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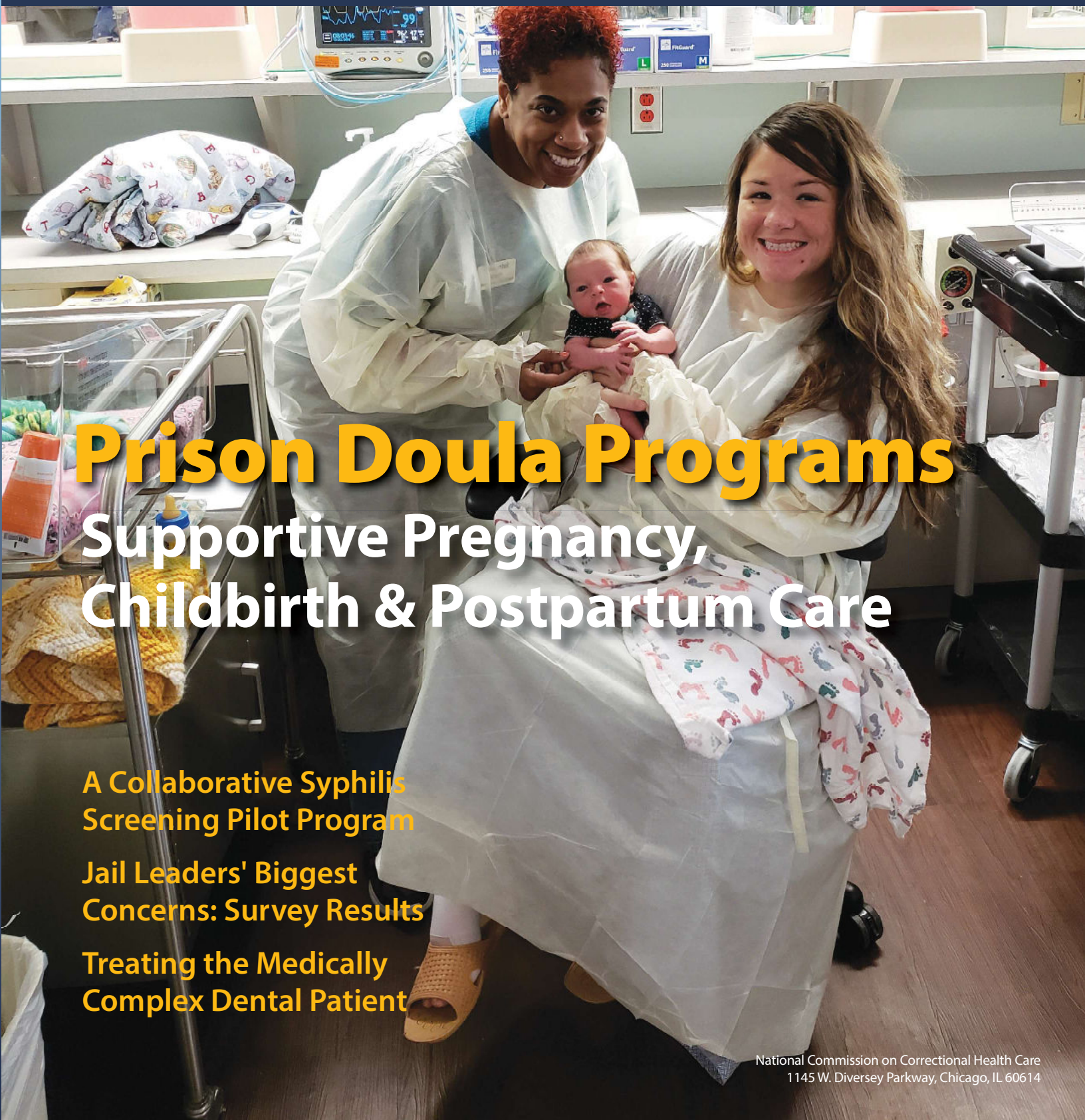
CorrectCare®

The magazine of the National Commission on Correctional Health Care



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CorrectCare®
The magazine of the National Commission on Correctional Health Care

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Cover design by Jill Cooper, photo courtesy Chauntel Norris, Alabama Prison Birth Project

Our Independence Matters

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NCCHC Foundation Launches Career Center

The NCCHC Foundation has launched a new online job board, a one-stop shop for correctional health professionals to look for opportunities and for employers to find the talent they need.

The Career Center is a great tool for both employers and for job hunters seeking new opportunities. Employers can post jobs or search the resume bank of qualified candidates. Job seekers can post multiple resumes and cover letters or choose a career profile that leads employers directly to them.

"By linking job seekers with employers, we can significantly reduce staffing challenges and improve patient care," said NCCHC CEO Deborah Ross, CCHP.

"We are very proud that the NCCHC Foundation is providing this essential service, fostering the growth and development of professionals in the field."

Learn more about the Career Center at **careers.ncchcfoundation.org**.

Position Statement on Aging Patients

NCCHC's most recent position statement, Care for Aging Patients in the Correctional Setting, is its first to address the "graying" of the incarcerated population. The overarching recommendation for correctional health professionals is to proactively assess and address their aging patients' evolving health concerns in four key areas: Mobility, Mentation, Medication, and What Matters – a framework widely used in geriatric medicine. Learn more at **ncchc.org/position-statements.**

Change in Accreditation Surveyor Policy

NCCHC is changing its accreditation surveyor scheduling process to include greater use of qualified professionals who are employed by correctional health care services vendors so that surveys can be conducted on a timely basis. Effective Oct. 1, 2024, physician and general surveyors assigned to a survey may be vendor-affiliated; lead surveyors assigned to a survey with a health services vendor will not be vendor-affiliated as per NCCHC's current policy.

Historically, NCCHC has honored requests from facilities not to assign vendor-affiliated surveyors. Increased demand for NCCHC accreditation and a large increase of accredited facilities using health services vendors has led to a backlog of surveys that necessitates the policy change.

"NCCHC relies on a volunteer cadre of surveyors. With the increased demand and limited number of non-vendor affiliated surveyors, accommodating requests to avoid vendor-affiliated surveyors has become extremely difficult," said NCCHC CEO Deborah Ross, CCHP. "These changes are designed to help keep accreditation costs down while still maintaining impartial accreditation surveying processes."

NCCHC Foundation Online Auction 2.0

Last year's online NCCHC Foundation auction was such a success, we're bringing it back again, bigger and better than ever! Don't miss your chance to bid on exciting experiences, weekends away, wining and dining, wellness packages, baskets of goodness, memorabilia, and more fun surprises. Bidding begins Sept. 23 and ends Oct. 22. Just scan the QR code to register, and get ready to bid!

All proceeds will benefit the Foundation's scholarship initiative, which so far this year has allowed 24 students and early-career professionals to attend NCCHC conferences. Fifteen more scholars have been selected to attend the 2024 National Conference on Correctional Health Care in Las Vegas, and with your support, those numbers will keep rising.

"My scholarship experience was a transformative journey that provided not only financial aid but also a supportive community and invaluable connections. It was a profound, deeply enriching opportunity," said 2023 National Conference Scholar Shaniqua Marsh, LPN. Hear more from the scholars on the NCCHC website or YouTube channel: **youtube.com/NCCHC.**

New AAPA Liaison Joins Board

Joshua Sung, PA-C, CCHP, CCHP-MH, has joined the NCCHC Board of Representatives as the new American Academy of Physician Associates liaison. With Rappahannock Creative Health, Sung provides acute and chronic medical and psychiatric care for incarcerated individuals throughout central Virginia.

Thoughts on Reentry and the Continuum of Care

By Elizabeth Lowenhaupt, MD, CCHP

As the psychiatrist and medical director of a juvenile correctional facility, I embrace the opportunity to develop and implement, alongside my team, state-of-the-art services for our incarcerated adolescent patients. They deserve every opportunity to grow and thrive, and it is our privilege to help them.

