



Fall 2022 | Volume 36 | Issue 2

# CorrectCare®

The magazine of the National Commission on Correctional Health Care



## CREATING SAFETY THROUGH HEALING

### Trauma-Informed Treatment in a Women's Facility

Defensive Documentation  
for Nurses

Decompensation in  
Segregation

STI Treatment Updates  
from the CDC

National Commission on Correctional Health Care  
1145 W. Diversey Parkway, Chicago, IL 60614



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Send correspondence to Barbara Granner, CCHP, Editor  
NCCHC, 1145 W. Diversey Pkwy., Chicago, IL 60614  
Phone 773-880-1460; Fax 773-880-2424  
info@ncchc.org; ncchc.org  
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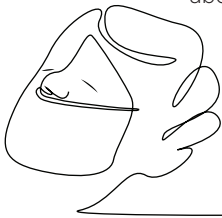
## New Position Statement On End-of-Life Care

**A**t the end of life, it is important to protect the patient's autonomy, rights, dignity, and desires – in corrections as in all other contexts.

People who are incarcerated, however, are less likely to be offered or participate in advance end-of-life care planning and less likely to document their desires. A study published in the *Journal of the American Geriatrics Society* found that correctional health staff have low baseline knowledge about advance end-of-life planning: 85%

reported familiarity with it, but only 42% provided accurate definitions.

NCCHC's new position statement on Medical Orders for Life-Sustaining Treatment (or MOLST, formerly called DNR orders) urges



Graphic © simple life/Shutterstock

correctional facilities to adopt measures to ensure that patients' desires regarding end-of-life care are followed. That includes establishing clear policies and procedures for discussing, documenting, and completing advance directives and medical orders for life-sustaining treatment; educating providers about those policies and procedures; asking patients whether they have advance directives and documenting responses; and honoring advance directives. ●

See page 20 for information about NCCHC's new position statement on Trauma-Responsive Care for Youths in Correctional Facilities.

Find more details and all position statements online: [ncchc.org/position-statements/](https://ncchc.org/position-statements/)

### NCCHC Recognizes Importance of Legal Abortion for Optimizing Maternal Health

NCCHC stands with 22 of our supporting organizations in opposing the *Dobbs v. Jackson Women's Health Organization* decision that enables states to restrict or eliminate access to abortion.

Each year, tens of thousands of pregnant people enter jails, prisons, and juvenile detention systems. As outlined in the NCCHC standards, we recognize the importance of providing full-scope, comprehensive health care, including access to safe abortion. Read our statement: [ncchc.org/news/](https://ncchc.org/news/)

### Fred Meyer Is New Managing Director

Fred Meyer, MA, CJM, CCHP, has joined NCCHC Resources, Inc., the organization's consulting subsidiary, as managing director. He recently retired from the Las Vegas Metropolitan Police Department, where he served as deputy chief over the Detention Services Division and led the Clark County Detention Center to NCCHC mental health accreditation.



## Upcoming Events

SEPT. 28	CCHP EXAMS, WACHSA CONFERENCE, SAN DIEGO
OCT. 22-26	NATIONAL CONFERENCE ON CORRECTIONAL HEALTH CARE, LAS VEGAS
OCT. 23	CCHP EXAMS, LAS VEGAS
DEC. 7-8	VIRTUAL WINTER CONFERENCE
APR. 29-MAY 2	SPRING CONFERENCE ON CORRECTIONAL HEALTH CARE, NEW ORLEANS
APRIL 30	CCHP EXAMS, NEW ORLEANS
JULY 14	CCHP EXAMS, WASHINGTON, DC
JULY 15-16	CORRECTIONAL MENTAL HEALTH CARE CONFERENCE, WASHINGTON, DC

## New Members Continue to Strengthen NCCHC Board

Several new members were recently elected to the Board of Representatives.

Sharen Barboza, PhD, CCHP-MH, a licensed clinical psychologist and correctional mental health consultant, expert, and trainer with nearly 30 years of experience, is the newly appointed board liaison for the American Psychological Association.

Elizabeth Barnert, MD, MPH, is the new Society of Adolescent Health and Medicine liaison. She is an associate professor of pediatrics at the David Geffen School of Medicine at UCLA, provides clinical care in a juvenile hall, and serves as an attending pediatrician at UCLA's Children's Health Center.

John Mills, DO, MPH, is the new liaison for the American Osteopathic Association. He is the founder and medical director for correctional programs at the University of North Texas Health Science Center, where he is also associate professor in the department of internal medicine.

Grant Phillips, MD, CCHP, medical director of the Arizona Department of Corrections, Rehabilitation and Reentry, is the new American Academy of Family Physicians liaison.

# Attracting Talent to the Profession

By Samuel Soltis, PhD, MHA, CCHP

In my last article I outlined four priorities for my chairmanship. In this article I would like to address the priority of attracting talent to the profession.

When I was preparing to graduate from my master's program in health care administration and enter the health care field, the only career choices that were regularly promoted were hospital administration, long-term care administration, and consulting. Correctional health care was never thought of or mentioned as a career option.

Like many of us, I stumbled on correctional health care halfway through my 34-year career. And as many of us do, I found it to be the most rewarding – and the most challenging – part of my career. My goal is to promote our profession to college students and young health care professionals through NCCHC.

One thing NCCHC is doing to promote this effort is offering scholarships, through the NCCHC Foundation, to college students and young professionals in the health care field to attend our conferences. This has been a great success and has opened the door to correctional health care to many students and young professionals by providing them with education and mentorship. We have had tremendous feedback from all the participants in this effort.

## Student Participation at Conference

Another idea we have recently discussed with the Board of Representatives and the Education Committee is promoting correctional health care to the local colleges and universities in the cities in which we hold our spring and fall conferences. This fall in Las Vegas will be our first attempt at this effort. We are collaborating with the University of Nevada, Las Vegas, to promote our conference to their multiple health care disciplines, and by encouraging UNLV students to attend our conference free of charge.

We have created a multidisciplinary panel for the students to attend on Sunday afternoon, to give them an opportunity to hear about correctional health care and ask questions about the profession. Several of our esteemed board members will sit on this panel to provide insights into the profession.

This will be an interactive session and hopefully very informative and inspiring to the students. Following the panel, we are inviting the students to attend the exhibit hall opening reception so they can learn about other correctional health care career opportunities from the exhibiting vendors.

## Playing Our Part

Our field needs young professionals. I believe there is significant talent in our colleges and universities, and young health care professionals are looking for alternate career paths. As I have stated to our board, I believe we can all play a role in promoting correctional health care as a career choice in our communities, colleges, and professional organizations. There is significant talent out there. I believe many exceptional people would find correctional health care as rewarding as we do if they were knowledgeable about this career path.

Please join us in promoting our profession whenever and wherever you can. Attracting talent to our profession requires awareness. I feel we all share in the responsibility to enhance and grow that awareness. ●

*Samuel Soltis, PhD, MHA, CCHP, is the 2022 chair of NCCHC's Governance Board and board liaison of the American College of Healthcare Executives.*



## Make a Difference Behind the Walls: Careers in Correctional Health Care

**National Conference Panel Discussion for Undergraduate and Graduate Students: Sunday, October 23, 4 pm - 5 pm**

Health care is a challenging career field, and perceptions of correctional health care are often dramatized and inaccurate. Aspiring health care professionals are invited to hear from leaders who will share their experiences and answer your questions. If you're considering a career serving in our nation's jails and prisons, attend this panel to explore the opportunities, challenges, and rewards. Or just come and cheer on our students and young professionals!

