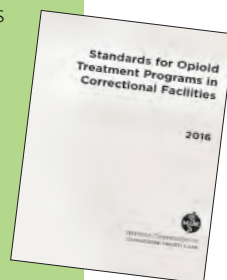
A task force has been formed to update NCCHC's *Standards for Opioid Treatment Programs in Correctional Facilities*. A primary focus is to bring the OTP standards into alignment with the 2018 editions of the *Standards for Health Services for jails and prisons*.

An important change is that the standards will now provide the option to operate a medication-assisted treatment program in cooperation with substance abuse treatment providers in the community. Traditionally, many corrections-based programs to treat opioid use disorder were not recognized as MAT programs because they transported the patient to an outside clinic. Now, these programs will be eligible to pursue OTP accreditation from NCCHC.

These efforts have the support of our partners at the Substance Abuse and Mental Health Services Administration, which has commended NCCHC for its plan to offer standards and accreditation for the two models of treatment delivery.

The task force is made up of experts in the fields of correctional health care, mental health care and substance abuse disorders. Its members include physicians, nurses, qualified mental health professionals, health services administrators, attorneys and substance abuse treatment professionals.

"The revised standards will greatly aid correctional facilities in developing and operating effective and efficient programs, whether the treatment is provided inside the facility or at an external site," says NCCHC CEO Deborah Ross. The 2020 *OTP Standards* should be available in April.



2019 Award Winners Shine at the NCCHC National Conference

NCCHC's annual awards pay tribute to leaders and innovators that have enriched the correctional health care field. We applaud this year's recipients of the most prestigious awards in this field. The awards were presented Oct. 14 during the opening ceremony of the National Conference on Correctional Health Care in Fort Lauderdale.

Bernard P. Harrison Award of Merit

NCCHC's highest honor, this award is presented to an individual or group that has demonstrated excellence and service that has advanced the correctional health care field, either through an individual project or a history of service. The award is named after NCCHC's cofounder and first president.



Dr. Roush receives congratulations from NCCHC's CEO, Deborah Ross

David W. Roush, PhD, LPC

In a 45-year career dedicated to juvenile justice, Dr. David Roush has worn many hats; directed many programs; published countless works; taught, trained, counseled, consulted and mentored—all in the service of youth

who find themselves in serious trouble. A nationally recognized expert and leader in his field, Dr. Roush has earned high accolades for his innovative programs to treat juvenile offenders and to prepare them for successful reentry to their home communities. His experience includes projects in more than 250 juvenile detention and corrections institutions in 49 states.

Currently Dr. Roush is an adjunct specialist in juvenile justice at Michigan State University's School of Criminal Justice. He recently retired after 10 years as a compliance monitor for the Civil Rights Division of the U.S. Department of Justice. He was an NCCHC board member from 1991 to 2019, providing wise counsel about trends and major shifts in juvenile corrections. He served continuously on the board's juvenile health committee, with terms on the executive and finance committees and one term (2000-2001) as chair. His expertise has proven invaluable in the periodic updates of NCCHC's *Standards* for juvenile facilities.



B. Jaye Anno Award of Excellence in Communication

This award pays tribute to innovative, well-executed communications that have had a positive impact on the field of correctional health care, or to individuals for bodies of work. It is named after NCCHC's cofounder and first vice president.

Marc F. Stern, MD, MPH

Over the course of his career, Dr. Marc Stern has been a hands-on practitioner, high-level administrator, researcher and consultant. The thread running through his diverse activities is teaching. From the time he received a bachelor's degree in biology in 1975, he has continually coached and inspired others to expand their knowledge and skills. He's had university faculty appointments from 1982 to present day, and now travels between New York and Washington State to teach budding public health professionals.

In the arena of correctional health care, Dr. Stern is well known for his lectures and workshops, including many at NCCHC educational events. He also serves on conference planning committees for NCCHC and other groups. Putting ideas to paper, his byline appears on dozens of published works. He has long served as an editorial board member for the *Journal of Correctional Health Care*, the *American Journal of Public Health*, the *Journal for Evidence-Based Practice in Correctional Health* and others.

