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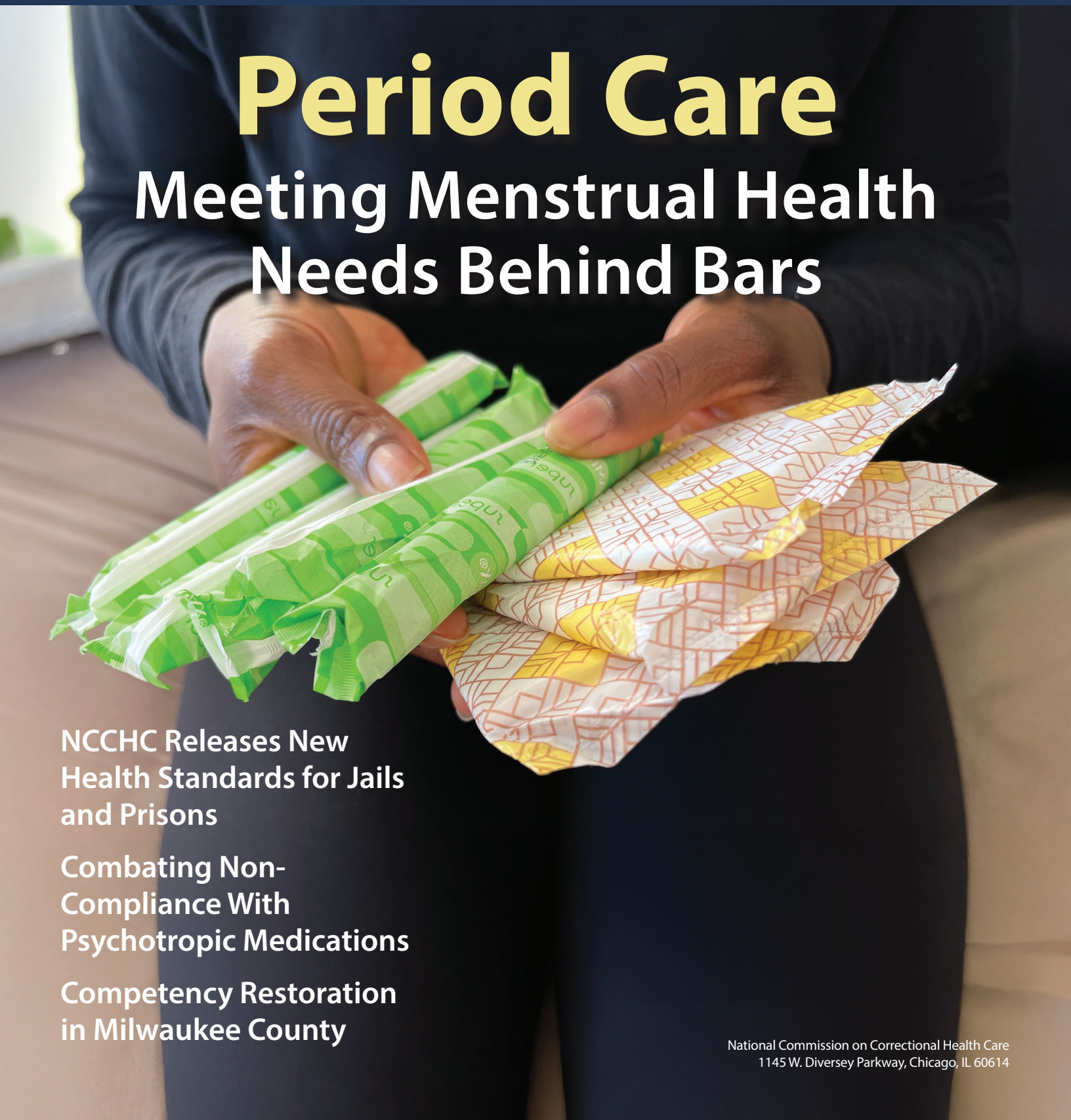
CorrectCare®

The magazine of the National Commission on Correctional Health Care



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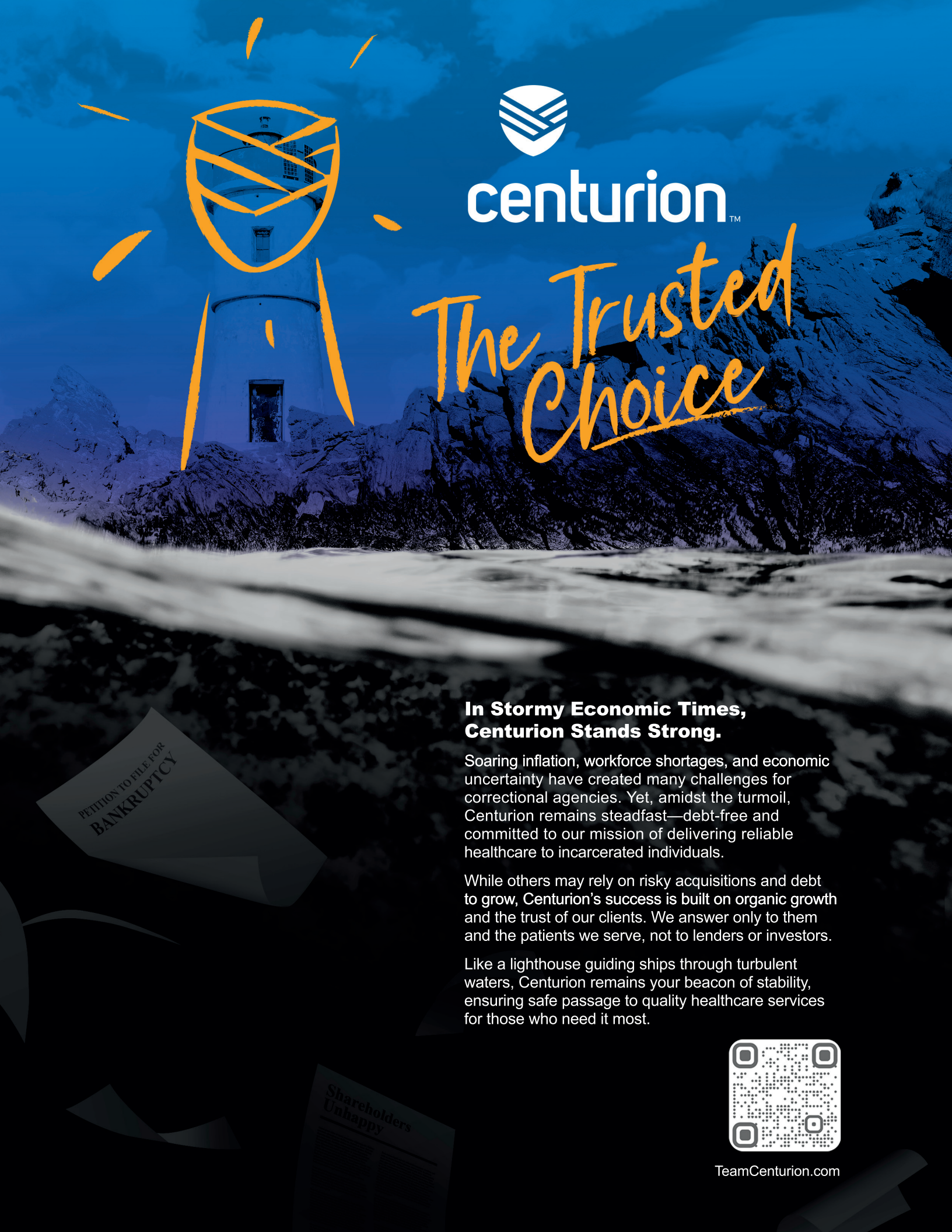
National Commission on Correctional Health Care
1145 W. Diversey Parkway, Chicago, IL 60614