### Featured panelists

Samuel Soltis, PhD, MHA, CCHP, NCCHC board chairman; Joseph Penn, MD, CCHP-MH, director, mental health services, University of Texas Medical Branch Correctional Managed Care; Nancy Booth, MSN, RN, CCHP-RN, national consultant; and Jeff Alvarez, MD, CCHP-P, CCHP-A, CMO, NaphCare.





# CREATING SAFETY THROUGH HEALING

## Trauma-Informed Treatment in a Women's Facility

**A conversation with social worker Rhonda Champagne, MSW, LICSW, and Michael Johnson, a retired lieutenant with the Montana Department of Corrections, adapted from their presentation “Blending Trauma-Informed Practices Into the Correctional Officer’s Role” at the virtual Spring Conference on Correctional Health Care. They are the authors of the book “Correcting Treatment in Corrections.”**

**Ms. Champagne:** Our story begins in 2015, when I was hired by the Montana Department of Corrections to implement a trauma-informed treatment pilot program for women at the Riverside Correctional Facility in Jefferson County. The experience was life-changing for everyone involved: for the women in the program, for me, and I dare say for Michael, the lieutenant who at the time oversaw the facility’s custody staff.

**Mr. Johnson:** That’s right. At the beginning I was, to put it mildly, dubious. We butted heads so hard when we were initially getting this program going. But the department had recognized research showing that incarcerated people have high levels of past trauma, which directly affects their criminal behavior and addictions. Our task was to implement trauma-informed treatment to reduce recidivism and get the women in the program back into the community successfully.

**Ms. Champagne:** Trauma-informed care means we treat the whole person, taking into account past trauma and resulting coping mechanisms when attempting to

understand behaviors and treat the patient. We consider the person in their environment. And that environment includes their social network, their cultural belief systems, all of it. It isn’t, “Here, take this medication and go away.” It helps people problem solve and understand how the trauma affects them and how they can move beyond it.

**Mr. Johnson:** Why do treatment facilities need trauma-informed care, and particularly correctional treatment facilities? Because trauma is an underlying factor in addictions and criminal behavior. The Montana Department of Corrections did the research and discovered that by addressing people’s trauma, we could reduce addictions, criminal behavior, and recidivism. The recidivism rates across the nation are unacceptable. It’s time to really start asking ourselves how we can do better, instead of suggesting that incarcerated people don’t want to change. That simply is not true. Through good treatment, we can bring people to a place where they’re ready for change.

**Ms. Champagne:** We used SAMHSA’s six principles to guide us in our initial planning meetings. (See box, right.)

**Mr. Johnson:** Rhonda handed out these little cards that list SAMHSA's six key principles and told me she wanted me to educate the custody staff about how to implement them. Right off the bat, I saw that safety was the first principle. I thought, great, I agree 100%, safety is what corrections is all about. But when we started talking, it became clear that my definition of safety was very different from hers.

**Ms. Champagne:** I am all for physical safety, but I needed the officers to understand the idea of psychological safety. There are plenty of policies and procedures that do not create psychological safety. When people don't know what's going on or risk getting sanctioned for certain behaviors, that creates an environment that is psychologically unsafe.

**Mr. Johnson:** All of us were told we were to develop "relationship-based rapport" with the women in the program. They encouraged us to interact with them. But I didn't get it at the beginning. It went against so much of the training that is pounded into corrections to keep people safe through authoritative power and control.

**Ms. Champagne:** We had to come together and figure out what safety means, both physically and psychologically. It only takes one person to be controlling and power-oriented to ruin the psychological safety of the environment. I remember one day I went to his office and said, "Mr. Johnson, you got a minute? Can we talk?"

**Mr. Johnson:** No, she didn't say, "You got a minute?" She said, "I'd like to connect with you." I remember thinking, what is she talking about? And should I be worried? In all my career, no one has ever said, "I'd like to connect with you." I don't even know what that means.


**Ms. Champagne:** I said, "To make this a successful program, we need everyone to get involved. I need you and your officers to understand trauma-informed care, and we need to work together to make this thing happen." His reply was: "I don't agree. I think you're causing harm. I think people are going to get hurt. But I will do everything you say to a T, and I will get my officers to do so, too. And we'll see."

**Mr. Johnson:** One thing that was really hard for me was

giving up strip searches. Right from the beginning, she told me we cannot have a trauma-informed environment if we're doing even one strip search. You can imagine my response. I said, "You're gonna get us all killed." According to my training, you absolutely need to do strip searches, you must look for contraband, you have to know they're not bringing anything in.

**Ms. Champagne:** One of the basics of being trauma-informed is to not retraumatize people. And a strip search is very traumatizing, especially for women, although I believe it's very traumatizing for men, too. So many women have trauma related to rape and sexual abuse. So doing a strip search? No way. I insisted on that.

**Mr. Johnson:** Another principle that was difficult for me was trustworthiness and transparency. The training officers receive is very much about keeping our boundaries from the incarcerated population and, frankly, not trusting them at all.

 Just as exposure to trauma affects an individual's neurobiological response system, trauma-informed interactions with others can create healing at the neurobiological level."

National Resource Center on Justice-Involved Women

**Ms. Champagne:** We were looking at building two-way trust: The officers needed to trust the residents and be transparent with them, and the residents needed to trust the officers and be transparent with them. That idea was not popular when we first implemented the program.

**Mr. Johnson:** No, it was not. Neither were the ideas of peer support or collaboration and mutuality.

**Ms. Champagne:** To get the officers and the residents to collaborate, you need a mutual understanding and a leveling of power. Michael was not thrilled about that idea.

**Mr. Johnson:** When she said she wanted to "level the power" I said, "Absolutely not, my officers will maintain the power."

**Ms. Champagne:** I told him we need to try to level it in as many ways as we can. We need to allow the residents to have empowerment, voice, and choice. And in general, corrections doesn't provide a whole lot of choice.

**Mr. Johnson:** Sure we do, I told her. The residents can follow the rules and expectations or get a consequence with sanctions. And they have a voice. They can fill out a request-to-speak-to-staff form, and a staff member will meet with them. When they have the availability. And her jaw just dropped. She said, "A form? What are you talking about? Why can't they just talk to an officer?" I said, "Do

## The Six Key Principles of a Trauma-Informed Approach

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, historical, and gender issues

Source: Substance Abuse and Mental Health Services Administration, Trauma and Justice Strategic Initiative

*Continued on next page*

you know what it's like to walk onto a unit and have 10 people bombard you with things they need or want? We need the forms to create some order.”

**Ms. Champagne:** Becoming trauma-responsive means looking at every aspect of an organization's environment and programming. We needed everything we did to cue safety and stability at the level of the nervous system, as this is where healing begins. So we took everything into account when we designed the program. For instance, to create choice for the women, we determined how many

I just couldn't believe we were doing that. I'm thinking the paint's contraband, they're gonna make alcohol out of it or whatever. But it made the rooms feel a little homier for them. And some of them are really good artists. There were some really nice murals.