In all of these endeavors—regardless of the specific topic—Dr. Stern's fundamental focus is on quality: evidence-based care, process improvement and optimal outcomes for the patient.



NCCHC Young Professional

This award recognizes new and upcoming leaders in the correctional health care field. It is presented to an outstanding correctional health professional, 45 years of age or under, who leads by example, takes initiative, demonstrates a strong work ethic and inspires others through his or her commitment to quality health care.



Leonora Muhammad, DNP, APRN, CCHP

Having grown up in a rough neighborhood, Leonora Muhammad started her career in nursing to make a better life. While she never expected to find her passion in corrections, she

was inspired by the opportunity to help others with similar backgrounds whose outcomes were decidedly less positive.

Her commitment to clinical excellence eventually found its outlet in her success as senior director of quality improvement and patient safety for Corizon Health. Her mission is no-nonsense: “decreasing and eliminating risk for our clients and customers is the No. 1 priority.”

Dr. Muhammad realized early that her own education was critical to patient care. She started her career as an LPN and eventually earned a doctorate in nursing practice.

Elected to the CCHP board of trustees in 2018, Dr. Muhammad is dedicated to making sure that CCHP exams measure real knowledge and skills by contributing high-quality questions. For Dr. Muhammad, the CCHP exam means “understanding how to apply a given question to real-life scenarios that we face every day.”

Her nomination for the Young Professional award notes her leadership, strong work ethic and professionalism as the foundation of her ability to make an impact for years to come.

R. Scott Chavez Facility of the Year

This award is presented to one facility selected from among nearly 500 jails, prisons and juvenile facilities accredited by NCCHC. It is named after NCCHC’s longtime vice president.

Farmington (MO) Correctional Center

A tight-knit multidisciplinary team and an exemplary focus on quality patient care are hallmarks of the health care delivery system at Farmington Correctional Center, one of the largest prisons in the state of Missouri.

The health services department, serving a medium-security male population with an average daily population of approximately 2,700, includes a medical clinic, six-bed infirmary, mental health offices and dental operator.

The facility runs many programs for substance abuse and sex offender treatment, as well as several units housing mentally ill patients from the state system. Security staff assigned to these units receive special training to help them meet the needs of these often-challenging patients.

Communication is key to Farmington’s smooth operations. The health services administrator and director of nursing wear headsets much of the day to readily answer calls from facility staff and inmates’ families. Their quick responses reduce frustration and build trust.

The surveyor who nominated Farmington Correctional Center noted the dedication, professionalism and training as the foundation of the exemplary patient care provided at the facility.



Representatives from Farmington Correctional Center on stage

NCCHC Program of the Year

This award recognizes programs of excellence among thousands provided by accredited jails, prisons and juvenile facilities.

Cook County Juvenile Temporary Detention Center – Ambassador Program

Cook County’s JTDC provides temporary secure housing for nearly 3,200 court-involved youth, ages 12-21, who would otherwise be incarcerated in the county jail. Mostly young men, they are awaiting adjudication of their cases or have been transferred from criminal court jurisdiction.

After letting longtime NCCHC accreditation slip, re-earning accreditation in 2012 became an important indicator of court-ordered reforms at the facility. Today, health care—provided by Cermak Health Services—is “one of the jewels in the detention center operations,” according to the nominator. The quality of health care is mirrored in the many innovative services, resources and programs designed to provide education, life and job skills the young people need to successfully return to, and remain in, their communities as productive citizens.

The Ambassador Program hand-picks detainees to act as role models for others and tour guides for visitors to the facility, including NCCHC accreditation surveyors. Dressed in gold sports coats, the Ambassadors explained to the surveyors how detained youth access medical and mental health care, the sick call process, med pass and grievance procedures. Through this program, the youth gain self-esteem and valuable experience that will serve them well upon return to the community.

Surveyor of the Year

This award was created in 2019 to recognize a surveyor who is an exemplary representative of NCCHC and demonstrates extraordinary dedication.