It has become increasingly clear, however, that our patients do not always have access to the services they need upon release to their communities.

John's Story

Take John, for example, an 18-year-old first detained at age 13. For five years, he cycled in and out of our facility – most recently for a two-year sentence.

Over the years, John was diagnosed with schizophrenia and ADHD. While in our care, he would consistently take his prescribed medications, only to stop each time he left, resume illegal substance use and gang activity, and return to the facility.

John did very well during his recent two-year bid with us. He earned his GED, maintained stability in terms of his psychiatric illness and aggression, and ultimately stepped down to a group home to complete the last few months of his sentence.

During a recent visit at my outpatient clinic, John expressed pride in his accomplishments and the fact that he had done well during his first weeks in the group home. He shared his intention to continue taking his meds and abstain from illegal substances … "for now."

But he wasn't sure what he would do once the external motivators for following the rules – probation and court supervision – ended. He talked about possibly staying in the group home until he is 21, which he is eligible to do, but also said he didn't like living with younger kids and having to follow rules like curfew. He did not yet have an identified primary care provider or therapist. He scheduled a medication management visit with me for a month later and asked me to give his regards to his clinical team back at the facility.

I'm not sure if John will return for his follow-up visit or if I will ever see him again. I certainly hope so. But I understand the enormous obstacles facing him and others like him: housing and employment challenges, the complexities of navigating the medical and mental health care systems, the pervasiveness of cannabis and stronger drugs, and the ever-present pull to return to gang-involved family and friends. Those forces far outweigh my influence as an outpatient psychiatrist.

Prioritizing Opportunities

I am fortunate to work at a facility that values rehabilitation, prioritizes access to clinical and educational services, and collaborates closely with other branches of the child welfare agency that create support upon release. John's prolonged period of incarceration allowed his team time to develop a discharge plan and make sure his insurance was active.

However, at 18, John is largely on his own to make decisions about where he will live, what type of job or classes he will pursue, and whom he will rely on to provide guidance and support. I can offer referrals for a new therapist or intensive psychiatric treatment programs, but those aren't his priority right now, nor are they necessarily what he needs as he sets out – currently stable from a psychiatric perspective – to make his way in the world.

Through the development of the HOPE for Justice Clinic (Hasbro Outpatient Psychiatric Evaluations for Justice-Involved and At-Risk Youth), which expands psychiatric treatment for youth involved in the juvenile legal system across a continuum of community-based and residential treatment settings, I can at least ensure that John has his medication and access to a health care professional he knows and trusts to help him make those decisions. And although I remain optimistic, it's clear to me that our system needs to do more to give patients like John a chance to see and experience the world differently outside the walls.

NCCHC for many years has supported correctional health professionals in providing the high quality health care that our incarcerated patients deserve. As we continue to work toward improving patient care and quality of life, we must prioritize – as individual providers, as facilities, and as an organization – access to services and opportunities for our patients upon reentry into the community. ●

Elizabeth Lowenhaupt, MD, CCHP, is the 2024 chair of NCCHC's Governance Board and board liaison of the American Academy of Child and Adolescent Psychiatry.

Prison Doula Programs
Supportive Pregnancy, Childbirth & Postpartum Care

Photo: courtesy Chauntel Norris, Alabama Prison Birth Project

By Rebecca Shlafer, PhD, MPH, and Carolyn Sufrin, MD, PhD, CCHP

Over the past three decades, the number of women incarcerated in the United States has increased dramatically. According to Bureau of Justice Statistics data, approximately 75% of women in prison are of childbearing age and a majority are mothers with minor children. While many jails and prisons do not systematically track pregnancy rates or outcomes, we conducted a landmark study, Pregnancy in Prison Statistics, which found that each year, more than 1,000 women give birth while incarcerated in U.S. prisons and jails.

Pregnant patients who are detained are at risk for poor birth outcomes, such as preterm birth, delivery complications, and postpartum depression. A number of reasons put them at higher risk for complications, including health conditions that preceded their incarceration, such as substance use and mental health diagnoses, and conditions of confinement that contribute to their increased risk, such as stress and limited social support.

Correctional health professionals play an essential role in the care and treatment of this unique patient population and have an opportunity to make a positive impact on not only the incarcerated mothers, but also their newborns. Timely, quality, patient-centered, trauma-informed care is critical, both throughout pregnancy and postpartum (after childbirth). In addition to appropriate medical care, prisons and jails have an innovative opportunity to promote the health of pregnant patients and their babies by providing doula services.

Introducing Doulas

A doula is a trained, certified professional who provides continuous physical, emotional, and informational support before, during, and after childbirth. Unlike doctors, nurses, and midwives, doulas do not provide medical care; rather their support complements the roles of the other health care professionals. They are by the patient's side

throughout labor and delivery to offer physical comfort and support, advocate for her, and collaborate with the rest of the health care team. They use physical touch and massage and suggest movements and positions to help ease pain.

While prison doulas provide their clients many of the same services as doulas in the community, they also offer some supports that are uniquely critical for incarcerated patients. For example, because most prisons prohibit family members from being present at the birth, a doula ensures that the patient won't be alone during the experience and offers support that might otherwise come from a family member. They are also permitted to take pictures of the mother and her newborn, providing important mementos that incarcerated patients would not otherwise have.

A prison doula is also there for the mother when she is separated from her newborn, usually soon after birth, and discharged back to prison. Not surprisingly, this is a difficult and traumatic time, and a prison doula can provide important emotional support.

have low rates of poor birth outcomes such as low birth weight and NICU admission, and high rates of skin-to-skin contact and breastfeeding initiation. As one client said, "Having a doula there made my experience a good one, it helped a lot! You have to find something positive about your birth experience while you're in prison, and my doula helped me achieve that."

Pregnant patients in prison often have a lot of questions, about their pregnancies in general and what will happen if they are still incarcerated when they give birth. Correctional health care staff have many demands on their time and may not be able to address all of their patients' pregnancy concerns. Prison doulas can step in and support the health staff by providing information, spending time with patients, and allaying their anxieties.

> "Having a doula there made my experience a good one. It helped a lot! You have to find something positive about your birth experience while you're in prison, and my doula helped me achieve that."
>
> Client

There are now more than 20 doula programs in prisons and jails across the U.S. The structure and services offered vary but most provide some combination of group-based prenatal education, one-on-one prenatal support and education (for example, helping clients create a birth plan), continuous labor and birth support, and breastfeeding and lactation support. Some programs offer additional services, including prenatal yoga or supported mother-infant visits.

The Many Benefits of Prison Doulas

There is considerable evidence on the benefits of doulas for pregnant patients in the general population. Studies suggest that doula care can make labor and birth safer for both mother and baby. Among the many benefits, doulas can increase maternal satisfaction with the birthing experience, reduce anxiety, reduce risk for birth complications, increase rates of breastfeeding, and reduce health care costs, according to research.

Our team has been working with prisons to provide doula services for nearly a decade. Over the years, we have conducted research with hundreds of clients and found that doulas fill a critical gap in the care and support of this patient population.

In qualitative interviews, clients who received doula support in custody reported feeling well-prepared for their births, had reduced feelings of stress and anxiety, and were highly satisfied with their experiences and the support they received before and after delivery.

Our research has also shown a positive impact for the babies. Those born to mothers with care from prison doulas

We have also found that doulas help custody staff with their job responsibilities and allow them to keep their focus on safety and security. We conducted qualitative interviews with custody staff who were with incarcerated patients during doula-supported births. Many of them expressed empathy and described a "natural" desire to offer the birthing person emotional support, but recognized the challenges of doing so given their role.

One officer said, "I think it's less stressful for staff when [the doulas are] there because it gives [the pregnant person] somebody to have for support so that [she] isn't trying to get that support from staff." Many officers reported that doulas made pregnant women feel more supported and comfortable. As another said, doulas "make our job easier, across the board."