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New Jail/Prison Health Standards Now Available

Introducing Digital Format, Key Enhancements, and New Requirements

After much anticipation, NCCHC has released new editions of the *Standards for Health Services in Jails* and *Standards for Health Services in Prisons*. Building on the foundation of the 2018 editions, the revised *Standards* introduce updates, new guidance, and expanded requirements to reflect best practices, legal expectations, and the evolving needs of incarcerated populations.

The 2026 *Standards* reflect years of expert input and field-tested insights. Key enhancements:

- New Supporting Survey Documentation section: Each standard now includes a detailed list of recommended documentation to guide facilities preparing for NCCHC accreditation surveys.
- Expanded Interpretive Guidance: Formerly titled Discussion, this section provides clearer explanations of compliance expectations, required elements, and best practices.
- Digital version: For the first time ever, the *Standards* are available in an online digital format as well as the traditional hard-copy format.
- Spiral binding: The manuals are now spiral bound for ease and convenience.

A handy crosswalk outlines the differences between the 2018 standards and the revised 2026 standards. "These revisions reflect our commitment to continually advancing correctional health care," says Amy Panagopoulos, BSN, RN, CCHP, vice president, accreditation/Chief Nursing Officer. "The new *Standards* integrate current medical knowledge, emphasize equity and access, and provide the tools needed to deliver safe, ethical, and constitutionally appropriate care."

Facilities seeking NCCHC accreditation will need to be in compliance with the new *Standards* starting January 1, 2026. The CCHP exam will be based on the new *Standards* beginning Feb. 25, 2026. Revised *Standards for Mental Health Services in Correctional Facilities* will be available in September.

More information on specific changes can be found at **ncchc.org/ncchc-releases-2026-jail-prison-standards.**

Order your *Standards* today! Digital and hard copy formats available at ncchc.org/online-bookstore.

Position Statement: STI Guidance

A newly expanded position statement, Screening, Diagnosis, Treatment, and Prevention of Sexually Transmitted Diseases, updates recommendations based on current CDC guidelines and adds additional recommendations for STI education and prevention. It expands upon and replaces the 2015 position statement titled STI Testing for Adolescents and Adults Upon Admission to Correctional Facilities. Learn more at **ncchc.org/position-statements.**

First Joseph E. Paris Memorial Lecture

Judge Ginger Lerner-Wren, founder of America's first specialized mental health court, will be the inaugural Joseph E. Paris Memorial Lecture Series speaker at the upcoming National Conference on Correctional Health Care in Baltimore. The speaker series is supported by an anonymous donation to the NCCHC Foundation.

Foundation Offers Free Planning Tool

The NCCHC Foundation is pleased to offer a new benefit: completely free access to FreeWill, a secure online platform that makes it easy to create a legally valid will or trust in about 20 minutes.

"Our partnership with FreeWill is the Foundation's way of giving back to the hardworking, compassionate professionals who care for justice-involved patients every day," says Julie Haugland, Foundation manager.

With FreeWill, you can create or update your will or revocable living trust; designate beneficiaries for retirement plans and life insurance policies; learn about non-cash giving options such as stocks, real estate, or charitable IRA distributions; and include a legacy gift to the NCCHC Foundation.

Start your plan today; it's completely free. Go to **NCCHCFoundation/free-estate-planning.**

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The Role of Patient Advocacy in Correctional Health Care

By Patricia Blair, PhD, JD, MSN, CCHP-RN, CCHP-A

Patient advocacy in correctional health care is a vital competency that encompasses the articulation and active support of patients' concerns, needs, and rights. Advocacy is foundational to the delivery of patient-centered care and requires a deliberate focus on skill development for health care professionals, whether they are advocating at the bedside or within institutional settings. Advocacy fosters an environment in which values such as individualized care, shared decision-making, and respect for patient autonomy are upheld, ultimately contributing to a sense of safety, hope, and trust among health care professionals and those they care for.

The role of advocacy in correctional health care extends beyond patient-provider interactions; patient advocacy embodies a profound ethical commitment to safeguarding and promoting the rights and needs of individuals. This obligation is underscored by the ethical guidelines provided by each health care provider's professional organization, such as the American Nurses Association "Code of Ethics for Nurses."

Correctional nurses have an ethical obligation to identify and challenge any unethical practices or policies that may compromise the rights or safety of their patients. For instance, if a nurse observes that a patient with diabetes is denied proper dietary accommodations or necessary medical supplies, it is that nurse's responsibility to report and advocate for changes to those policies.