**Ms. Champagne:** We also turned one of the confinement rooms into a meditation room. We painted the walls, put pillows in there, and there was music they could listen to when they felt like they needed some time away. But there was never any forced segregation.

“ Trauma-informed care ... takes into account knowledge about trauma: its impact, interpersonal dynamic, and pathways to recovery ... (It) is a person-centered response focused on improving an individual's all-around wellness, rather than simply treating symptoms of mental illness.”

Alameda County Trauma-Informed Care

hours they needed to complete the program, but we let them choose how and when to complete those hours. When the women got all their hours completed, they were discharged from the program. But it was up to them.

**Mr. Johnson:** That was another idea that was extremely hard for me to swallow when she first presented it. I'm used to this: Do the program, and if you refuse, here's your consequence for not following expectations, and you get

enough of those you get a sanction.

**Ms. Champagne:** I wanted a more natural consequence. If you skip the group, that's going to extend your stay. We gave them that choice. We looked at every aspect of the environment, even the walls. The environment in most criminal justice settings is challenging, but there's always paint. Each resident was allowed to paint a mural on her wall.

**Mr. Johnson:** That was another nightmare for me.

**Mr. Johnson:** You can imagine my response to that.

**Ms. Champagne:** Another thing we looked at was language. We settled on calling the participants residents, and we called their rooms, well, rooms! Rather than cells. And they didn't refer to the officers by military rank, but as Mr. or Mrs. He was Mr. Johnson to them.

**Mr. Johnson:** One important part of the program was the gratitude circle. The idea is very simple. All you do is get together and list what you're grateful for. It could be anything: your kids, the sun, you name it. But if you have been incarcerated for a long time, reminding yourself how to be grateful for the little things is an important step toward a more positive attitude. These women were coming from a place where they'd lost their kids, they'd lost their freedom, and they tell you they feel like they've been treated like animals. So creating a positive focus before they're released is absolutely imperative to their success.

**Ms. Champagne:** We saw some amazing results. We did not have a single suicide attempt. We never had a fight.

**Mr. Johnson:** We had personality conflicts and arguments, but they were defused quickly. And disciplinary infractions were far and few between. We only had one use of force, and it was barely even that. An officer just had to put his hand on her arm and walk her away from a tense situation.

**Ms. Champagne:** Another benefit was the value it brought to the role of the officers. Custody roles are high-burnout, high-turnover positions. But when they can see the value in what they're doing, it's whole new ball game. I heard so many comments like, “I absolutely love this program. I told my wife I couldn't wait to get to work today.”



Photos: Mike DeVries for The Capital Times

*Continued on page 20*



# NCCHC STANDARDS: STRENGTHEN YOUR HEALTH CARE QUALITY

Authoritative guidance from the organization that “wrote the books” on correctional health care

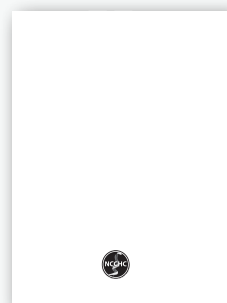
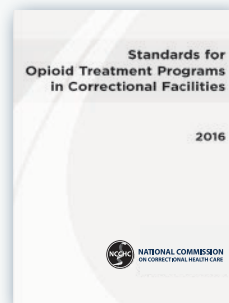
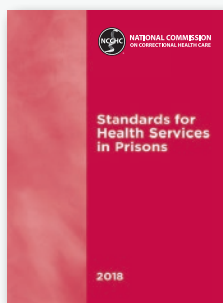
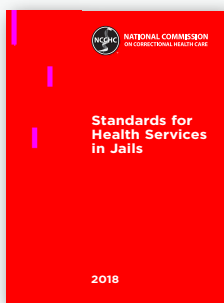
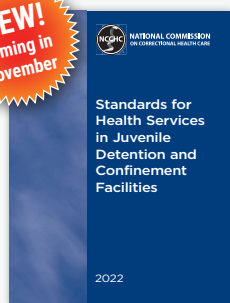
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# Defensive Documentation for Nurses: Protect Yourself With a Strong Offense

By Nicole Walker, MSN, RN, CCHP

**A**n old proverb states, “The best defense is a good offense.” While no one is quite sure who said it first (was it George Washington talking about war? Michael Jordan talking about basketball?) it could have been Florence Nightingale talking about nursing documentation.

Defensive documentation is defined as “documentation that’s undertaken with the sensitivity that individuals on the outside may be reviewing the records looking for fault at a later date.” Especially in the litigious world of correctional health care, documentation that is accurate, thorough, timely, and complete not only proves that safe, quality care was provided to a patient, it also protects the nurse.

The main purpose of the medical record is to record patient care. At any time, a health care provider should be able to look in a patient’s medical record and know exactly what the plan of care is for the patient. The medical record also serves as the main communication tool among members of the health care team.

Nurses are legally bound to document patient care in the medical record, and the medical record itself serves as a legal document.

Additionally, many state nurse practice acts include language requiring nurses to document. For example, the Wisconsin Nurse Practice Act states that a nurse may be disciplined for failing to observe the condition, signs, and symptoms of a patient, record them, or report significant changes to the appropriate person,” and the American Nurses Association “Scope and Standards of Practice” lists the duty to document in every standard of practice.

The medical record itself is a very persuasive witness. Nursing documentation within the record should leave no unanswered questions that a plaintiff’s attorneys could use to construct their own version of events. Such questions might come up if there are long gaps on the record, a lack

of supporting documentation when an order is changed, multiple addendums, or incomplete information.

## A Brief History

A brief review of the history of nursing documentation sheds light on how the concept of defensive documentation developed.

In the 19th century, Florence Nightingale first discussed the need for nurses to document with the goal of collecting, restoring, and retrieving data (all documentation nurses continue to do today).

In the 1930s, American nurse, researcher, theorist, and author Virginia Henderson promoted nursing care plans as the means to communicate nursing care not only to nurses, but to the entire health care team.

In the 1950s, The Joint Commission documentation standards became the gold standard for evaluating nursing care.

In the 1970s, additional regulatory and legal requirements were added to nursing documentation.

In the 1980s, the electronic health record began to gain ground, and medical records began to be transferred to an

electronic format.

In the 1990s, as the internet became well-established, the EHR was solidified as the preferred way to document.

Each of those steps produced more complex documentation standards, which resulted in more opportunities for gaps in documentation to occur and, ultimately, more opportunities for plaintiffs’ attorneys to find fault in patient care.

Examples of poor documentation include not charting follow up of nursing interventions, not reviewing dictated documentation before signing it, including the wrong



Photo © Blaj Gabriel/Shutterstock

date and/or time, not documenting significant changes in the patient's condition, adding multiple addenda (which can be perceived as an attempt to cover something up), including unprofessional comments in the chart, arguing among providers (including nursing) regarding the plan of care, pointing out another nurse's mistake in the chart, and deleting another nurse's charting.

Many tools exist to assist nurses when documenting patient care. One tool especially suited for defensive documentation is the acronym FACT, which stands for Factual, Accurate, Complete, and Timely.

### F Is for Factual

When documenting, record only information and behavior you observe. Avoid value judgments, bias, labels, and subjective opinions. Examples to avoid: patient is malingering, faking, abusive, violent, appears confused, does not look good. Additional examples of words that will not hold up in court are demanding, grumpy, noncompliant, always, never, uncontrolled, good, bad. Instead, stick to what you see, hear, smell, and feel. For example, pointed a finger at me, unresponsive to sternal rub, cheeks sunken, skin pale. If a mistake is made, state the facts, the actions taken, and the provider you notified. Be sure to document the provider's name. A legal case can take five to seven years to go to court, and you may not remember the name of the provider you spoke with.