Considering a Doula Program? Start Here

If you're considering starting a prison doula program in your facility, you don't have to start from scratch! States including Michigan, Minnesota, and Alabama have long-standing programs that can serve as models; other states, including Connecticut and Oregon, have started programs more recently. In addition, the Bureau of Prisons has recently launched a prison doula training program in partnership with the Ostara Initiative, a nonprofit organization that also supports the Minnesota Prison Doula Project and Alabama Prison Birth Project. Several jails also have doula programs.

Continued on the following page

The core elements to consider when starting a prison doula program are:

- Services: Prenatal, birth, and postpartum support activities
- People: Trained doulas, community partners, and champions at your facility
- Resources: Funding, supplies, education for facility staff

> "Doulas make our job easier, across the board."
>
> Custody Officer

First, **identify your patient population and their needs.** Examine existing data sources and collect new data as needed to more fully understand the patient population. What does your facility know about these patients? What are the gaps? How are people screened for pregnancy? How many people admitted each year are pregnant? How many give birth? What pregnancy care services and specialists does your facility provide access to?

After collecting facility-level data, **seek the perspectives of those with lived experiences.** With the help of a skilled, trauma-informed facilitator, hold listening sessions with incarcerated people who were pregnant and/or postpartum at your facility. What would have helped them feel more prepared and supported during their pregnancy, birth, and beyond? Be open and willing to explore solutions to address concerns they raise.

Gather the perspectives of front-line staff about their experiences working with pregnant people in the facility. Custody officers and other front-line staff generally have valuable insights and can offer practical solutions to challenges they encounter in their work.

Understand the screening, care, and treatment of people who are postpartum (gave birth in the last year), whether they gave birth while in custody or not. Like pregnant people, those who are postpartum have physical and mental health needs that are different from the general population.

Review current policies and practices that impact the health and well-being of pregnant and postpartum patients, both directly and indirectly. A majority of states have passed laws that limit the use of restraints on pregnant and postpartum patients – know your state's law. Pregnant people have special nutrition and clothing needs, and those needs change over the course of pregnancy and postpartum. Do your current policies reflect those changing needs? Prison policies often include unclothed body searches following off-site appointments, which happen frequently for pregnant patients. In what ways are the physical needs of postpartum people considered in these policies? Also consider your facility's policies and practices related to hydration, exercise, transportation, lockdowns, and visiting. That examination will likely provide new insights into possible improvements.

Consider who should be involved in the development of your facility's program. Are there existing or potential partners within your agency or region? For example, does the hospital your residents are transferred to for labor and delivery employ or work with doulas? In our experience, correctional doula programs are most successful when they partner with existing community-based services. Doulas should have deep expertise with birth work and understand the complex needs of the justice-involved population – that makes it easier for everyone involved. We strongly recommend that the perspectives of directly impacted people be infused into every aspect of the program, from development to implementation.

Building a Doula Program

We have found that the most effective prison doula programs offer consistent and predictable programming. Many programs include once-weekly 90- to 120-minute group sessions with a skilled facilitator that combine prepared pregnancy-related educational content with open time for group members to share, reflect, and support one another. Some programs offer a nutritious meal or snack during the group. Many also include one-on-one prenatal support; doulas meet individually with their clients each week during pregnancy and postpartum for emotional support and information.

Probably the most essential component of these programs is the one-on-one continuous support doulas provide during labor and delivery at the hospital or birthing center. Making this work requires clear policies and procedures for everyone who has a role in ensuring the patient's safe transport off prison grounds, her safety at the hospital, and her return to prison. That includes facility staff, transport staff, doulas, and hospital staff.

Facility staff must have a process in place to notify the doula when a client goes into labor and, given the unpredictability of labor and birth, these systems must be time-sensitive and responsive. It is also essential that

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Treating the Medically Complex Dental Patient

By Mark Szarejko, DDS, CCHP

I spent more than half of my 38-year general dentistry career as a staff dentist in county jails in Florida. Most of the patients I treated had at least one chronic disease; many had not received routine medical or oral care until they were incarcerated, at which point the exacerbations of their untreated medical or dental problems were evident.

Each patient is of course unique; dentists must evaluate each individual's circumstances and medical history before proceeding with treatment and seek medical consultation when necessary. This article highlights the ways some of the most common medical conditions among the incarcerated population impact oral health and dictate appropriate, safe treatment for dental problems.

Hypertension

Hypertension is a common cardiovascular medical condition that can present as a "stand-alone" disease or with comorbidities such as diabetes or other cardiovascular diseases. Also known as high blood pressure, it is a major risk factor for cardiovascular disease and stroke.

Anxiety about dental procedures can increase production of epinephrine and norepinephrine, vasoconstrictors that increase blood pressure (so-called "white coat" hypertension). Most local anesthetics used in dentistry contain epinephrine, because it increases the depth and duration of the anesthetic and promotes hemostasis, the process that stops bleeding after an injury or surgery. In patients with acute ("white coat") or chronic high blood pressure, therefore, local anesthetics with epinephrine should be used conservatively and only if local anesthetics without epinephrine are not available.

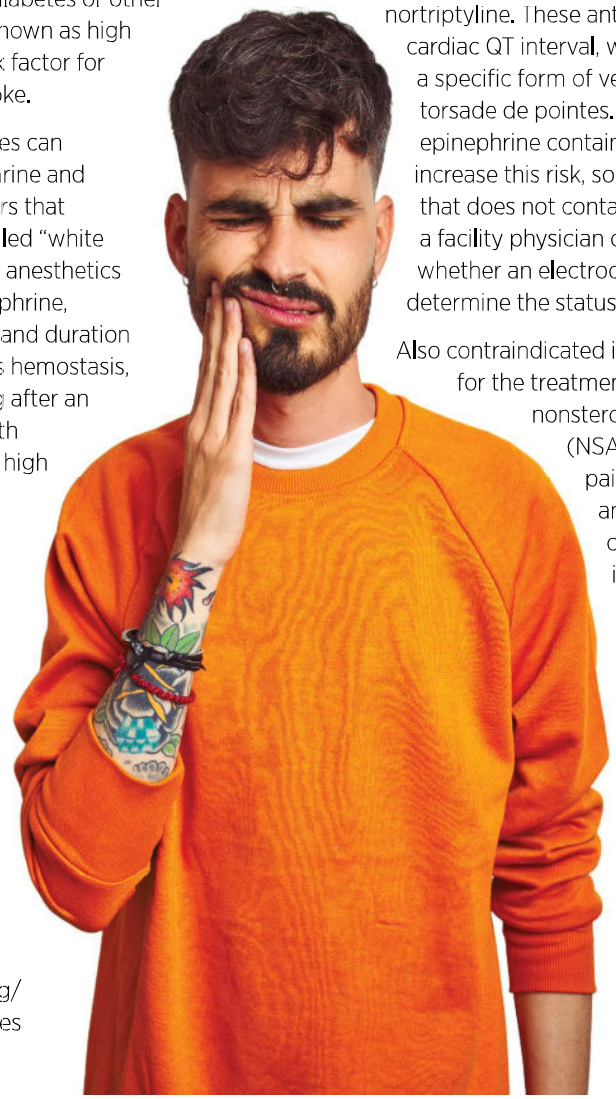
There is debate within the dental profession about the level of blood pressure at which elective oral treatment should be deferred or postponed. Some studies suggest that elective oral treatment can safely be performed if blood pressure (systolic/diastolic) is 179 mm Hg/110 mm Hg or lower. Most studies take those numbers down to 160 mm Hg/100 mm Hg, and recommend that the higher reading be used very carefully if at all.

It is essential that the patient's blood pressure be evaluated prior to any dental procedure to determine a baseline level. The decision to proceed with elective treatment of a hypertensive individual must be made on a case-by-case basis, with the patient's safety as the overriding concern.