Elizabeth Piatek, CCHP

For 23 years, Liz Piatek has been the behind-the-scenes powerhouse of the NCCHC accreditation program, scheduling and coordinating thousands of survey teams over the years. This requires mastery of spreadsheets, exceptional communication skills, grace under pressure and enormous patience with the endless scheduling tweaks that inevitably arise.

Ms. Piatek is also in charge of recruiting and orienting surveyors, and through her close work with each of them, she has detailed knowledge of myriad facts about them, their individual areas of expertise, their travel preferences and more. And the surveyors love her as a trusted colleague. As one of them noted about Ms. Piatek, well known for her menagerie of pets, “Liz takes care of and cares about us just about as much as her precious puppies.”



Representatives from the Cook County JTDC display their award



Liz Piatek (center) enjoys a moment with two longtime lead surveyors, Janice Hill and Jim Voisard



Sue Smith (R) with Sue Lane (L), Academy chair

Academy Launches the Margaret Collatt Service Award

The Academy of Correctional Health Professionals conferred the inaugural Margaret Collatt Service Award at its annual meeting on Oct. 15, in conjunction with the NCCHC National Conference on Correctional Health Care in Fort Lauderdale. The award recognizes an Academy member who has made exceptional contributions to correctional health care through service to professional education and training within the field.

The recipient was Sue Smith, MSN, RN, CCHP-RN, an avid nurse mentor. Smith served as staff nurse, nurse administrator and nurse educator for 20 years at the Ohio Department of Rehabilitation and Correction before retiring and establishing a consulting business, Instructional Connections. Among Smith's many professional activities are five years of service as NCCHC's lead nurse planner for continuing nurse education; membership on NCCHC's education committee; frequent presentations at conferences; and contributions to *Essentials of Correctional Nursing*, the ANA's *Correctional Nursing: Scope and Standards of Practice*, *CorrectCare* and other publications.

The award is named after a longtime training and development specialist for the Oregon Department of Corrections who was involved with the Academy for many years, including service on its board of directors.

Nurses Join Forces to Form New Association

Plans to form a membership group for correctional nurses took a big step forward at NCCHC's National Conference. On Oct. 15, approximately 50 nurses attended a two-hour meeting of the fledgling American Correctional Nurses Association to discuss key matters. Topics included the reasons for creating such a group, mission and vision statements, membership strategies, proposed activities, professional development opportunities and more.

Many participants said that a membership group to recognize, validate and promote the specialty is "long overdue." They also pointed to the support that such an association would provide. "When I started my job, I looked for my professional organization and there wasn't one. I need the support and connection to other nurses," one participant said.

One outcome of the meeting was the designation of a "vision team" to provide temporary leadership as the structural components are established. The team members are Annette Maruca, PhD, CCHP, Mary Muse, MSN, RN, CCHP-RN, CCHP-A, Louise Reagan, PhD, ANP, Deborah Shelton, PhD, RN-C, CCHP, and Sue Smith, MSN, RN, CCHP-RN, who were part of the initial discussions in 2018, joined by Patricia Blair, JD, PhD, CCHP-RN, CCHP-A, Lori Roscoe, DNP, APRN, CCHP-RN, and Ramesh Upadhyaya, MSN, MBA, CCHP.

For now, meetings are virtual, with the next one planned for mid-January. For more information, write to Shelton at sheltonconsultingservices@gmail.com or join the "nurses" discussion group at NCCHC Connect.

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Suicide Risk Assessment (continued from page 8)

However, the litigiousness surrounding inmate deaths and the media attention those lawsuits attract can create a degree of hesitancy about fully discussing and documenting the specifics of an inmate suicide. Fear of litigation might make full transparency seem like a liability and legal risk rather than a quality improvement opportunity. To fully examine the event and understand where improvements are needed, staff must be able to study events in an open and transparent way.

Guidance may be needed on how to conduct thoughtful, relevant, and transparent reviews that inform quality improvement and procedural changes without putting the correctional system at undue risk for liability and litigation.

Collect and share data on suicide. Sharing suicide data among facilities is essential to the field's increased understanding of this complex behavior and the unique risks and protective factors specific to incarcerated and justice-involved populations.

Download the complete *Suicide Prevention Resource Guide* at www.ncchc.org/suicide-prevention-plan.