As expressed in provision 3.2 of the ANA code, nurses must be willing not only to act on behalf of their patients but also to promote social justice within their health care environment. Such commitments highlight how advocacy is essential not only to patient care but also to the health care profession as a whole.

Advocacy's Ripple Effect

Nobel Peace Prize Laureate Malala Yousafzai said, "When the world is silent, even one voice becomes powerful." That assertion aptly reflects the transformative potential of advocacy. A tangible illustration of this principle can be seen when a health care provider champions a patient's need for effective chronic pain management. Such advocacy not only directly benefits the patient but can also instigate changes in institutional practices regarding pain management protocols. The implications of such advocacy have the potential to promote wider systemic reforms within health care systems.

For health care providers to become effective advocates, it is necessary to cultivate and nurture advocacy skills. A critical component of this process involves self-awareness and the ability to assess personal strengths and weaknesses in advocacy. Engaging in self-reflective practice enables health care providers to identify areas for improvement and development, thus fostering a culture of ongoing professional growth and active participation in policy discourse.

> "I raise up my voice - not so I can shout but so that those without a voice can be heard."
>
> Nobel Peace Prize Laureate Malala Yousafzai

Specialized education and training become crucial for the cultivation of advocacy competencies. Programs that address areas such as correctional health care, for example, equip health care providers with the necessary skills to advocate for vulnerable patient populations facing unique challenges. The importance of educational initiatives cannot be overstated; they not only enhance health care advocacy skills but also instill a sense of professional obligation among health care providers to engage in meaningful policy development and institutional change.

Ultimately, advocacy within health care professions is not just a task, but a fundamental aspect of health care providers' identity – one that requires continuous reflection, education, and action to promote holistic patient care and uphold the dignity and rights of each patient. ●

Patricia Blair, PhD, JD, MSN, CCHP-RN, CCHP-A, is the 2025 chair of NCCHC's Governance Board and board liaison of the American Bar Association.

Period Care

Meeting Menstrual Health Needs Behind Bars

By Regan Moss, MPH, Anna Grace Morgan, MD, MPH, Haley Fenn, MS, and Silvia Vilches, PhD

As the proportion of women in prisons, jails, and juvenile facilities increases, so does the need to ensure that their menstrual health needs are supported.

Monthly periods are among life's most ordinary occurrences. But for women who are incarcerated, not having access to the menstrual products they need and the health care considerations they deserve can be frustrating, stressful, and dehumanizing.

Depending on the age of the incarcerated individuals in your facility, their needs will be slightly different (see sidebar). But menstruating people of all ages deserve access to an adequate, no-cost supply of menstrual products and respectful consideration of their health.

This article sometimes uses the term "women" while understanding that some nonbinary, intersex, and trans people menstruate, and some women do not.

Period Products and Why They Matter

Although the majority of incarcerated women are at an age where they may be menstruating, their access to menstrual products is often inadequate and inconsistent. They may experience a lack of access to free, safe, plentiful menstrual products and resources to manage menstruation.

Incarcerated individuals often have existing depression or anxiety or may have worsened mental health while incarcerated. Lacking access to period products can elevate these mental health issues, causing unnecessary stress and shame. Lack of period products also increases the risk of "accidents," which, in addition to increasing the demand for laundry services, can cause anxiety and embarrassment. Using period products for too long can also lead to infections, such as rashes, vaginitis, or even toxic shock syndrome, which may be fatal.

The National Commission on Correctional Health Care's position statement on women's health calls for providing access to an adequate, no-cost supply of menstrual products; the American College of Obstetricians and Gynecologists (ACOG) also recommends that menstrual products be free and unlimited for incarcerated women.

In most jails and prisons, however, period products may be limited and are generally distributed by custody staff on an as-needed basis. According to Wendy Habert, MBA, CCHP-A, NCCHC's director of accreditation, "Processes may vary from facility to facility, but most consider pads and tampons as sanitary/hygiene items, much like soap or toothpaste, and distribute them for free. They are usually

provided in small quantities, such as one or two at a time, by custody staff within each housing unit so people do not use them for alternative purposes (for example, lining the toilet seat with pads so they do not have to sit directly on the seat) or to hide contraband." She adds that in some facilities, extra items may be available for purchase at the commissary.

Menstruating people have different product needs at different times, and periods can be unpredictable. Even if someone's period follows a consistent cycle, the exact hour/day they get their period will vary, as will the amount of bleeding. For those reasons, it is important to supply a broad range of products. Facilities need to provide a variety of thicknesses of pads, from light to "maxi," to support people who have different flows or amounts of blood, as well as tampons, panty liners, and more. The ideal is to have a large quantity and variety of period products available at all times - either in bathrooms and other common areas, or with support from custody staff to ensure continuous access to needed supplies.

When people have their period, they may have more frequent bowel movements or irritable bowel symptoms. Plentiful toilet paper may also be needed to manage not only blood but these other symptoms as well.

Not all period products are equal in quality. Some can be rough and uncomfortable to use, potentially causing rashes or irritation, especially if they contain added fragrances. Fragrance-containing products may expose the vagina, which easily absorbs compounds, to dangerous chemicals. The products that are least likely to irritate the vulva and vagina are fragrance-free and made from organic cotton, which is less likely to contain pesticides, dyes, and other potentially harmful chemicals.

Reusable options such as discs and cups may work well for some individuals, as they are fragrance- and dye-free in addition to being cost-effective and environmentally friendly, although there may be logistical challenges with reusable products while in custody.

It is important to let everyone know how and where they can access period products, the types and sizes available, and any extra accommodations for postpartum bleeding after childbirth. Consider adding that information to the residents' handbook.

Some facilities have withheld period products and toilet paper for disciplinary reasons. This causes significant harms to mental and physical health and should be strictly avoided.

Beyond PMS

Most menstruating people will agree "that time of the month" can be anything from mildly unpleasant to extremely painful. It's important to understand the range of menstrual disorders, both mental/emotional and physical, and know what is outside the range of normal.

Menstruation: The Basics

Menstruation is a natural process in which the lining of the uterus (endometrium) is shed if pregnancy does not occur. This shedding results in vaginal bleeding, commonly known as a period.