Mental Health

At the correctional facility where I worked, about 40% of the population was prescribed one or more psychotropic medications. Oral treatment is generally not contraindicated in patients taking psychotropic meds, but some precautions must be observed to avoid adverse drug interactions.

As for people with high blood pressure, the use of epinephrine in local anesthetics is a concern for those taking tricyclic antidepressants such as amitriptyline and nortriptyline. These antidepressants can prolong the cardiac QT interval, which can increase the risk of a specific form of ventricular tachycardia called torsade de pointes. It is unclear whether the epinephrine contained in local anesthetics will increase this risk, so it is safer to use an anesthetic that does not contains epinephrine. Consult with a facility physician or nurse practitioner to clarify whether an electrocardiogram is indicated to determine the status of the patient's QT interval.



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Also contraindicated is lithium, a mood stabilizer used for the treatment of bipolar disorder, taken with nonsteroidal anti-inflammatory drugs (NSAIDs) commonly used to relieve pain such as ibuprofen (Advil®) and naproxen (Aleve®). The combination of lithium and either ibuprofen or naproxen can cause lithium toxicity, or overdose, which can be fatal. For patients taking lithium, acetaminophen (Tylenol®) should be used for analgesic purposes, pending compatibility with the individual's medical history.

Facilities differ in the availability of over-the-counter NSAIDs for purchase at the canteen/commissary. Patients for whom lithium has been prescribed must be educated about this potentially dangerous contraindication. In

my experience, I have found that many patients consider "over the counter" to mean completely safe, without the potential for any adverse drug interactions, since they are available without a prescription. Many patients also believe that amounts exceeding the recommended maximum daily dosage will provide additional therapeutic benefits without any adverse systemic effects. As health care professionals, we must teach our patients that neither belief is true.

HIV/AIDS

Since the discovery of the human immunodeficiency virus in the 1980s, there has been exponential progress in the medications and treatment protocols available to people living with HIV/AIDS. Groundbreaking antiviral regimens allow many people with HIV to maintain decreased viral loads and reasonable CD4 cell levels, white blood cells that fight infection (also known as CD4+ T cells). Consequently, most HIV patients do not need modifications for oral treatment.

Unless there is a preexisting cardiac condition, antibiotic premedication prior to invasive dental treatment or oral surgery is generally not necessary for HIV/AIDS patients, or for those who are not HIV-positive. In 2007 the American Heart Association revised the guidelines for antibiotic prophylaxis prior to invasive treatment such as oral surgery to reflect concern over the growth of antibiotic resistance and the potential for allergic reaction to prescribed antibiotic.

Some issues, however, can influence oral health and the ability to provide oral treatment for people with HIV/AIDS.

As with lithium, some of the myriad antiviral medications used for the treatment of HIV/AIDS may have an adverse drug interaction if combined with NSAIDs, which can cause renal complications. A different analgesic, such as acetaminophen, that is compatible with the patient's medical history should be used instead.

One complication of HIV/AIDS is cyclic thrombocytopenia (low platelets), which can occur at any point in the progression of the disease. Platelets are essential for achieving hemostasis; a decreased platelet level can challenge the ability to obtain hemostasis, which can be exacerbated if conditions such as hepatitis C or cirrhosis decrease the production of coagulation factors synthesized in the liver.

If there is any doubt about a patient's ability to obtain hemostasis, laboratory tests such as a complete blood count with differential and a prothrombin time can be ordered; the results will determine the patient's ability to obtain hemostasis after oral surgery.

As HIV progresses and CD4 levels diminish, oral and systemic opportunistic infections develop, which in HIV/AIDS patients can present with more virulence and be refractory to common treatment regimens. Oral candidiasis, or thrush, is the most common opportunistic infection within the oral cavity.

Because oral microorganisms can be disseminated from dental extraction sites, opportunistic oral infections must be resolved before oral surgery is performed on HIV/AIDS patients. The dissemination of microorganisms through the body is generally not an issue for individuals with healthy immune systems but can wreak havoc on someone with a rapidly depleting CD4 level, causing regional or systemic infections and even sepsis.

Ischemic Heart Disease

Many individuals with ischemic heart disease, caused by reduced blood flow to the heart, are prescribed either antiplatelet or anticoagulant medications, which prevent clots from forming and prevent blood from clotting too easily. These medications can save lives by preventing stroke or heart attack but hinder the patient's ability to achieve hemostasis after oral surgery. For that reason, in the past it was common to hold antiplatelet and anticoagulant medications for a period of time before oral surgery.

This temporary interruption, however, caused some patients to experience adverse cardiovascular or cerebrovascular events. Several studies have indicated that most oral surgery procedures can proceed without a temporary deferral of antiplatelet or anticoagulant medications, and the temporary hold of these medications is no longer a uniform practice.

Dental clinicians treating people who take antiplatelet or anticoagulant medications should consult with the patient's physician or nurse practitioner to determine if the use of these medications can be continued. Patients must be evaluated on a case-by-case basis, with considerations given to the extent and complexity of the surgery and the degree of the individual's anticoagulation. Patients taking warfarin can be assessed by a laboratory measurement known as the international normalized ratio; a prothrombin time can be prescribed for those taking newer anticoagulants such as dabigatran and rivaroxaban.

In corrections, collaboration between health care professionals is always called for, and collaboration between dental clinicians and facility physicians is especially important given the chronic diseases that can present challenges for oral treatment. Dental clinicians must understand these factors to ensure oral treatment that is safe, efficacious, and improves the patient's quality of life. ●

Mark Szarejko, DDS, CCHP, recently retired after 38 years as a general dentist, 22 of them as a correctional staff dentist with Hillsborough County Jail and Pinellas County Jail in Florida.

RELEVANT NCCHC STANDARD

E-06 Oral Care: Inmates' dental needs are addressed.

NCCHC Standards for Health Services 2018

A Collaborative Syphilis Screening Pilot Project

By Elizabeth Samson, MA, LMHC, CCHP, and Diane Bartlett, CCHP

According to Centers for Disease Control and Prevention surveillance data, cases of syphilis among the general public increased 74% from 2017 to 2021, and congenital syphilis soared by over 203%. For individuals who are incarcerated and those with a history of incarceration, the risk of syphilis is one and a half times higher than for those who have never been in jail or prison.

Many county jails test for syphilis and other sexually transmitted infections only if a patient presents with symptoms or requests testing. That limited form of testing, known as "passive case detection" or "opt-in testing," is inadequate in that it fails to identify asymptomatic individuals and misses the opportunity to safeguard the health of incarcerated patients and their future sexual partners, as well as creating potential medical issues for any future children.

Untreated syphilis during pregnancy increases the risk of miscarriage, prematurity, and stillbirth, as well as severe birth defects. According to the CDC, clinical manifestations may include saddle nose due to destruction of cartilage, frontal bossing, tibial thickening, joint swelling, perforation of the hard palate, abnormal tooth development, interstitial keratitis, neurologic deafness, and optic atrophy.

In Palm Beach County, Fla., 2022 county-level surveillance data showed a syphilis rate (all stages) of 25.0 per 100,000 among women – a strikingly high increase from just one year before. To address the rising rate, Wellpath, in collaboration with the Palm Beach County Sheriff's Office, designed an opt-out testing pilot program to screen all women processed into the Main Detention Center within 48 hours of their intake. The goal: to identify and assist – as early as possible – those who may require treatment and services from the local Department of Public Health.

At the core of the pilot program is the compelling story of one patient, Jane Doe. Her interaction with the criminal justice system unveiled a complex medical history, demonstrating the critical role of proactive health care initiatives in correctional facilities (see sidebar, next page).

Pilot Program Design

Subject matter experts from the CDC and Emory University were instrumental in developing the testing protocol and selecting the location. The Florida Department of Public Health generously provided rapid syphilis testing kits, a qualitative assay for detection of syphilis antibodies that requires two drops of blood using a finger stick.