### A Is for Accurate

Be as precise as possible. Use numbers to quantify your findings. Document only the care you provided. For example, if a CNA measured vital signs for the nurse, only the CNA can chart the vital signs. Never delegate documentation. Documentation is a nursing task that can never be delegated. Always review your documentation for errors before signing it.

### C Is for Complete

Nursing documentation must reflect the entire nursing process. Several situations if left undocumented may leave the nurse open to a liability claim in court.

Be sure to document any condition changes and the name of the provider contacted. Document patient responses to any intervention you initiated, especially if the response is unusual, unexpected, or undesired. Continue to document your follow-up interventions in these cases until the patient is stable. Document chain of command use; this will not absolve you from patient responsibility, but can be used to prove you followed the facility policy and procedure when needing to escalate a concern up the chain of command. Document all communication with the patient and/or family. More intense documentation is needed when

a patient's condition suddenly declines, a patient injury occurs, a medication error occurs, equipment fails, or the nurse is unable to contact a provider.

### T Is for Timely

Always attempt to document care at the time it is rendered. If this is not possible, label the documentation as a late entry. An entry is considered a late entry if it is made after your shift is complete and you have left for the day.

### Final Thoughts

Documentation is a big responsibility. The weight given to a medical record in legal proceedings is massive, and documentation errors will greatly influence the outcome of legal proceedings in favor of the plaintiff. Medical records are always presumed to be accurate unless evidence is provided to prove the record has been tampered with or altered.

So document carefully, and be proud of it. Nursing documentation continues to solidify the profession as a highly regarded, critically important one.

In closing, I'd like to quote an unnamed nursing instructor who often said, "Dance like no one is watching. Chart like it may one day be read in a deposition." ●

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Nicole Walker, MSN, RN, CCHP, is a nurse clinician 2 at the Taycheedah Correctional Institution in Fond du Lac, Wisconsin.



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## DECOMPENSATION IN SEGREGATION

### The Harmful Effects of Solitary Confinement

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By Tommy Williams, BSN, RN, CCHP, and Pamela Rollins-Mazza, MD, BSN, CCHP

**S**egregation in correctional facilities in the United States dates to the 19th century, and its damaging psychological effects were noted as early as 1829 at a penitentiary in Philadelphia. A Supreme Court ruling in 1890 recognized that solitary confinement reduced mental capabilities. Yet some form of segregation continues to take place in almost every correctional facility in the U.S.

While originally implemented as a form of severe punishment, segregation is currently used for other purposes as well; there are several different types with varying degrees of isolation.

Medical segregation is commonly used when incarcerated individuals pose a communicable medical risk to others (such as tuberculosis, COVID-19, or MRSA) or are at a higher risk for infection (such as immunocompromised individuals). "Own request" is voluntary segregation from the general population. Protective custody can also be voluntary and is reserved for individuals who would be at high risk of harm or death if housed in the general population, such as gang members, pedophiles, rapists, and transgender and nonbinary individuals. Punitive segregation is applied to individuals guilty of serious

infractions who could jeopardize the safety of others or compromise security of the facility. Administrative segregation, sometimes called keep lock, special housing unit or SHU, restrictive housing, ad-seg, or "the hole," is a security classification of indefinite isolation for managing individuals considered too dangerous or disruptive to be housed in general population.

Regardless of the purpose or type of segregation, NCCHC's position statement on solitary confinement states that "an individual who is deprived of meaningful contact with others is considered to be in solitary confinement" and concludes that "prolonged (greater than 15 consecutive days) solitary confinement is cruel, inhumane, and degrading treatment, and harmful to an individual's health." Furthermore, the position statement maintains that "juveniles, mentally ill individuals, and pregnant women should be excluded from solitary confinement of any duration."

Segregated individuals are often housed in a small cell for up to 23 hours a day. Any meaningful interaction or contact with other people is limited or nonexistent. Segregated housing offers little (if any) sunlight, sensory stimulation, or access to reading materials and personal property.

The numerous harmful effects of solitary confinement have been well-documented. People in segregated housing exhibit increased risk for a wide range of psychiatric symptoms and disorders including depression, mania, anxiety, reduced impulse control, self-mutilation, psychosis, and suicidal behavior. Manifestation of many of these psychiatric symptoms and disorders tends to increase the risk of violence directed toward others, thus prolonging the time in segregation.

## Decompensation Defined

When presentation of psychiatric symptoms and disorders increases in frequency and severity, an individual is considered to be in a state of decompensation, defined as the functional deterioration of one's mental health in response to stress.

Those with mental illness are even more susceptible to decompensation while in segregation and are at a significantly greater risk of suicide. However, it is important to note no one in segregation is immune from its deleterious effects.

Indication of decompensation is often evident both in the physical housing area and by an individual's presentation. As you interact with or observe people in isolation, watch for these things.

Decompensated individuals frequently present with a disheveled appearance. They may not be fully oriented to person, place, or time, and make limited or no eye contact. Speech may be altered; there may be a change in volume, their speech might be pressured, or they might become verbose. The incarcerated individual or custody staff may notice and report a loss of appetite or the need for little or no sleep. There might be hallucinatory activity and disturbed sensory perception in the absence of external stimuli; the individual may report hearing voices or seeing things that are not there. Disturbed thought process is often marked by delusional or nonreality-based thought and is often accompanied by themes of grandiosity or paranoia.

Cell condition is often disorganized and might include uneaten food and garbage littered on the floor or liquids thrown at a wall. A strong odor of urine or feces may be present, sometimes accompanied by smearing.

Decompensation can lead to serious adverse events including violence toward self and others. Health care professionals should evaluate "individuals in solitary confinement upon placement and thereafter, on at least a daily basis," per the NCCHC position statement. While health care staff may be more attuned to the negative consequences of isolation, custody staff has the best opportunity to observe the manifestation of decompensation as they have greater interaction with the incarcerated.

It is critical that education and training be provided to all staff involved with those in segregation—not only to

recognize signs and symptoms of decompensation, but also to learn who (and when) to notify of a problem or deteriorating situation. Follow your facility's protocols regarding placement on constant observation any time there is a concern about lethality or self-harm.

Contact the behavioral health team when you observe:

- Evidence of psychosis: Mumbling, talking, or laughing to self; inappropriate responses; tilting the head as if listening to someone; disorientation to person, place, or time; reports of hearing voices or seeing things that are not there; egocentricity; paranoia; inappropriate thoughts or nonreality-based thinking; inaccurate interpretation of environment
- Evidence of mania: Exaggerated sense of well-being and self-confidence; pressured or verbose speech; decreased need for sleep; increased energy or agitation
- Provocative or agitated behaviors
- Poor hygiene/grooming or body odor
- Insufficient food intake

Behavioral health clinicians will need to assess the decompensated individual. Pharmacological and nonpharmacological interventions can be employed to reduce severity of mild to moderate psychiatric symptoms and disorders such as depression and anxiety. For more serious psychiatric conditions or those accompanied by hallucinatory activity, nonreality-based thought, or mania, a recommendation can be made to place the incarcerated individual on suicide precautions. Behavioral health clinicians can also advocate for the incarcerated individual and explore with custody staff other types of behavioral modification that do not include extreme isolation.