There are three main menstrual milestones. It is important for the facility staff who distribute period products to understand the differences.

Most girls get their first period between the ages of 12 and 13, although there is a wide range of normal variation. Several factors, including socioeconomic conditions, nutrition, chronic stress, and body mass index, can influence the age when menstruation begins. Early on, cycles tend to be irregular, lasting from two to seven days and occurring anywhere from 20 to 45 days apart. Cramps and general feelings of unwellness tend to be more pronounced in young, newly menstruating women.

As the young woman matures, periods tend to become more regular and routine. While 28 days is often cited as the average, cycles can vary significantly from person to person and even for the same person from month to month.

Pregnancy generally stops uterine bleeding and menstruation, usually the first symptom of pregnancy. After childbirth, women can begin to resume cycles anywhere from two to 12 weeks postpartum, with most resuming around six weeks.

For two to three weeks after delivery, postpartum women often experience heavy bleeding called lochia, which is composed of blood and uterine tissue. During lochia women may soak one thick maxi pad every two to three hours, and the first few periods after pregnancy will be heavier and may contain more clots. Postpartum people need increased access to menstrual products, predominately pads as nothing should be inserted vaginally for six weeks.

Menopause is when women stop having periods, generally occurring around 50 years of age. The years preceding menopause are known as perimenopause.

During perimenopause, menstrual cycles may become lighter or heavier, and the time between periods may become longer or shorter. There may also be vaginal changes including dryness and increased risk of infections and urinary tract changes leading to increased risk of infections and urgency/incontinence. Menopause is officially diagnosed after 12 months without a period.

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Effective Strategies for Combating Non-Compliance with Psychotropic Medications

By Emily Scordellis, PsyD, CCHP, and Tommy Williams, BSN, RN, CCHP

In corrections, compliance with psychotropic medications is crucial for maintaining patients' mental health and stability and an essential aspect of providing humane and effective care. Effective management of psychiatric symptoms reduces the risk of self-harm, violence, and behavioral issues, promotes a safer environment for both incarcerated individuals and staff, and supports the overall rehabilitation process.

Yet according to studies, the adherence rate among incarcerated individuals who are prescribed psychotropic medications is generally low.

As clinicians, we have seen firsthand how noncompliance with psychotropics can lead to a rapid decline in a patient's mental health and worsening of symptoms, such as increased depression, anxiety, psychosis, or mood instability. That often results in a decline in overall functioning, making it difficult for patients to participate in rehabilitation programs or manage daily activities. In severe cases, noncompliance can increase the risk of self-harm, aggressive outbursts, and suicidal behavior.

The effects of noncompliance extend beyond the patient and may disrupt the correctional facility as a whole. Unmanaged symptoms can contribute to behavioral issues including refusal to comply with directives from custody staff. That in turn can sometimes necessitate the use of restrictive measures, including segregation and solitary confinement, which can then further exacerbate mental health issues. Noncompliance can strain correctional health systems by increasing the need for crisis management and emergency care, diverting resources from proactive treatment.

To improve compliance, it is important first to understand the reasons behind noncompliance.

The "Why" of Noncompliance

Assessing barriers involves identifying the factors that may hinder a patient's ability or willingness to take their medication as prescribed. Barriers can include one or more of the following:

- Practical issues such as forgetfulness or accessibility to med pass
- Complexity of the medication regimen
- Psychological factors such as stigma, distrust of medications, or denial of mental illness

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- Cognitive impairments
- Lack of social support
- Misconceptions or anxiety about the medication being prescribed
- Fear of side effects
- Poor therapeutic alliance with health care providers

A thorough assessment of potential obstacles requires open communication between the patient and health care professional. Understanding and addressing those barriers provides an opportunity for tailored interventions that address specific concerns, which can increase medication adherence and help improve treatment outcomes.

Interventions to Create Trust

Over the years, we have learned that building trust is crucial to promoting medication compliance. Many patients are hesitant to take psychotropics due to stigma or mistrust. By creating a supportive environment in which patients feel heard and respected, we have seen even the most resistant individuals become more open to medication.

Psychoeducation, which helps patients understand their mental health conditions and the purpose of their prescribed medications, is one effective intervention. Learning about the mechanisms, benefits, and potential side effects of their psychotropics can demystify the treatment process, reduce anxiety, and challenge misconceptions. By fostering an open dialogue about the importance of adherence, potential obstacles, and strategies for managing side effects, psychoeducation can empower patients to take an active role in their treatment. This informed approach also helps patients understand the long-term benefits of maintaining their medication regimen, thus reducing the likelihood of relapse or exacerbation of symptoms.

Management of side effects is crucial, as unpleasant and distressing side effects, in particular the sedative effects of antipsychotic medications, are a frequent reason patients avoid or discontinue use. By proactively addressing drowsiness and other potential side effects, health care professionals can work with patients to develop strategies to minimize them, including adjusting dosages, changing medications, or incorporating supportive therapies and strategies to manage drowsiness. Educating patients about what to expect and how to manage side effects empowers them to handle those challenges without feeling overwhelmed or discouraged and can enhance their ability to tolerate the medications.

Collaborative decision-making is a patient-centered approach in which health care professionals and patients work together to make informed decisions about treatment, including the use of psychotropic medications. Patients actively participate in this process; their values, preferences, and concerns are openly discussed and considered in putting together a treatment plan. By collaborating with their health care professionals, patients gain a sense of ownership and autonomy over their treatment, which can significantly increase motivation to adhere to prescribed psychotropics. Collaborative decision-making fosters trust and strengthens the therapeutic alliance, creating an environment in which patients feel supported and understood.

Regular monitoring and feedback also help maintain motivation, trust, and engagement in the treatment plan. By consistently tracking patient progress, health care providers can quickly identify issues with adherence, such as missed doses or the development of adverse effects. Ongoing assessment allows for timely adjustments to the treatment plan, ensuring psychotropics remain effective and tolerable for the patient. Feedback reinforces positive behaviors, helps patients understand the importance of sticking to their regimen, and addresses any concerns or barriers they face. Regular check-ins also foster a supportive therapeutic relationship, making patients feel more engaged in their treatment.