Over the course of the pilot program, opt-out testing was offered to all women entering the Palm Beach County Main Detention Center during their health and physical exam (H&P). Typically, H&Ps and STI testing occur within seven to 14 days of arrival, but with the sheriff's department assistance, patients were transferred to the clinic sooner – between days two and three – for their assessments, including the rapid syphilis test. Three cohorts were considered: pregnant women, non-pregnant women, and those with an unknown pregnancy status.

Photo © Jarun Ontakrai/Shutterstock

Results

During the 90-day project, a total of 1,417 women were booked. Of these, 1,005 were released prior to screening being offered. Thirteen were not clinically indicated for rapid testing as

they reported a history of syphilis. A total of 145 patients were tested. Of those, three had reactive tests, indicating current or past syphilis and the need for further testing.

Of the women booked, 33 had a known pregnancy status; of those, 19 were released before screening. Of the remaining 14 pregnant patients, eight opted out of testing and six received the rapid test. Among those tested, three had reactive tests. Two were released before confirmatory testing could be conducted; for the third, Jane Doe, confirmatory testing indicated the presence of syphilis.

Preliminary data indicates the average length of stay for women was less than 24 hours. As a result, approximately 71% of them were released prior to being screened. Ideally, testing would have taken place closer to intake; however, the constraints of existing staff workloads and the complexity of the intake process made that impossible.

Final Thoughts

The implementation of the Syphilis Opt-Out Testing Pilot at the Palm Beach Main Detention Center demonstrates the pivotal role of promptly identifying and addressing active syphilis infections and emphasizes the broader impact of public health initiatives within vulnerable populations such as incarcerated individuals.

The pilot program serves as a model for other correctional facilities, highlighting the potential to not only improve the health of individuals within the system but also protect the well-being of current and future generations. ●

Elizabeth Samson, MA, LMHC, CCHP, is continuous quality improvement director and Diane Bartlett, CCHP, is clinical innovations coordinator with Wellpath.

The authors would like to express their gratitude to the individuals and organizations that played pivotal roles in the successful completion of this project: Wellpath Corporate, Regional, and on-site leaders and staff; the Palm Beach County Sheriff's Office; the Florida Department of Public Health; and subject matter experts from the CDC and Emory University.

Case Study: Meet Jane Doe

Jane Doe, a 33-year-old woman, was arrested and booked into the Palm Beach County Sheriff's Office. During intake, Ms. Doe disclosed a recent emergency department admission for suspected chest pain. According to hospital records provided to the jail with the patient's consent, a blood test revealed elevated D-dimer levels, hinting at a potential pulmonary embolism or other dangerous blood clot. Despite that, the patient had signed out of the emergency department against medical advice.

The hospital records also revealed that Ms. Doe had been given a pregnancy test, which confirmed that she was 11 weeks pregnant. She reported recent alcohol, opiate, and cocaine use.

At the jail, appropriate detox protocols were initiated, and she was referred for medical appointments, started on prenatal vitamins, and given a pregnancy diet order. She was housed in an infirmary unit at the jail and seen by a medical provider before transfer to a general population housing unit.

Prior to administering the syphilis rapid test, the nurse coordinator conducted a mandatory risk assessment, which helps ensure that patients with a history of syphilis or active symptoms are not tested, as their results will always be reactive. The assessment form also includes questions about the patient's medical history and risk factors.

Ms. Doe denied any history of previously being diagnosed with syphilis but reported several risk factors during the 12 months prior to her current arrest, including multiple sex partners, sex for money/drugs, commercial sex, and illicit drug use. The physical symptoms she reported were swollen lymph nodes in the groin and an abscess in her leg from IV drug use. She also reported being homeless.

Ms. Doe's result was reactive, indicating current or past syphilis. Further testing confirmed that she was positive for syphilis. She also tested positive for chlamydia and gonorrhea. All required documents were completed, and contact was made with Department of Public Health community case workers

Over the course of the 12 days she was in custody, Ms. Doe received the first of three injections of an antibiotic to treat the syphilis, as well as treatment for chlamydia and gonorrhea. She left the facility with a discharge plan and prescription for two more injections.

Prepared with the patient's contact information and discharge plan provided by the detention center's Wellpath health care team, the local health department was equipped to follow up with her and support her in securing the last two doses of medication, with continued support from the Florida Department of Public Health and community case workers.

The Opt-Out Testing Pilot not only found and treated an active syphilis infection in Ms. Doe but also played a crucial role in preventing potential long-term effects on her unborn child. By identifying the infection early in the pregnancy, timely and appropriate interventions were started early, minimizing the risk of severe birth defects associated with congenital syphilis.

Patients are our passion.

Together, we can tackle the opioid addiction crisis.

The opioid crisis is a national public health emergency, and the criminal justice system is also feeling the impact of the epidemic. People using opioids have a 52–77% chance of becoming involved in the criminal justice system. Opioid use disorder can be treated effectively with medication, and such medication is not only effective, but can save lives.[1]

Reference:

1. Substance Abuse and Mental Health Services Administration (SAMHSA). Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings. U.S. Department of Health and Human Services. 2019. PEP19-MATUSECJS. Accessed February 2023.

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Challenges Facing Jails Today - and Tomorrow

Findings From an NCCHC Resources Survey of Jail Leaders

By Claire Wolfe MPH, MA, CCHP, and Fred Meyer, MA, CJM, CCHP

Within jails, both custody and health staff are charged with working to improve the likelihood that those who leave will be able to live self-directed, successful lives in the community. The perspective of custody staff is essential in the pursuit of effective cross-disciplinary collaboration.

To learn what custody leaders see as the most pressing challenges facing U.S. jails, NCCHC Resources staff conducted an anonymous online survey of graduates of the National Jail Leadership Command Academy at Sam Houston State University, an ongoing partnership between the American Jail Association, the Correctional Management Institute of Texas, and the university.

NJLCA is a rigorous leadership training course for those transitioning into senior and executive leadership positions within jails. More than 1,800 correctional leaders from throughout the country have graduated from the program.

The "Perceptions of Primary Challenges Facing Jails" survey included both closed and open-ended questions about current and ongoing challenges. The survey was emailed to potential respondents twice by the AJA.

Survey Results

In total, 55 correctional leaders responded to the survey. Respondents were concentrated in the southeastern United States (45%), followed by the Midwest (22%), southwest (13%), and west (13%). Two respondents (4%) were from the northeast. Over 90% reported that they have worked in corrections for more than 10 years. Most respondents (59%) were from medium-sized jails, which the AJA defines as having an average daily population between 100 and 999, followed by large jails (30%), defined as having an ADP of more than 1,000.

Figure 1 illustrates responses to closed-ended questions where respondents were asked to rank their agreement on a Likert scale regarding substance use, suicide prevention, and collaboration between custody and health staff as top challenges facing jails. Based on our experience and prior research, we hypothesized that these issues would be considered the primary challenges. The majority of respondents either strongly or moderately agreed.

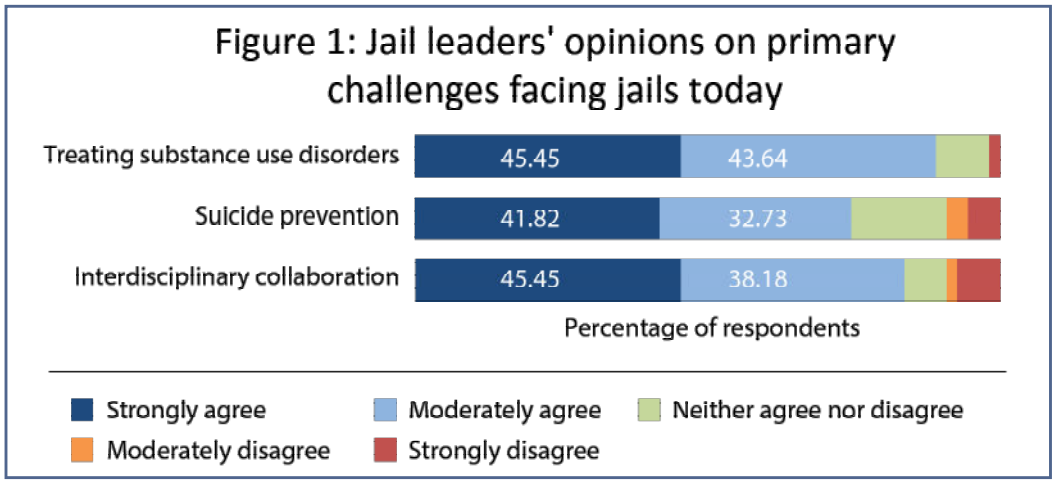
Respondents were then asked to describe, in their own words, the top five challenges facing jails today. Responses were analyzed for common themes.