The practice of solitary confinement continues, but so too does reform in corrections. Many states are now severely restricting segregation, including when it can be used and for how long. New York recently passed the Humane Alternatives to Long-Term Solitary Confinement Act (HALT), and other states are in the process of passing or considering similar bills. Until segregation is eliminated altogether, security, medical, and behavioral health staff must remain vigilant for signs of decompensation to help ensure safety for segregated individuals and staff alike. ●

### RELEVANT NCCHC STANDARD

Standard G-02 Segregated Inmates: Any practice of segregation should not adversely affect an inmate's health.

*NCCHC Standards for Health Services 2018*

### FOR MORE INFORMATION

NCCHC Position Statement on Solitary Confinement, 2016

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*Tommy Williams, BSN, RN, CCHP, is the clinical research and informatics specialist for Personalcare Registered Professional Nursing, PC, and works with PrimeCare Medical of New York; Pamela Rollings-Mazza, MD, BSN, CCHP, is chief medical officer for PrimeCare Medical, Inc.*

# Treatment of Sexually Transmitted Infections: Updated Guidelines from the CDC

By Paula Braverman, MD

**A**dolescents and young adults between the ages of 15 and 25 account for approximately one-half of all new sexually transmitted infections in the United States each year. Youth and adults in correctional facilities have a higher prevalence of STIs than the general population. Those higher STI rates are associated with a variety of factors: sexual behaviors, substance use, limited access to health care, and the negative impact of certain social and economic determinants of health.

The Centers for Disease Control and Prevention's Sexually Transmitted Infections Treatment Guidelines were updated in 2021 to include revised recommendations specifically for gonorrhea, chlamydia, and trichomonas as well as pelvic inflammatory disease. The guidelines also include an expanded section on *Mycoplasma genitalium*, a type of bacteria that is the most common cause of persistent and recurrent urethritis in males.

This article delineates the primary recommended treatments for those common STIs. Alternative treatment regimens can be found in the CDC guidelines (see "For More Information" on page 21).

## Chlamydia

Chlamydia, caused by *Chlamydia trachomatis*, is the most frequently reported bacterial STI and is commonly asymptomatic in both males and females.

To treat chlamydia, the 2021 guidelines recommend one week of oral doxycycline (100 mg twice a day). A delayed release 200 mg tablet that has fewer gastrointestinal side effects is also available and can be taken once a day. This is a change from the previous recommendation of a single oral dose of azithromycin; recent studies found a higher failure rate with azithromycin for urogenital and rectal infection in men and a lower cure rate for rectal infection in women.

Doxycycline, which is in the tetracycline class of drugs, is contraindicated in pregnancy because of concerns about side effects seen with tetracycline. Although it is not proven that doxycycline has the same negative effects as tetracycline, single dose oral azithromycin (1g) with a test of cure is recommended during pregnancy. Azithromycin can also be considered if nonadherence to doxycycline is a significant concern.

## Gonorrhea

Gonorrhea, caused by *Neisseria gonorrhoeae*, is the second most commonly reported STI. Gonorrhea is more likely to be symptomatic in males than in females. Treatment recommendations for gonorrhea have changed due to new patterns of antibiotic resistance.

Previous CDC guidelines recommended dual therapy with a single dose intramuscular ceftriaxone and a single dose of oral azithromycin to help mitigate the emergence of ceftriaxone resistance. The benefits of dual therapy no longer outweigh the disadvantages, however, as azithromycin has become less effective against gonorrhea, as well as against chlamydia, *M. genitalium*, and some common gastrointestinal pathogens.

Furthermore, treatment failures to ceftriaxone have been seen in other parts of the world, and resistant strains are expected to emerge in the United States as well.

The new CDC guidelines recommend higher doses of intramuscular ceftriaxone for uncomplicated cervical, urethral, rectal, and pharyngeal infections. The new recommendation is a single 500 mg dose or a single 1 g dose if the patient weighs more than 150 kg (330 pounds). One week of doxycycline is also recommended if chlamydia infection has not been ruled out through NAAT testing.

The CDC emphasizes the importance of screening for pharyngeal gonorrhea, based on the patient's sexual history, since that can be a major source of community transmission and possibly a driver of antimicrobial resistance. Ceftriaxone is the only reliable treatment option for pharyngeal infection, which is more difficult to eradicate than infection in other anatomic sites.

## Trichomonas

Trichomonas, caused by the *Trichomonas vaginalis* parasite, is the most prevalent nonviral STI worldwide. Most patients are asymptomatic, but trichomonas can cause malodorous vaginal discharge, genital itching, and painful urination in women. Screening is usually directed toward vaginal infection in females. Although there are no screening recommendations for males, men who have sex with

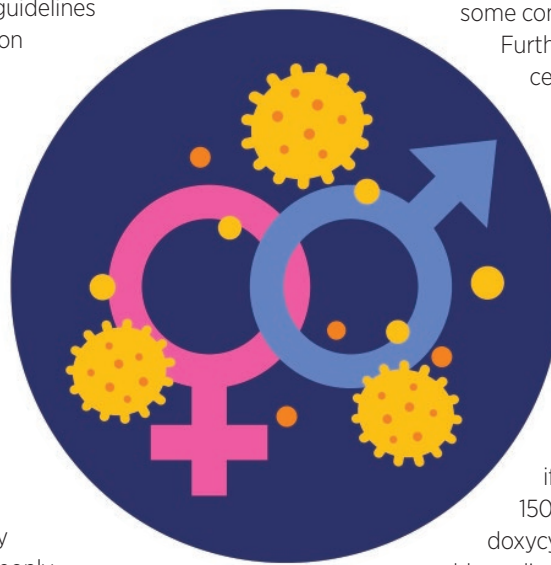


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women are more likely to be infected than men who have sex with men. A urine or vaginal swab sample for NAAT can be used and, although less sensitive than NAAT, there is also a rapid nonamplified antigen detection test that can be used for vaginal swabs in females as a point-of-care test. Testing and presumptive treatment is recommended in cases of recurrent/persistent urethritis in men who have sex with women when trichomonas is prevalent in the population.

The CDC's new treatment guidelines recommend one week of metronidazole (500 mg twice a day) for all women with trichomonas whether or not they are positive for HIV infection. Although the previous guidelines discussed the need for one week of treatment for women with HIV infection, recent studies have also demonstrated poorer efficacy in eradicating trichomonas infection in women without HIV when using single dose oral metronidazole as compared to one week of oral metronidazole. Since there are no similar studies in men, the single oral dose (2g) of metronidazole is still recommended for men.

The 2021 guidelines also discuss that it is not necessary to refrain from alcohol use when taking metronidazole.

### ***Mycoplasma genitalium***

*Mycoplasma genitalium* causes 15-20% of nongonococcal urethritis and is the most common cause of persistent/recurrent urethritis in males. It also is associated with cervicitis and pelvic inflammatory disease in females.

Testing for this organism using NAAT tests is recommended for males with persistent/recurrent urethritis and females with recurrent cervicitis, but unlike gonorrhea, chlamydia, or trichomonas, screening for asymptomatic infection is not recommended.