Psychosocial support is a holistic care framework that addresses the underlying psychological, emotional, social, and environmental factors that often influence adherence to treatment. Counseling, peer support groups, and family involvement when possible are all part of psychosocial support. By offering a space to discuss challenges, fears, and misconceptions about psychotropic medications, this support can help reduce negative perceptions and isolation, making patients feel understood and less alone. It also helps develop coping strategies, improves problem-solving skills, and increases their motivation to stick with the treatment plan.

Communication aids, when allowed by the facility, can also assist in promoting compliance. These can include reminder apps on tablets or posters on the unit – anything that may increase compliance. Such tools can be particularly helpful for patients with complex medication schedules or those who struggle with forgetfulness. It is worth noting, however, that some patients find such aids intrusive or difficult to navigate. Not all interventions work universally, highlighting the need for an individualized approach.

Interventions for noncompliance with psychotropic medications should be tailored to individual patient needs, preferences, and circumstances. Health care providers can optimize treatment outcomes and improve patient quality of life by addressing barriers to adherence and providing comprehensive support. Promoting compliance with psychotropic medications is crucial to maintaining the mental well-being of incarcerated individuals and ensuring a safer, more manageable environment. ●

Emily Scordellis, PsyD, CCHP, is vice president of behavioral health services at PrimeCare Medical; Tommy Williams, BSN, RN, CCHP, is the company's director of public relations.

Montana DOC Reduces Pain...and Opioid Use

By Michelle Foster Earle

When Paul Rees, MD, became medical director at the Montana Department of Corrections in 2016, he was confronted with a problem that plagues correctional facilities throughout the nation.

"Despite oversight by staff members, incarcerated individuals were abusing narcotics and opioids prescribed for pain," he says. "We know long-term use of narcotic analgesics just leads to more pain. It's not a cure for anyone. And it causes a lot of problems."

Rees's review of pain management processes uncovered an alarmingly high rate of prescriptions written for gabapentin, oxycodone, tramadol, and other opioids. "We knew we had to find a solution."

That solution was a comprehensive plan to reduce the use of opioids and other narcotics throughout Montana DOC facilities while treating patients' chronic pain with safer alternative therapies.

The Impact of Pain in Prison

Although pain prevalence literature is limited, some estimates suggest that up to 25% of people incarcerated in state and federal prisons suffer from chronic pain. The impact of pain, either chronic or acute, can be profound, affecting both physical health and mental well-being.

Pain can worsen existing mental health conditions, leading to heightened aggression and a greater risk of violent behavior. Chronic pain can lead to reduced cognitive function and impair a person's ability to think clearly, learn, and make reasonable decisions. The constant discomfort and frustration associated with chronic pain can contribute to depression, anxiety, and feelings of hopelessness and despair. Individuals may turn to drugs or alcohol as a means of coping, leading to substance abuse, addiction, and further health problems.

Clearly, many incarcerated individuals need – and deserve – pain relief. The U.S. Supreme Court has held that incarcerated patients have a right to adequate medical care. Lack of required medical care can be a violation of the Eighth Amendment, which prohibits cruel and unusual punishment. Montana and other states have faced individual and class-action lawsuits involving negligence of incarcerated patients' chronic pain and lack of management and treatment of that pain.

But dispensing pain medication in prisons has long posed security concerns due to the risk of substance misuse and diversion – the unauthorized transfer of prescribed medications to another person for illicit use. Prescription narcotics can be used as currency in the prison economy. Overdose is a real risk.

Medication diversion and misuse can also impact correctional operations through an increase in emergency room referrals, increased demand on nursing, unnecessary imaging and workups as a result of symptom exaggeration, and increased violence.

A Plan Is Born

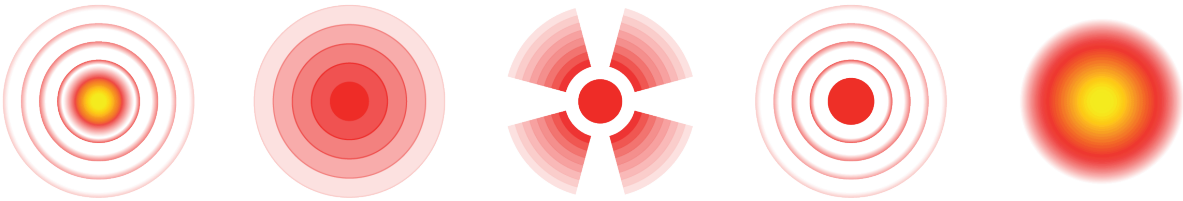
After looking at the Montana DOC's narcotic prescription numbers, Rees knew that his department needed to combat medication misuse. He also knew it wouldn't be easy, and that the initiative would need to be a statewide, multidepartmental effort. The goal: to replace narcotic medications with alternative treatments, even though the department's current pain management alternatives were severely limited.

The first steps included open discussions about the medication abuse problem and suggested solutions; meetings with providers to provide education and gain cooperation; and facilitywide education. Outreach and education involved community providers, DOC management and administration, and the state's governor.

"Once everyone was on board, we established a pain committee, a group of providers that evaluates each patient with chronic pain, and a pain clinic separate from our chronic care clinic so we can better serve each group," explains Rees.

The department identified 300 patients who were prescribed narcotic pain medications and met with each one to review their care plans. When appropriate, tapering schedules were established to get them off their meds or to lower their doses to a safer dose, and alternative treatment plans were created. In most cases the tapering took place over the course of one to two weeks. These patients' activities of daily living (ADLs) were regularly monitored for signs of deterioration.

Now, intakes who present with prescriptions to restricted medications are immediately tapered and alternative plans



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are developed and implemented. Commonly misused medications are labeled as nonformulary, requiring medical director approval. Oral muscle relaxants have been removed from the statewide formulary after an initial attempt to utilize them resulted in misuse; currently, injectables are used when indicated for acute pain involving muscle spasms.