The most common response, ranked by 55% of respondents as the top challenge, related to staffing. Concerns included recruitment, retention, and pay, with one person citing burnout as a top concern. Some responses mentioned staffing generally, while others specified custody and/or health care staffing issues.

After staffing, mental health – of incarcerated individuals, staff, or both – was cited most frequently; 24% of respondents ranked mental-health issues as the top challenge. Substance use (e.g., "overdose" and "substance use disorder") and overpopulation/issues with physical space (e.g., "overcrowding" and "building design") were each cited by 7% of respondents.

Other topics mentioned frequently included funding, both generally and specifically for health care (e.g., "medical

Continued on page 17



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care/cost" and "funding for proactive activities"), a need for culture change in jails (e.g., "law enforcement culture change" and "bringing about and welcoming effective change"), and legal, political, and legislative factors (e.g., "unfunded mandates," "legislative/political influences," and "slow court movement").

When asked about top challenges in the next five years, the responses largely mirrored those from the previous question, with staffing (42%), mental health (18%), and overpopulation/lack of space (16%) cited most frequently as the anticipated top challenge.

Takeaways

While these results largely align with what we know about the challenges facing jails, they reiterate important points that warrant discussion.

Within jails, current strategies to recruit and retain accountable and dedicated custody and health staff appear to be deficient. This is also true in the community in regard to health care workers, with shortages evident now and expected in the future. We recommend these recruitment and retention strategies, with the understanding that they may not all be immediately feasible:

- **Strengthen recruitment.** Use targeted recruitment strategies, engage with local community and educational institutions to raise awareness about career opportunities in corrections, and implement a referral program that rewards current employees for recruiting new hires.
- **Cultivate your culture.** Promote a safe and supportive work environment, creatively allow for sustainable work-life balance, provide resources for stress management and positive mental health, and appreciate and recognize staff's hard work and dedication.
- **Seek feedback.** Conduct exit interviews with both structured and open-ended discussion, provide dedicated time or a formal mechanism for both positive and negative feedback from current employees, be open to feedback and make relevant changes when possible.
- **Support personal growth.** Offer training and continuing education opportunities that go outside the bounds of mandated topics, create and communicate clear career advancement pathways, and establish mentorship programs to support new employees and encourage professional growth.

The intersection between mental health, substance use, and incarceration is a long-standing public health problem that continues to put pressure on jails. Engaging in advocacy at the local and state levels can ensure that voices reflecting the needs of patients and staff in jails are heard.

Inside the walls, ensuring that proper behavioral and pharmacological treatment is provided for mental health and substance use disorders can reduce risks and adverse events. Sound policies, procedures, training, and external partnerships are crucial in ensuring comprehensive screening, timely assessments, evidence-based treatment, and reentry services.

Correctional leadership and policymakers must thoughtfully and intentionally consider the role that time in jail should be designed to play and implement policies that support such an environment, including those regarding the workforce. Additionally, it is increasingly imperative to investigate how community resources can be made accessible before and after incarceration to prevent and treat mental health and substance use issues. Sustained, long-term leadership and coordination at all levels and across disciplines is crucial. Despite constraints, solutions are clearly needed. ●

Claire Wolfe, MPH, MA, CCHP, is a program manager with NCCHC's consulting arm, NCCHC Resources, Inc. Fred Meyer, MA, CJM, CCHP, is managing director.

CCHP Certification: It's for Custody Staff Too!

By Richard Forbus, MBA-HCM, CCHP, and Fred Meyer, MA, CJM, CCHP

A major challenge that impacts the provision of effective correctional care is the gap that can exist between health care and custody. Those critical operational functions are often seen as separate from each other.

In reality, the mission and goals of health care and custody overlap considerably, and collaboration between the two areas is key to ensuring quality care, safety, and security. Anyone working in a facility where there is a close working relationship between health care and custody understands that. And anyone working in an NCCHC-accredited facility knows that adherence to the NCCHC standards fosters and supports that collaborative relationship.

Certification as a Certified Correctional Health Provider (CCHP) demonstrates knowledge of and proficiency in NCCHC's nationally recognized standards for health care services. With the management of carceral facilities becoming increasingly complex, knowledge of the standards is as important for custody leadership and staff as it is for health care leadership and staff. Mastery of NCCHC's standards is directly correlated with understanding the "whys" of the health services operations.

Authors Fred Meyer (left) and Richard Forbus at the National Association of Counties annual conference.

Custody administration shares responsibility for ensuring access to care, as well as liability for not doing so. We all have a vested interest in ensuring that care is accessible, appropriate, and meets standards of care. "I don't know" will not suffice in today's environment of public scrutiny, accountability, and liability. We need to work together to provide effective care, reduce adverse events, and mitigate risk.

Despite the high stakes, certification is underutilized by custody staff. Many custody professionals may not even know they are eligible to take the CCHP exam. Rest assured, they are. All professionals working in correctional health, including administrative, mental health, and support staff, are eligible to participate in the CCHP program.

The benefits of certification are just as significant for custody as they are for health staff, especially for those in key roles related to health care operations. If that is you, think back to what kind of training you received when you took on the role. Whether it's line operations or oversight, there is often no formal training requirement for those roles, despite their demands. The responsibilities are often much more significant than expected.

Coming from those roles, we understand the value CCHP certification brings to them. Understanding the context behind operational decisions allows leadership to see potential gaps that could lead to liability and litigation. The same is true for dedicated line staff such as medical liaisons, for the same reasons.

We've only scratched the surface in discussing the benefits of CCHP certification for custody professionals. For more information, contact info@NCCHCresources.org. ●

Richard Forbus, MBA-HCM, CCHP, is NCCHC's vice president of program development, and a retired corrections captain; Fred Meyer, MA, CJM, CCHP, is managing director of NCCHC Resources, the organization's consulting subsidiary, and a retired deputy chief.

A Firsthand Testimonial from a Retired Deputy Chief

By Fred Meyer, MA, CJM, CCHP

As a bureau commander in a large jail facility, one of my responsibilities was oversight of custody and health care operations, as well as contract compliance. I attended NCCHC conferences and identified many educational sessions that applied to my position. We are all aware that suicide is the leading cause of death in jails and that the inmate population is much more acutely ill compared to the general population. I was determined to engage with medical and mental health leadership as much as possible to improve operations and mitigate our risk.

Over time, we began to reference the NCCHC standards to encourage effective operations analysis during inter-disciplinary and administrative meetings. I wanted to learn more. I studied and was successful in my efforts to earn CCHP status. As a result, I was able to actively participate in continuous quality improvement meetings with the knowledge to identify concerning trends. We were subsequently able to better ensure accountability from our health care services vendor and build a true interdisciplinary leadership team.

Once I was appointed to executive staff as deputy chief, I carried that knowledge with me and encouraged the leadership team to become CCHP-certified as well. Our facility experienced success with a substantial reduction in suicides and improved care for those in our custody. We worked toward the interdisciplinary team approach at all levels and were able to attain both health care services accreditation and mental health accreditation through NCCHC.