Treatment for *M. genitalium* is challenging because of rapidly increasing resistance to azithromycin, which until

recently was a recommended treatment. There have also been indications that some strains are developing resistance to the quinolone class of broad-spectrum medications, although those mutations are less likely to be associated with treatment failure. Currently, there is no available resistance testing in the U.S. for this organism.

The CDC's current recommendation for a patient who is positive for *M. genitalium* is one week of oral doxycycline to reduce the bacterial load (100 mg twice a day), followed by one week of oral moxifloxacin (400 mg once a day).

### **Pelvic Inflammatory Disease**

Pelvic inflammatory disease is a polymicrobial inflammatory disorder of the upper genital tract in women. It is a complication of gonorrhea and chlamydia but also associated with other organisms including anaerobic bacteria and possibly *M. genitalium*. Recommended treatment now includes triple drug therapy with use of metronidazole to cover anaerobes as a standard part of the medication regimen. It is not known if screening and treatment for *M. genitalium* decreases PID.

The outpatient treatment for PID in the 2021 guidelines is 500 mg once of intramuscular ceftriaxone with 14 days of both oral doxycycline (100 mg twice a day) and metronidazole (500 mg twice a day). If the patient weighs more than 150 kg (330 pounds,) the dose of ceftriaxone is 1 g, and if *M. genitalium* is identified, 14 days of oral moxifloxacin (400 mg daily) is added to the standard triple dose regimen.

Patients who fail to improve with outpatient treatment or cannot tolerate oral medication may need further evaluation and possibly treatment as an inpatient.

### **Recommendations for Follow-up**

Partners of patients with chlamydia, gonorrhea,

*Continued on page 21*

## **CDC Screening Recommendations for Correctional Facilities**

The Centers for Disease Control and Prevention recommend screening for STIs during the intake process at correctional facilities. CDC recommendations include opt-out testing for females age 35 and younger for gonorrhea, chlamydia, and trichomonas and for males under age 30 for gonorrhea and chlamydia. The CDC also recommends opt-out screening at any age for HIV and screening for syphilis and viral hepatitis based on local prevalence and vaccination status.

The NCHC Standards for Health Services in Juvenile Detention and Confinement Facilities (2015) also require that testing for sexually transmitted infections be offered to all juveniles upon arrival or within 24 to 48 hours to allow for early detection and treatment. The intent of this recommendation is to prevent problems that may develop without early intervention and prevent infection of others in the community upon release.

Nucleic acid amplification testing is the recommended method of screening for gonorrhea, chlamydia, and trichomonas because these tests are more sensitive than older testing methods and can be performed from a single specimen. First-catch urine is the preferred specimen in males and can also be used for females, but vaginal swabs are more sensitive and therefore preferred. NAAT can also be used for rectal and pharyngeal (throat) swabs. Both vaginal and rectal swabs can be self-collected by the patient.

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EOE

# Sickle Cell Anemia: A Primer for Correctional Health Care Professionals

By Nicole Cassarino and Yoseph Boku

**S**ickle cell anemia is a painful hereditary blood disorder that predominantly affects African-American and Hispanic populations. According to the CDC, sickle cell anemia impacts 1 out of 365 African-American people, and 1 out of 16,300 Hispanic people. As those populations are overrepresented in jails and prisons, it is essential that correctional health care professionals understand sickle cell anemia and the health needs of those who suffer from it.

People with sickle cell anemia have a genetic mutation that causes some of the red blood cells to become misshapen, taking on a C or “sickle” shape, unlike healthy red blood cells that are round. The main manifestations of the disease are pain, infection, and fatigue.

## Treat Pain to Prevent Complications

People with sickle cell anemia can experience extreme pain in a flare of illness called a “pain crisis.” The pain crisis is brought on by a blockage of blood vessels due to buildup of the sickled blood cells, which clump more easily than normally shaped round red blood cells. The intensity and duration of these pain crises can last anywhere from several hours to days. Patients can experience dozens of pain crises each year, often requiring hospitalization.

People with sickle cell anemia experience fatigue related to low red blood cell count, or anemia, as the sickled red blood cells die after 10-20 days in the circulation, compared to normal red blood cells that last 120 days. This shortage of red blood cells prevents organs from getting enough oxygen, causing fatigue.

Undertreatment of pain in people with sickle cell anemia has been documented in the literature. Several studies show that clinicians think people with sickle cell anemia over-report their pain, leading to less than adequate care.

But adequately treating pain is the standard of care. More than just symptom management, pain treatment is part of essential care to ensure positive patient outcomes and reduce the risk of more severe complications like heart attack and stroke.

There are other serious complications as well. Sickled red blood cells can damage the spleen, which puts patients at risk for recurring infections. Patients are also at an increased risk for stroke, due to the increased likelihood of clot formation, and for Acute Chest Syndrome, a period of pain and respiratory distress caused by the congregation of sickled cells in the small blood vessels of the lungs.

## Care for Sickle Cell Anemia in Corrections

Given the chronic nature and preponderance of sickle cell anemia, correctional facilities are advised to develop protocols and guidelines for both acute and long-term treatment of patients with the disease.

- At intake, ask about a diagnosis of sickle cell anemia.
- For those with sickle cell anemia, find out what medications they are on. The main treatment is a medicine called hydroxyurea which, when taken daily, can reduce the occurrence of pain crises as well as the need for blood transfusions and hospitalizations. Opioid-based medications, including oxycodone, morphine, and hydromorphone, are currently the standard of care when treating acute sickle cell crises. Research is seeking to identify alternatives to opioid medications, particularly for patients with a history of opioid use disorder.
- Develop an individualized care plan that incorporates any previous plan and medications and details management of the individual's pain crises. Ideally, the plan will take the patient's preferences into account and ensure consistency of care if the patient is seen by different providers. If possible, refer to a hematologist.
- Intravenous fluids and oxygen therapy also should be provided to patients undergoing an acute crisis. Pharmaceutical-grade L-glutamine and crizanlizumab are recently approved drugs that reduce the frequency of pain crises. Voxelotor, another recently approved drug, can help reduce fatigue and anemia. Those medications should be continued for any patients who were prescribed them prior to incarceration.
- Ensure access to accommodations for adequate warmth (blankets and heating pads) and hydration during the length of the patient's incarceration. Cold temperatures and dehydration both increase the severity of symptoms.
- Include continuity of care in discharge planning. Ensure that the incarcerated individual knows where to access care in the community and will have access to medications.

Currently, bone marrow transplant is the only cure for sickle cell anemia, though it is difficult for patients to find a matching donor. Genetic therapies are also being explored, although none have yet received FDA approval. ●

*Nicole Cassarino is a student at Tufts University School of Medicine; Yoseph Boku is a student at Harvard University School of Medicine.*

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# Strategies to Recruit Mental Health Professionals May Help, but Bigger Fixes Are Needed

**H**aving trouble hiring enough qualified mental health professionals to meet the needs of your jail or prison population? That's no surprise. Correctional facilities must secure "adequate numbers of appropriately trained [MHPs], performing duties for which they are trained and authorized," says the American Psychiatric Association. But given the need to conduct mental health screenings and evaluations, provide emergency and ongoing care, and prescribe medications – coupled with high rates of mental disorders and substance use disorders among incarcerated people – that's a tall order.