When Montana introduced its multimodal protocol, they made sure they were offering patients an array of pain-relief alternatives. Those include:

- Non-narcotic medications including neuromodulators such as amitriptyline and nortriptyline; duloxetine (Cymbalta); or oxcarbazepine (Trileptal)
- Greater utilization of physical therapy
- TENS (transcutaneous electrical nerve stimulation) therapy with personal TENS units
- Cognitive behavioral therapy (CBT)
- Trigger point and intra-articular injections (administered on-site)
- Interventional pain management techniques, including injection and spinal stimulator implantation (administered off-site)
- Topical anti-inflammatory gels and anesthetics
- Weight loss and exercise programs
- Ergonomic exercise equipment and instruction on proper weightlifting biomechanics
- Corrective surgeries when indicated
- Better mattresses ("For an incarcerated person, something as simple as a thicker mattress can result in a reduction in pain," according to Rees.)

Positive Results

Rees reports that the initiative was a success. All restricted medications were significantly reduced or eliminated over the course of 12 months. Gabapentin has been completely eliminated. "With the exception of managing end-of-life and postoperative pain, we are narcotic-free," says Rees.

A look at the dramatic decrease in medication dosages issued in 2016 compared to 2023 tells the story:

	May 2016	May 2023
Gabapentin	19,048	0
Bupropion	630	30
Oxycodone	1,208	30
Tramadol	3,000	810
Hydrocodone	600	200

When Rees and his team implemented their new plan, he says patients offered some resistance, but not as much as anticipated. Overall, they expressed an improved sense of well-being. Many patients experienced significant improvements in three months, reporting their lowest daily pain scores ever after 18 months. For some, being free from opioids and other substances helped them rebuild family relationships and receive parole. The health staff have received "kites" from patients expressing thanks for taking the initiative to help them get off opioids.

For the Montana DOC, the results were also positive: the new approach resulted in decreased violence, fewer instances of self-harm, a reduction in overdose cases, and improved job satisfaction among nursing staff and other health care providers. It is now an accepted practice within Montana DOC facilities that opiates are not used in the management of chronic pain.

Two years after Rees became medical director and the department began limiting the use of controlled substances, Montana State Prison underwent an unscheduled audit by the Drug Enforcement Administration. Auditors reviewed Montana's change in policy, examined medical charts, and interviewed staff and patients. In the end, Montana State Prison was commended by the chief auditor as demonstrating the best example she had ever seen of a correctional facility eliminating narcotics. ●

Michelle Foster Earle is CEO of OmniSure Consulting, a health care risk management consultancy.

Pain Points: What Does NCCHC Say?

In its 2023 position statement, Management of Chronic Pain, NCCHC calls for the following:

- Noninvasive, nonpharmacologic interventions should be considered as first-line treatment for patients with certain chronic pain conditions in accordance with evidence-based guidelines.
- Medications should be considered for certain patients with chronic pain while considering the limitations of their long-term efficacy and potential for adverse effects.
- Nonopioids are preferred over opioids when medications are used to treat chronic pain.
- If prescribed opioids are discontinued in patients with chronic pain, they should be tapered slowly according to pain management guidelines. Patients should be monitored closely for suicidal ideation and mental health crises as opioids are tapered.
- Correctional health care systems should expand patient access to interdisciplinary health care professionals who can provide an array of noninvasive, nonpharmacologic treatment interventions for chronic pain.
- Mental health and substance use disorders associated with chronic pain should be thoroughly assessed and treated as an essential element of the patient's treatment plan. Suicide risk assessments should be conducted as clinically indicated.

FOR MORE INFORMATION
NCCHC Management of Chronic Pain position statement: ncchc.org/position-statements

Reducing the Pipeline for Competency Restoration Treatment in Milwaukee County

By Sarah McKnight, LPC, CCHP

In 2022, an estimated 130,000 referrals were made for evaluations of competence to stand trial in U.S. felony cases. Of that number it is estimated that just under 30% are found incompetent to stand trial (IST) with some state-specific studies in recent years showing rates as high as 56%. The most common reasons for a finding of incompetence are psychotic disorders, cognitive impairments, and intellectual disability.

Although there is not a singular evidence-based model for competency restoration treatment, most programs focus on stabilizing acute psychiatric symptoms such as psychosis or mania and providing legal education on the court process. Competency restoration treatment may be offered in different settings based on the charges the individual faces, the severity of mental illness, and the availability of treatment options. State psychiatric hospitals, however, continue to be the primary option for treatment. According to the National Association of Mental Health Treatment Directors, in 2018 state psychiatric hospitals housed more than 83% of all involuntary forensic admissions, with the highest proportion of patients being IST.

In response to lawsuits related to delays in care, some jails have implemented specialized housing units for competency restoration treatment; others rely on contracted providers, separate from jail mental health staff, to provide this service. Many individuals held in jails are referred for inpatient treatment, but there are often lengthy admission waitlists that result in an average wait time of anywhere from 55 days to 11 months. This wait time is problematic as jails are not equipped to provide the level of psychiatric care necessary for many IST individuals or provide sufficient discharge planning to help avoid a repeating cycle of competency restoration. In addition, mentally ill individuals are more likely to be segregated, putting them at higher risk for medical emergencies, victimization, self-harm, and suicide.

In 2012 the National Judicial College convened experts to create a competency best practices model recommending standards for conducting hearings and evaluations, creating competence-restoration treatment plans, establishing a competence court docket, and addressing the need for cross-systems collaboration. Since then, there has been little evidence that those best practices have been adopted.

In 2024, Milwaukee County in Wisconsin established a mental health court docket with the goals of addressing the significant backlog of cases dealing with competency as well as expanding the capacity of the current mental health treatment court. By the end of that year, the judge overseeing that docket established a competency restoration workgroup that includes representation from all systems involved in the competency process in Milwaukee County: individuals from the district attorney's office, public

Photo © Frame Stock Footage/Shutterstock

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As of 2019, drug overdoses are a leading cause of injury-related deaths in the US.[1]

In 2022, **81.8%** of drug overdose deaths involved at least one opioid. Illegally made fentanyls were the most commonly involved drug class and were found in **74.6%** of overdose deaths.[2]

IMAGINE a better future for patients. WE DO.

Indivior was founded to help tackle the opioid crisis,
one of the largest and most urgent public health emergencies of our time.