Becoming a CCHP was an important and valuable step in this journey, and I recommend it for all correctional professionals.

Ready to become a CCHP? The CCHP exam will be offered at the National Conference on Correctional Health Care in Las Vegas on Sunday, Oct. 20, 1 - 3 pm. Learn more and submit your application (by Sept. 26) at ncchc.org/cchp.

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Pain, Depression in Older People in Custody

As in the U.S., Canadian prisons are seeing a rise in the proportion of older adults (often defined as age 50+ due to accelerated aging in custody). Older adults in federal custody will make up nearly 25% of the census by 2030, according to the Canadian government.

Given the higher rates of poor health among older adults, it's no surprise that mood disorders and pain are two concerns seen more often in prisons than in the community. Researchers from several universities in the province of Ontario, Canada, as well as from Correctional Service Canada (CSC) and a health system, examined health indicators associated with pain and depressive symptoms among people age 50+ from multiple federal facilities across the country. The cross-sectional study included residents from a variety of general population security levels, a facility's assisted living unit, and community correctional centers.

Study Methods

As reported in the August *Journal of Correctional Health Care,* Mofina and colleagues conducted recruitment and data collection in two phases. In the first, the two subgroups were men aged 65+ and women aged 50+. Phase two subgroups were men aged 50-64 and men in community correctional centers. The numbers of participants in each group were 465, 63, 66, and 828, respectively.

After receiving training, CSC nurses who were part of the research team assessed participants using the interRAI Emergency Department Contact Assessment (ED-CA), which captures key health indicators of cognitive, social, and functional aspects of health. The 39 items in the assessment are measured via clinical observation, clinical records, client reporting, self-report, and reporting by others close to the client.

The ED-CA also addresses institutional risks (e.g., levels of care available, patients' impairment in activities of daily living), urgency of the need for a more comprehensive assessment, and the clinical problem list, which gauges severity and/or impairment to inform care planning. The instrument was modified to include questions about the prison system, such as history of incarceration and type of residential setting.

Findings

Of the 1,422 participants in this study, the majority (55%) experienced pain. Depression and anxiety were recorded for between 30% and 52% of participants, and the prevalence of moderate depressive symptoms, as measured on the mood scale, ranged from 22% to 41%. The authors report that these rates are notably higher compared to those of older Canadians in the community.

The highest rates of functional difficulties were seen in men aged 65+, with 12.5% of men having difficulty completing ADLs and nearly 20% having difficulty with instrumental ADLs. However, men in the younger group had the highest rate of acute cognitive change, 11.5%.

With regard to predictors of mood/depressive symptoms, the three significant indicators were functional health items: managing medications, falls, and dyspnea. For pain, the significant indicators were dyspnea, medication management, and falls, as well as results from the mood scale.

In discussing these results, Mofina and colleagues highlight that, from a clinical perspective, the finding that functional indicators were the main predictors of pain and depressive symptoms suggests that interventions should address these underlying functional issues. They propose a biopsychosocial approach that entails interprofessional team involvement working collaboratively to address these broader health domains that present as risk factors for depression and pain.

This is especially important given the evidence that, if left untreated, depression and pain can lead to further functional and clinically distressing symptoms or adverse events such as increased risk of suicidal ideation, self-harm, violence, and increased functional dependence. The authors also say it is important to identify risk factors early to support more preventive upstream holistic interventions to address functional risk factors. ●

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- Compassionate Release: A Call to Social Workers
- Peer Education as a Tool to Improve Health Knowledge for People Who Are Incarcerated: A Secondary Analysis of Data From the Indiana Peer Education Program ECHO
- Correlates of Staff Acceptability of a Novel Telemedicine-Delivered MOUD Program in a Rural Detention Center
- Perinatal Health Outcomes Among Women on Community Supervision: A Scoping Review
- Prescription Patterns in Jails Before and Since the COVID-19 Pandemic: A Multisite Serial Cross-Sectional Investigation
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Abrupt postoperative reversal of opioid depression may result in adverse cardiovascular (CV) effects. These events have primarily occurred in patients with preexisting CV disorders or who received other drugs with similar adverse CV effects. Monitor these patients closely in an appropriate healthcare setting.

In newborns, opioid withdrawal may be life-threatening if not recognized and properly treated and may also include convulsions, excessive crying, and hyperactive reflexes. Monitor for symptoms of opioid withdrawal.

Risk of Opioid Overdose from Attempts to Overcome the Blockade: Taking large or repeated doses of opioids, such as heroin or prescription pain pills to overcome blockade, may lead to opioid intoxication and death.

ADVERSE REACTIONS: Most common adverse reactions (incidence at least 2%) are nasal discomfort, headache, nausea, dizziness, hot flush, vomiting, anxiety, fatigue, nasal congestion, throat irritation, pain in the nose, decreased appetite, changes in sense of taste, skin redness, and increased sweating.

To report a pregnancy or side effects associated with taking OPVEE® or any safety related information, product complaint, request for medical information, or product query, please contact PatientSafetyNA@indivior.com or 1-877-782-6966. You are encouraged to report negative side effects of drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

Please see Summary of Important Safety Information on following page and full Prescribing Information at OPVEE.com.

References: 1. Prescribing Information for OPVEE®. **2.** Somerville NJ, O'Donnell J, Gladden RM, et al. Characteristics of fentanyl overdose — Massachusetts, 2014-2016. *MMWR Morb Mortal Wkly Rep.* 2017;66(14):382-386. **3.** Skolnick P. Treatment of overdose in the synthetic opioid era. *Pharmacol Ther.* 2022;233:108019.

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Risk of Recurrent Respiratory and Central Nervous System Depression: While the duration of action of nalmefene is as long as most opioids, a recurrence of slowed breathing (respiratory depression) is possible after an apparently adequate initial response to OPVEE®. Therefore, it is necessary to seek emergency medical assistance immediately after administration of the first dose of OPVEE® and to keep the patient under continued surveillance. A second dose may be necessary if there is recurrence of symptoms of opioid overdose.

Risk of Limited Efficacy with Partial Agonists or Mixed Agonist/Antagonists: Improvement in respiratory depression caused by medicines such as buprenorphine and pentazocine may not be complete. Repeat doses of OPVEE® may be required.

Precipitation of Severe Opioid Withdrawal: Use in patients who are opioid dependent may cause symptoms of opioid withdrawal like body aches, fever, sweating, runny nose, sneezing, goose bumps, yawning, weakness, shivering or trembling, nervousness, restlessness or irritability, diarrhea, nausea or vomiting, abdominal cramps, increased blood pressure, and rapid heart rate. Some patients may become aggressive when an opioid overdose is treated.

Abrupt postoperative reversal of opioid depression may result in adverse cardiovascular (CV) effects. These events have primarily occurred in patients with preexisting CV disorders or who received other drugs with similar adverse CV effects. Monitor these patients closely in an appropriate healthcare setting.

OPVEE® is not indicated for use in patients less than 12 years of age. In newborns, opioid withdrawal may be life-threatening if not recognized and properly treated and may include convulsions, excessive crying, and hyperactive reflexes. Monitor for symptoms of opioid withdrawal. Particularly during the postpartum period in neonates with known or suspected exposure to maternal opioid use, it is preferable to avoid abrupt precipitation of opioid withdrawal symptoms. In these settings, use an opioid antagonist product that can be titrated to effect and, where applicable, dosed according to weight.

Risk of Opioid Overdose from Attempts to Overcome the Blockade: OPVEE® is unlikely to produce acute withdrawal symptoms in non-opioid dependent patients. Attempts to overcome opioid withdrawal symptoms caused by opioid antagonists such as OPVEE® by taking large or repeated doses of opioids such as heroin or prescription pain pills could lead to opioid intoxication and death. Inform patients of potential consequences of trying to overcome opioid blockade. Get emergency treatment right away after use of OPVEE® regardless of withdrawal symptoms.