The APA's expectation is cited by authors Nathaniel Morris and Matthew Edwards in their article in the latest *Journal of Correctional Health Care*. Without adequate mental health staffing, the work those professionals normally do may fall to general medical or custody staff with little or no mental health training – or be absent altogether. Another risk is greater utilization of use-of-force measures to manage people in psychiatric distress. The unfortunate consequence is undue suffering, morbidity, and mortality.

## Proposed Strategies: Pros and Cons

The article examines strategies to alleviate shortages of mental health professionals in correctional facilities.

**Compensation.** Despite tight budgets, some systems are increasing salaries and offering incentives such as loan forgiveness or pension benefits. However, the authors say vacancies persist in some jurisdictions that have used this approach.

**Telemental health services.** Remote provision of care has been shown to expand access to care and to reduce costs. It also may appeal to MHPs who perceive the correctional setting as unsafe. But research has yet to determine the effectiveness of remote care compared to traditional in-person care. The technology also requires considerable investment, which may be out of reach for some facilities.

**Use of interdisciplinary health staff.** MD- or PhD-level professionals are not required for all mental health care, and many facilities employ master's-level social workers and therapists/counselors. In addition, RNs, PAs, nurse practitioners, and physicians can handle tasks such as screening intakes, triage, initial treatment, and referrals. This approach also helps with integrating mental health care into a broader treatment plan. A potential downside is the risk of health staff providing care outside the scope of their training, experience, and licensure.

**Flexible schedules.** Work-life balance incentives appeal to mental health professionals, but present challenges in ensuring adequate coverage. Qualified staff are needed to address acute mental health emergencies 24/7, and gaps in coverage can complicate scheduling of clinical appointments and routine communication.

## Broader Reforms Needed

These measures may alleviate some MHP shortages, the authors say, but shortages will likely persist without policy reforms that decrease the size of correctional populations or increase the numbers of MHPs across the country. ●

## JCHC Vol. 28, No. 4: August 2022

- Addressing Shortages of Mental Health Professionals in U.S. Jails and Prisons
- Preventing Interruptions in Health Care After Release From Jail
- Louisiana State Penitentiary: A Textual Analysis of Correctional Staff Views on End-of-Life Care
- A Case for Comprehensive Transitional Care for Formerly Incarcerated Individuals
- Jail-Based Competency Restoration: What's Out There and What's Missing
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## 'Se habla español': CCHP Program in Puerto Rico

In response to growing enthusiasm for the CCHP program in Puerto Rico, NCCHC representatives traveled to the island in May to provide training on the NCCHC standards and administer the CCHP exam – en español.

This is not the first time that Physician Correctional, which provides health care services to Puerto Rico's incarcerated population, has hosted NCCHC for two days of comprehensive CCHP test preparation followed by the exam. But it is the first time the exam was provided in Spanish.

"Even though the CCHP exam has been available in Puerto Rico for a long time, it had only been administered in English," says Matissa Sammons, MA, CCHP, NCCHC's vice president of certification. "I knew and hoped we would one day be able to better accommodate those examinees whose first language is Spanish. After all, the exam is meant to measure knowledge and competency of NCCHC's standards, not mastery of the English language," she says.

Spanish is the first official language of Puerto Rico and English is the second, though the English fluency rate is only around 20%. "We feel honored to be the first group to have this privilege and are very thankful to NCCHC for administering the exam in Spanish," says Raul Villalobos, MD, CCHP, president of Physician Correctional. "Although our professionals understand all the NCCHC standards

in English, they feel more confident answering the exam questions in Spanish, because it is our primary language."

That confidence was well-founded: 98% of the Spanish-language test-takers passed the exam.

### A Matter of Mission

Physician Correctional's mission is to promote a process of change in the physical, mental, and dental health of all inmates, adults, and juveniles admitted to the Department

of Corrections and Rehabilitation in Puerto Rico. Dr. Villalobos feels that CCHP certification is essential to meeting that mission.

"It is of optimal importance for our professionals to be certified as CCHPs to show our commitment to the best quality of care for our patients," he says. "The NCCHC

standards are the fundamental guidelines our professionals use and apply to the delivery of health care services. Our mission and vision are based on the standards, and every day we aspire to the highest quality of care." ●

*Special thanks to NCCHC Governance Board member Oscar Aviles, CJM, CE, CCHP, for translation services; and to Denise Rahaman, MBA, RN, CCHP-RN, CCHP-A, and Jim Martin, MPSA, CCHP, for excellence in training.*



Graphic © bobby20/Shutterstock; Jill Cooper

### Muchas Gracias and Many Thanks

*Gracias al liderazgo correcto, que estuvo abierto a esta posibilidad y dispuesto a hacer que sucediera, en el momento correcto, junto con el compromiso de Physician Correctional de ver a los empleados capacitados y certificados, el primer examen en español se presentó en Puerto Rico. Creía de todo corazón que eliminar la barrera del idioma nos permitiría medir mejor el conocimiento de estos profesionales de la salud, y tenía razón. A veces, una sola palabra o matiz puede cambiar todo el significado de lo que se pregunta. Me siento inspirado por su arduo trabajo y dedicación.*

Thanks to the right leadership – who were open to this possibility and willing to make it happen – at the right time, along with the commitment of Physician Correctional in seeing employees trained and certified, the first Spanish-language exam was presented in Puerto Rico. I believed wholeheartedly that removing the language barrier would allow us to better measure these health care professionals' knowledge, and I was right. Sometimes, just one word or nuance can change the entire meaning of what is being asked. I am inspired by their hard work and dedication.

~ Matissa Sammons, MA, CCHP, vice president, certification, NCCHC

**Mr. Johnson:** Putting them in that relationship-based rapport model and having them facilitate groups and interact with people, not just give orders, was huge. I heard things in gratitude circle like, “I am grateful for this officer who really helped me” and “I’m grateful for this resident who provided some really good insight in the group I ran

The respect that the women had for the environment and the officers grew and grew. Each day there was more.

**Mr. Johnson:** And respect supports a safe and secure environment. I was amazed. I did not believe that this kind of environment was going to be safe for the population or

“ Trauma-responsive care, which involves an organizational commitment in the form of concrete policy and procedure changes, has emerged as the most beneficial framework for providing treatment to traumatized individuals ... It shifts the paradigm from ‘What is wrong with them?’ to ‘What happened to them?’ and creates an environment aimed at rehabilitation rather than punishment.”

NCCHC Position Statement, Trauma-Responsive Care for Youths in Correctional Facilities

yesterday.” This created a level of respect that far exceeded any kind of power and control or fear of consequences.

**Ms. Champagne:** When you respect people as human beings, they will meet you with that same level of respect.

the staff, but this program provided a far more safe and secure environment than I have ever experienced because it was out of trust and respect. I’ve never had a job, in corrections or outside, that was as meaningful to me.

I found myself going home after a counseling session with a woman who was working through trauma, which takes an enormous amount of courage, and being able to say, “I think I really helped that person today.”

**Ms. Champagne:** Another amazing thing about this program is that when the women left, they would call back to tell us, “Hey, I got a job” or “I ran into my old drug dealer and I said no. I couldn’t believe that I said no.” They really wanted to make us proud.