Our purpose is to bring science-based, life-transforming treatments to patients.
We strive to help eliminate the stigma of addiction.

Reference:

1. National Center for Health Statistics. *Drug Overdose Deaths*. Centers for Disease Control and Prevention (CDC); 2023. Accessed January 2024. https://www.cdc.gov/nchs/hus/topics/drug-overdose-deaths.htm
2. CDC. State Unintentional Drug Overdose Reporting System Dashboard: Fatal Overdose Data. Updated December 26, 2023. Accessed February 2024. https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html#

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defender's office, and corporation counsel; competency evaluators; outpatient and jail-based competency restoration treatment providers; and mental health providers from the state psychiatric institution, the jail, the county's behavioral health division, and mental health treatment court.

Cross-System Collaborative Efforts

The focus of the workgroup was to reduce the waitlist of IST individuals waiting to be admitted to the state psychiatric institution. In Milwaukee County there is an average of 40-45 individuals on the waitlist for inpatient competency restoration treatment and an average wait time of 99 days for those who remain in the jail while waiting for treatment. Since the establishment of this workgroup, the jail mental health team has taken the following actions to improve patient care, reduce the number of individuals waiting for inpatient treatment, and reduce the length of time individuals wait to be admitted.

Assigning one clinician to follow the patient while in jail: Many IST individuals are designated as mental health special needs patients and have regular appointments with mental health providers. Instead of their appointments being attended by any scheduled clinician on that day, one clinician is responsible for the creation of the treatment plan and scheduling follow-ups as clinically indicated. This approach allows for quicker recognition of issues such as decompensation or medication nonadherence, bringing those problems to the attention of mental health supervisors and psychiatry in a timely manner.

Providing weekly updates to competency restoration treatment providers and hospital admission staff: In our county, the restoration treatment providers are not part of the jail mental health staff and are contracted through an outside agency. Through sharing critical information each week about suicidal behaviors, hunger strikes, medication adherence, engagement with treatment providers, and medical concerns, we have been able to prioritize admissions and reduce admission wait time for the most acute patients. In one case, we were able to have a patient evaluated, found to be IST, and admitted to the state psychiatric hospital in one week.

Alerting evaluators to changes in condition: When an individual has been found IST, they are scheduled for a future court date to review their status. In Wisconsin, this hearing is set every 90 days. The increased collaboration between the restoration treatment providers, jail mental health staff, and evaluators has shown success in having patients reevaluated sooner than 90 days if the patient shows improvement while in the jail. This earlier reevaluation has led to individuals either transitioning to outpatient services or an earlier finding of competence to proceed; both remove them from the inpatient waitlist. (The transition from the jail to outpatient services is contingent upon bail or bond issues being resolved.)

Caring for individuals with mental illness in a jail has many challenges. Creating avenues in which jail mental health staff can foster better patient relationships and advocate for the appropriate level of care is critical to effective jail mental health services. Establishing collaborative relationships with legal and community mental health systems is creating positive patient outcomes in Milwaukee County as we continue to explore ways in which we can maximize existing resources to ultimately reduce the number of individuals referred for inpatient competency restoration services. ●

Sarah McKnight LPC, CCHP, is the mental health director of the Milwaukee County Jail and Milwaukee County Community Reintegration Center. She is a doctoral candidate in Walden University's Forensic Psychology program and is writing a dissertation on jail-based competency restoration services.

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CCHP Program Prepares for New Standards

By Matissa Sammons, MA, CCHP, and Pauline Marcussen, DHA, RHIA, CCHP

Updated versions of NCCHC *Standards for Health Services* in jails and prisons have recently been released; new mental health standards will soon follow. This is the first time the standards have been revised since they were last published in 2018, so anticipation has been high – and they are now available!

At first glance, these new *Standards* will appear very different. For starters, they are now spiral bound, with an attractive redesigned cover. The new manuals are also longer, as many topics have been expanded to include more robust practical guidance. The discussion section of each standard has been replaced with a more comprehensive Interpretive Guidance section.

These revisions will have implications for the CCHP exams, which are based on the standards. Added content will mean that test-takers need to study more material. Despite the additional content, the heart of most standards – and those that directly impact exam questions – remains unchanged.

As occurs every time a new set of standards comes out, there is a six-month grace period before the changes are reflected on the exams. Some key activities during this six-month period:

The exams are updated to reflect changes in the standards. All CCHP test questions and answers are being meticulously reviewed against the new standards by the CCHP Board of Trustees. Although the CCHP exam includes 80-100 questions, they are drawn from a large "bank" of items – not everyone taking the exam gets the same test questions. There are several hundred questions that need to be reviewed and rechecked. Some will be edited, some will be marked for deletion, and others will remain untouched. New questions will be written based on the new material, creating a more robust exam. The same process is concurrently being undertaken for specialty and advanced exams, including the CCHP-MH exam based on the new mental health standards. The CCHP-MH test is anticipated to involve the most changes because the mental health standards have not been revised since 2015.

Test-takers can take the exam based on the standards they are familiar with during the six-month grace period. Until the end of this period, all the exams – CCHP, specialty, and Advanced – will continue to be offered based on the current standards.

Individuals who are familiar with the current standards because they already own a copy, have attended a standards preconference seminar or watched the exam prep webinar, or work at a facility that is accredited or attempts to operate in compliance with the standards – and anyone who has been thinking about becoming certified – might want to consider taking the test sooner than later. Six months may seem like plenty of time to schedule an exam, but we all know time flies, and there are several steps involved.

First, you need to apply to take the exam. For that, you need to collect and possibly update your resume or CV to reflect your educational and professional experience. You also need to supply copies of your credentials – a copy of a valid license (if you are currently employed in a clinical position that requires licensure) or a copy of your diploma or educational transcript that meets the requirements for your work position.

You will also need to decide where and when to take the test. Exams can be taken online from the convenience of your home or office, at one of hundreds of Prometric test centers across the country, or at the upcoming National Conference on Correctional Health Care in Baltimore on Nov. 2. (*Please note:* The deadline to apply to take the exam at the National Conference is Oct. 16.)