ADVERSE REACTIONS: Relative frequencies of treatment-related adverse events from pharmacodynamic and pharmacokinetic studies respectively (≥2%) were nasal discomfort (8.2%, 42.7%), nasal congestion (3.3%, 4.5%), throat irritation (4.9%, 3.4%), pain in the nose (1.6%, 3.4%), shortness of breath (3.3%, 0), sore throat (3.3%, 0), headache (55.7%, 6.7%), dizziness (14.8%, 5.6%), changes in sense of taste (3.3%, 1.1%), pins and needles (3.3%, 0), nausea (36.1%, 3.4%), vomiting (11.5%, 2.2%), hot flush (19.7%, 0), anxiety (11.5%, 0), agitation (3.3%, 0), claustrophobia (3.3%, 0), fatigue (4.9%, 3.4%), chills (3.3%, 0), skin redness (0, 3.4%), increased sweating (6.6%, 0), and decreased appetite (3.3%, 1.1%). Increases in heart rate and blood pressure (5% each) were also seen with nalmefene injection.

USE IN SPECIFIC POPULATIONS

Pregnancy: An opioid overdose is a medical emergency and can be fatal for the pregnant woman and fetus if left untreated. Life-sustaining therapy for opioid overdose should not be withheld because of potential concerns for the effects of OPVEE® on the fetus.

Lactation: There are no data on the presence of nalmefene and its metabolites in human milk, the effects of nalmefene on the breastfed child, or the effects on milk production. However, because nalmefene and its metabolites were secreted in rat milk during animal studies, it is likely the drug will be present in human milk.

Pediatric Use: The safety and effectiveness of OPVEE® for emergency treatment of known or suspected opioid overdose with respiratory and/or central nervous system depression have not been established in those younger than 12 years of age.

Geriatric Use: Clinical studies did not include subjects 65 and over. Other reported clinical experience has not identified differences in responses between elderly and younger patients. The systemic exposure of nalmefene can be higher in geriatric patients because they have a greater frequency of decreased hepatic, renal, or cardiac function and of concomitant disease or other drug therapy.

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Prison Doulas *continued from page 8*

custody staff who will accompany the patient to the hospital knows that a doula will be present, understands the role of the doula, and ensures the doula can carry out duties as outlined in policy.

Many doula programs also offer lactation services to facilitate breastfeeding or expressing breast milk for the infant, as breastfeeding and breast milk have many short- and long-term benefits for both the infant and mother. Psychological benefits include improved bonding between the mother and child, which is particularly important when the mother is incarcerated. Lactation support often includes patient education about breastfeeding; supplies for expressing, storing, and shipping breast milk; and help putting prison policies and infrastructure in place to support lactation.

The Julia Tutwiler Prison for Women, for instance, in partnership with the Alabama Prison Birth Project, retains a certified lactation consultant and created a dedicated lactation room where postpartum mothers can pump and store their breast milk; program staff ship the milk to the infants' caregivers weekly.

A culture of continuous quality improvement is critical to program success. That requires monitoring and feedback systems to ensure the program is meeting its goals and processes to address identified challenges and barriers. We have found that challenges most often arise when there are gaps in communication or in training about roles and responsibilities for custody staff and doulas.

Pregnant patients in custody have distinct needs and present unique challenges. Doula programs are exciting opportunities for correctional facilities to tackle those challenges, while providing many benefits for staff, patients, and their babies. Many states across the country now have robust doula programs that provide critical support to pregnant and postpartum people. These programs hold important lessons that can help you start a doula program at your facility. ●

FOR MORE INFORMATION

NCCHC position statement, Breastfeeding in Correctional Settings, 2023: ncchc.org/position-statements

University of Minnesota Enhanced Perinatal Programs for People in Prison project: e4p.umn.edu

Johns Hopkins University Medical School Advocacy and Research on Reproductive Wellness of Incarcerated People (ARRWIP), Pregnancy in Prison Statistics Project: arrwip.org

Ostara Initiative: ostarainitiative.org

Alabama Prison Birth Project: prisonbirth.org

Minnesota Prison Doula Project: mnprisondoulaproject.org

Michigan Prison Doula Initiative: mpdi.org

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For guidelines, email editor@ncchc.org. We invite letters to the editor, which will be printed as space allows.

Expert Advice on the NCCHC Standards

By Wendy Habert, MBA, CCHP

Follow-Up After Removal from Suicide Watch

Q After an individual has been removed from suicide watch monitoring requirements, is there a specific timeline in which the person needs to be seen by a qualified mental health professional (QMHP)?

A No. Standard B-05 Suicide Prevention and Intervention, compliance indicator 5, states, "Patient follow-up occurs as clinically indicated." There is no specific time requirement, as each patient should have a treatment plan that meets their individual mental health and safety needs. Some may require daily contact for a few days until deemed safe and taper to three times a week before moving to weekly, while others may require less frequent follow-ups. Many factors need to be taken into consideration when identifying the patient's treatment plan. Some facilities may have a site-specific policy that each individual cleared from suicide watch is seen by a QMHP within 24 or 48 hours, followed by the specific follow-up time identified in the patient's treatment plan, but each facility can identify their own specific guidelines as long as the patient has an individual treatment plan.

Administrative, CQI, and Health Staff Meetings

Q We use sign-in sheets for staff who attend our quarterly administrative and CQI meetings and monthly health staff meetings; however, for those not present, is it sufficient to ensure they have access to the minutes or do we need verification that they have reviewed the minutes?

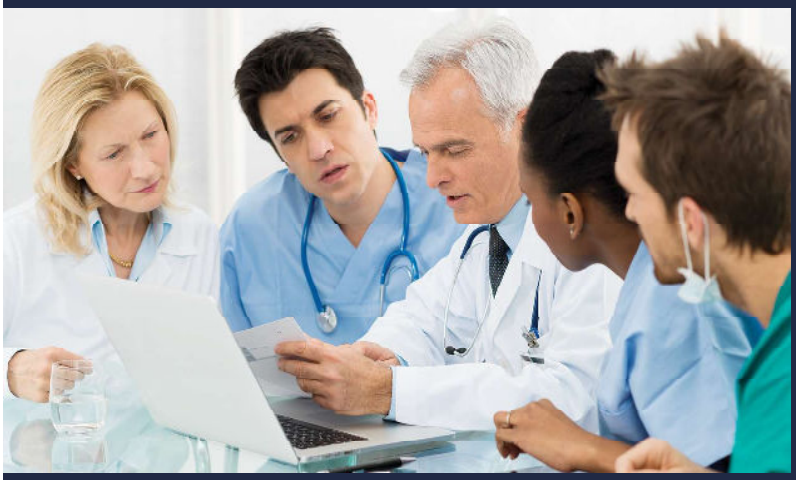
A When staff members are invited to a meeting but are not able to attend, it is good practice for the RHA (or program sponsor for an OTP) to obtain written confirmation that those staff members have in fact reviewed the vital information presented during the meeting. That can be achieved using a sign-in sheet specifically for those who did not attend, noting the post-meeting date on which they received the meeting information and documenting that they were given an opportunity to ask questions about the meeting materials.

Q For administrative and CQI meetings, who needs to receive the meeting minutes? Is it sufficient to cover the topics in the health staff meeting or are we required to distribute the minutes to all staff?

A Decisions about what information discussed in the administrative and CQI meetings should be shared at monthly health staff meetings are up to the RHA (or program sponsor for OTP); some information discussed in those meetings may not necessarily be relevant or appropriate to line-level health staff. Topics related to medication errors, adverse events, mortality review results, CQI study topics and results, and grievance trends, however, are commonly shared during monthly health staff meetings and also seen on administrative and CQI meeting minutes.

For more information, see standards A-04 Administrative Meetings and Reports and A-06 Continuous Quality Improvement Program. ●

Wendy Habert, MBA, CCHP, is director of NCCHC's accreditation program.



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