**Mr. Johnson:** This program has flipped my whole outlook on what it means to hold people accountable, to make them do time, and then through that process, get them to a place where they can go back into the community, not use drugs, and not engage in criminal behavior. How we go about that, especially when we’re trying to get people to understand what happened in their past and how that influences them, makes all the difference. ●

**FOR MORE INFORMATION**

Ms. Champagne and Mr. Johnson’s book, “Correcting Treatment in Corrections,” is available from your favorite online book seller or at [correctingtreatment.com](http://correctingtreatment.com).

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## Position Statement on Trauma-Responsive Care for Youths in Corrections

Numerous studies have demonstrated that youths in juvenile detention centers are 30% to 65% more likely to have been exposed to childhood trauma - community violence, domestic violence, violent victimization, neglect, sexual abuse, emotional abuse, and traumatic loss - than the average adolescent and four times as likely to have experienced four or more traumatic events. The consequences of such trauma are severe.

The new NCCHC position statement speaks to the vital importance of treatment that is conducive to youths' psychological and emotional healing. It calls for use of "universal precautions" (approaching all youths with the assumption that they may be a trauma survivor); formation of guide teams dedicated to implementing trauma-responsive policies; provision of mentoring, evidence-based training, and staff support; appropriate clinical interventions; and trauma-responsive culture and policy changes.

To read the full statement: [ncchc.org/position-statements/](https://ncchc.org/position-statements/)

## Sexually Transmitted Infections *Continued from page 13*

or trichomonas should be treated even if they are asymptomatic, and patients should have repeat screening in three months to ensure they have not been reinfected by a new or untreated partner.

In the case of *M. genitalium*, it is not clear if treatment of asymptomatic partners reduces reinfection and is therefore not recommended. Posttreatment testing of the patient also is not recommended since the clinical significance of a positive *M. genitalium* test in asymptomatic individuals is unknown.

Multiple studies have demonstrated that people entering correctional facilities have a high prevalence of STIs as well as HIV and viral hepatitis, especially those aged 35 and younger.

Since individuals age 15-25 years have among the highest rates of STIs, it is especially important to screen and treat adolescents and young adults who may have experienced multiple barriers to care in the community, including issues related access, confidentiality, cost of care, and transportation to appointments.

Addressing STIs in correctional settings is vital for addressing the spread of STIs overall. ●

### FOR MORE INFORMATION

Centers for Disease Control and Prevention: Sexually Transmitted Infections Treatment Guidelines, 2021: [cdc.gov/std/treatment-guidelines](https://cdc.gov/std/treatment-guidelines)

*Paula K. Braverman, MD, is chief of adolescent medicine at Baystate Children's Hospital in Springfield, Mass. She is the American Academy of Pediatrics liaison to the NCCHC Board of Representatives and a member of the Juvenile Health Committee.*

### STI Update Webinar: Sept. 20

Learn more about the CDC's updated Sexually Transmitted Infections Treatment Guidelines with Dr. Braverman and Cara Wolf, DNP, APRN, FNP-C, corrections nurse practitioner with the University of Utah College of Nursing.

**Sept. 20, 10 am CDT**

**To register: [ncchc.org/events](https://ncchc.org/events)**



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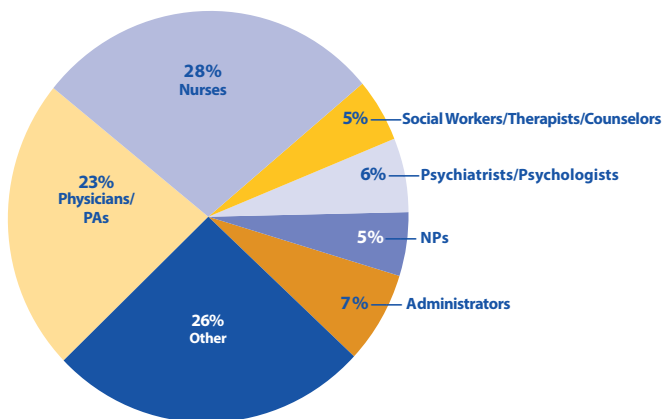
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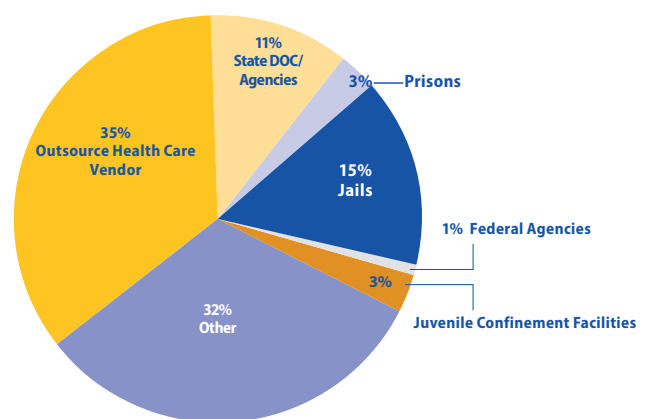
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## Expert Advice on the NCCHC Standards

By Wendy Habert, MBA, CCHP

### Qualification of Segregation Status

**Q** We have a restricted housing unit that allows individuals to leave their cells but only to interact with others who share their segregation status and are in their specific housing unit. Are they considered segregated?

**A** The short answer is yes. The key components for segregation status, regardless of level of contact a segregated individual may have with others, is the fact they are isolated from the general population and receive services and activities apart from other inmates. The living and confinement conditions define the segregated status, not the reason the person was placed in segregation. This may include administrative segregation, disciplinary segregation, protective custody, or special housing. Individuals who are segregated and have limited contact with staff and other inmates require monitoring three days a week by medical or mental health staff per Standard G-02 Segregated Inmates.

### Role of Facility Administrator versus RHA

**Q** I work in a jail, and I am confused about something. Who is the facility administrator? Is it the same person as the responsible health authority?

**A** This question comes up periodically; you are not alone in your confusion. The two roles are not the same person. The facility administrator is a custody-specific role, generally the top custody administrator (for instance, the warden or chief) who is specifically assigned to oversee facility operations. The responsible health authority (RHA) is a health services-specific role, generally the top health services person (for instance, the health services administrator or nursing supervisor) who is assigned to oversee health services operations. There are instances in which the RHA is a company (a private health services vendor), an agency (a local health department), or a regional- or corporate-level person (usually for small sites that do not have an on-site nursing supervisor). In these instances, the RHA must be designated to be on-site at least weekly.

### Policy and Procedure Crosswalk

**Q** I am a new HSA and am trying to find where the NCCHC standards are addressed in my policies and procedures. Is there an easy way to keep track of this? Is it OK that my policies are not numbered the same as the NCCHC standards manual?

**A** Yes and yes. This is actually a very common situation. Your health services policies and procedures are not required to mirror the numbering system used in the NCCHC standards manuals, although each NCCHC standard must be addressed in your policies and procedures. If your policies do not mirror the NCCHC standards numbers, we highly recommended creating a policy and procedure crosswalk document to quickly identify the NCCHC standard that corresponds to each health services policy. Make a spreadsheet that has all the NCCHC standards in one column. In the next column put the corresponding health services policies and procedures that address the compliance indicators within that standard. This document is a great resource when you are revising policies and an invaluable tool during your NCCHC accreditation surveys. ●

*Wendy Habert, MBA, CCHP, is NCCHC's director of accreditation. Send your standards-related questions to [accreditation@ncchc.org](mailto:accreditation@ncchc.org).*

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