Trustee Sue Lane Models Leadership

by Matisa Sammons, MA, CCHP

The latest candidate to win a seat on the CCHP board of trustees through election by her peers is B. Sue Medley-Lane, RN, CCHP-A.

Lane is the corporate infection prevention and control coordinator for Centurion. In this role, she updates and monitors all infection control policies, procedures and manuals for the company's clients; tracks exposures and outbreaks; and develops and delivers staff training.

Lane has worked in correctional health care for 22 years, but infection control has been a mainstay of her career for 30 years. She has experience working in just about every setting possible as a nurse: medical office, hospital med-surg, mental health, postanesthesia recovery, critical care, trauma, labor and delivery, and even home health care—all before joining the correctional world.

But in 1997, she received a call from a friend who was the director of nursing in a large metropolitan jail and needed her help. In true Sue Lane fashion, she readily agreed to lend a hand—and she has never looked back.

Combining Her Passions

The breadth of Lane's experience and skills in the community translated well into the correctional environment where health professionals wear many hats. For many years now, she has been able to combine the two things that she is most passionate about on a professional level: correctional health care and infection control.

Lane's passion for her work is a reflection of her concern for the underserved individuals in society. She finds inspira-

tion in being a vocal advocate of patients. "It is important that we remember our patients are from our communities and we need to be responsible and proactive in the care and treatment for all," she says.

Commitment and Giving Back

A strong commitment to professional growth is a natural extension of Lane's work ethic. She has felt compelled to seek certification in any field of practice or specialty she has worked in. "Choosing to practice in a nursing specialty is an important decision," she explains. "You must be willing to commit your time and resources to become the best you can be." Of CCHP certification, she adds that it goes beyond knowledge of the NCCHC standards: "By attaining your CCHP, you demonstrate your competency and commitment to your specialty."

When it comes to her personal life, Lane says family comes first, and she also enjoys cooking and photography. She also believes in volunteering and giving back to the community. Lane has volunteered for more than 17 years with the Amateur Athletic Union karate youth team. She also speaks to various groups in her community about correctional health care and infection control.

Lane also serves as chair of the Academy of Correctional Health Professionals. She believes it is important to educate and support professionals new to the field and give them the guidance and opportunity to become leaders. "My goal in life is to make a difference," she says, "help where I can and be a voice for education, improvement and change."

Matisa Sammons, MA, CCHP, is vice president of certification for NCCHC. To learn more about certification, visit www.ncchc.org/cchp.

Kudos to trustee Leonora Muhammad on receiving the 2019 Young Professional award! (See page 14.)



Celebration of the CCHP-Advanced program's 25th anniversary was a big deal at the National Conference on Correctional Health Care, with all sorts of special activities. In this photo, CCHP-As are enjoying a dinner outing together.



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Attendee Profile, 2019

Nurse
Nurse practitioner
Physician/physician assistant
Administrator
Psychiatrist/psychologist
Social workers/therapist
Other

Attendee Workplace

Jail facility
Prison facility
State DOC/agency
Private corporation
Federal agency
Juvenile detention or confinement facility
Other

34% • Contract management
27% • Dialysis services
20% • Education and training
14% • Emergency preparedness
10% • Health care staffing
8% • Information technology
10% • Medical devices, equipment
• Mental health services
• Pharmaceuticals
36% • Publications
19% • Substance abuse services
12% • Treatment programs
12%
6%
5%
6%

Categories of Interest

• Dental care and supplies
• Disaster planning
• Electronic health records
• Health care management
• Infection control
• Laboratory services
• Medical supplies
• Optometry services
• Pharmacy services
• Safety equipment
• Suicide prevention
• Uniforms/scrubs

Exhibitor Benefits

NCCHC will conduct a comprehensive marketing campaign that includes email broadcasts, direct mail, social media, online banners and direct outreach.

- Three days of dedicated, expo-only activities
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- CCHP lounge host
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- Wi-Fi
- Relax & Recharge Lounge
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- Educational programming
- Wellness center
- Ice cream social
- Photo booth
- Conference bags
- Twitter wall
- Exhibit hall aisle sign
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MARKETPLACE

Standards for Opioid Treatment Programs

These standards present the requirements for OTPs seeking NCCHC accreditation and adhere to SAMHSA 2015 guidelines for OTPs. The standards address patient care and treat-

ment, clinical records, governance and administration, personnel and legal issues, with consideration for issues unique to correctional settings. 2016. Softcover, 141 pp. \$69.95. Order at www.ncchc.org/ncchc-store or 773-880-1460.

About CorrectCare®

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

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

Advertising: Contact us at sales@ncchc.org or call 773-880-1460, ext. 298.

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Expert Advice on NCCHC Standards

by Jim Martin, MPSA, CCHP

Mental Health Training for Detention Staff

Q *Our jail wants to strengthen its mental health program. The health staff are well trained in mental health and coexisting disorders, but we need to increase the training for detention staff. Do you have any recommendations?*

A Congratulations on striving for excellence in your mental health program. In the *Standards for Mental Health Services in Correctional Facilities*, MH-C-04 Mental Health Training for Correctional Officers requires that all officers who work with inmates receive mental health-related training at least annually. At a minimum, this includes recognizing signs and symptoms of mental illness, substance abuse and intellectual and developmental disabilities; communicating with inmates who have signs of mental illness, substance abuse and intellectual and developmental disabilities; procedures for suicide prevention and intervention; and procedures for referral of inmates with mental health complaints or suicidal behaviors to mental health staff.

Officers assigned to receiving screening and mental health areas are to receive additional training from mental health staff in order to fulfill their specific roles. Where appropriate, correctional staff should receive training on the dynamics of sexual abuse and sexual harassment in confinement, psychological reactions to sexual abuse/harassment and how to detect and respond to the psychological signs of threatened and actual sexual abuse.

CO Shortage Effect on Patient Care

Q *Our prison has a shortage of custody staff right now. As a result, inmates sometimes miss their on-site clinic appointments for annual assessments. Since we can document that the patients were scheduled for the assessment, would this meet the standard?*

A This problem could affect two standards. P-A-01 Access to Care requires that the responsible health authority identify and eliminate any unreasonable barriers, intentional and unintentional, to inmates receiving health care. P-D-06 Patient Escort states in compliance indicator #1 that patients are transported safely and in a timely manner for medical, dental and mental health clinic appointments inside and outside the facility. Compliance with these standards could be compromised if custody is not transporting patients to the clinic in a timely fashion. Custody staff shortage is not an acceptable justification for missing appointments.

Sharing Results From Off-Site Clinics

Q *We understand the importance of informing patients of test results, but we are having difficulty receiving test results from off-site clinics, particularly the HIV clinic. We receive results only if something is abnormal. Is it acceptable to document this and note any abnormal findings that we receive back from the clinics?*

A In standard E-09 Continuity, Coordination, and Quality of Care During Incarceration, compliance indicator #6 requires that treatment plans, including test results, are shared with patients. Engaging patients in their treatment plans leads to better compliance to ordered care and better treatment results. Although it can be difficult to get results from outside providers, the lack of communication for normal and abnormal findings would not meet the intent of the standard. Facilities must find ways to share information with each other and with the patient.

Jim Martin, MPSA, CCHP, is NCCHC's vice president of development. 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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Accreditation provides public recognition that correctional facilities are meeting NCCHC's nationally recognized standards for quality health services. Accreditation reduces exposure to costly liability and recognizes the institution's commitment to meeting quality goals and using best practices.



PROFESSIONAL CERTIFICATION

The Certified Correctional Health Professional program provides formal recognition for individuals who have engaged in a process of ongoing, focused and targeted professional development.

STANDARDS AND PUBLICATIONS

NCCHC's highly respected *Standards* serve as a framework to ensure that systems, policies and procedures are in keeping with nationally recognized best practices. NCCHC also publishes *CorrectCare* and the *Journal of Correctional Health Care*, the leading periodicals in the field.



EDUCATION

NCCHC conferences are renowned for their exceptional educational programming, abundant networking and the best commercial exhibitions in this field.

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