In short, allow yourself plenty of time to complete the application and registration process and secure your spot. We suggest completing your application approximately six weeks before you want to take the exam. (But please don't wait until six weeks before the new exam drops!) Once the six-month grace period ends, so does the opportunity to test on the 2018 *Standards*.

Those who prefer to wait and test on the new standards can start studying. For anyone who cannot take the exam in the next six months, and those overachievers who want to be among the first to test under the new standards, order your new *Standards* and start reading! The new manuals are over 200 pages long, so there is lot to learn. However, the task force and review council that wrote and reviewed the revisions are confident the field will appreciate and benefit from the information that was added. ●

Matissa Sammons, MA, CCHP, is NCCHC's vice president of Certification; Pauline Marcussen, DHA, RHIA, CCHP, is chair of the CCHP Board of Trustees and a member of the NCCHC Governance Board.

The new CCHP exams based on the revised *Standards* will go into effect beginning Feb. 25, 2026. Order hard copies or digital *Standards* at ncchc.org/online-bookstore.

The most common complaint about periods is premenstrual syndrome or PMS, which refers to symptoms many people have before and during their period. ACOG explains that "many women feel physical or mood changes during the days before menstruation. When these symptoms happen month after month, and they affect a woman's normal life, they are known as premenstrual syndrome or PMS." Symptoms include depression, irritability, angry outbursts, crying spells, anxiety, and insomnia. Physical symptoms, according to ACOG, can include food cravings, bloating and weight gain, headache, breast tenderness, and fatigue.

These symptoms are a natural consequence of hormonal changes, and many women experience – and live with – at least some of them. But if symptoms seriously interfere with mental stability and physical well-being, they may point to a more serious disorder that requires medical intervention: PMDD or PME. These are serious health conditions that often go undiagnosed.

Premenstrual dysphoric disorder (PMDD) is a severe type of PMS that affects a small percentage of women. Premenstrual exacerbation (PME) refers to the premenstrual exacerbation of preexisting symptoms of another disorder, such as major depressive disorder, generalized anxiety, or obsessive-compulsive disorder.

PMDD has been more extensively researched and is officially recognized as a diagnosis in the DSM-5. PME, on the other hand, is still primarily explored in research settings and has not yet been formally recognized or widely treated in clinical practice, according to the International Association for Premenstrual Disorders (IAPMD).

Both are associated with suicidality, self-harm, depression, mood swings, and more. Providers should screen for these conditions and help connect patients to treatment. The IAPMD recommends asking these three screening questions:

- Do your symptoms (such as mood swings, irritability, or depression) occur in a cyclical pattern – worsening in the two weeks before your period and improving within a few days of menstruation?
- Are these symptoms severe enough to interfere with your daily life, relationships, work, or school activities?
- Do you feel like a different person during this time, with significant emotional or physical changes that feel out of your control?

Facilities can also consider using self-screeners (paper- or computer-based self-assessments) that allow patients to thoroughly describe their symptoms. From there, clinicians can provide thorough clinical assessments.

Although PMDD and PME are psychiatric conditions, they are believed to be heavily influenced by neurological and biological factors and cannot be easily managed by self-care or other personal behaviors. Facility staff should be trained in trauma-informed responses to PMDD and PME, given that people may show aggression, suicidality, or other behavioral health challenges around their period due to these conditions.

Physical Menstrual Disorders

In addition to PMS and related more extreme conditions, there are many other types of menstrual disorders.

Heavy menstrual bleeding: According to ACOG, any of the following can be a sign of heavy menstrual bleeding: bleeding that lasts more than seven days, bleeding that soaks through one or more tampons or pads every hour for several hours in a row, needing to wear more than one pad at a time, needing to change pads or tampons during the night, or flow with blood clots that are as big as a quarter or larger. However, any bleeding that is heavy enough to cause distress should be considered heavy menstrual bleeding and be assessed, notes Andrea Knittel, MD, PhD,

Know Your Period Products

A wide variety of period products, sometimes called feminine hygiene products, are available commercially, although in most correctional facilities, availability is limited to pads and tampons, the most commonly used products.

Menstrual pads (also known as napkins) can be thin, regular, or maxi-sized, absorbing different amounts of blood. If someone has a heavy period, thin pads are not enough, but for someone with a light period, maxi pads can be irritating.

Tampons also come in different sizes. They may have a cardboard or plastic applicator or come without an applicator.

Menstrual cups and discs are newer products that are inserted into the vagina to collect blood. They can be washed and reused.

Women often use a panty liner in addition to a tampon, cup, or disc in case of leaks, or at the very beginning or very end of the period.

Period underwear has a unique, built-in lining similar to a pad and can be reused after being washed.

CCHP, associate professor in the department of Obstetrics and Gynecology at the University of North Carolina at Chapel Hill and ACOG liaison to the NCCHC Board of Representatives.

Painful periods (dysmenorrhea): More than half of women who menstruate have some pain for a day or two each month, according to ACOG. Usually, the pain is mild. But for some women, the pain is so severe that it keeps them from their normal activities for several days a month. Severe pain can be indicative of many different health issues, such as endometriosis, fibroids, or other conditions.

Irregular periods (oligomenorrhea, polymenorrhea): Irregular periods result from endocrine conditions affecting ovulation or structural conditions of the uterus, which may be benign, precancerous, or malignant.

Absence of menstruation (amenorrhea): Pregnancy, stress, restrictive eating/eating disorders, metabolic disorders, or structural conditions of the uterus or genital tract can cause a woman to stop menstruating.

Abnormal bleeding of any kind can be indicative of serious health issues such as fibroids, cysts, endometriosis, or an eating disorder. In fact, several health societies consider menstruation to be the "fifth vital sign," as it can point to underlying systemic health issues. The NCCHC Women's Health Care position statement recommends implementing intake procedures that include histories on menstrual cycles, to include last menstrual period, frequency, and whether periods are heavy.

It's also a good idea to talk to patients about their periods at every health visit. Ask about their cycles and any concerns they have about their mental state, the amount they bleed, how often they bleed, and the length of their periods. Since everyone is different, getting their perspective can help identify whether their normal has shifted. Ask whether their period has changed from what it has typically been. Find out if it is impacting their daily well-being.

Medications, including many that are also used for contraception, may be helpful in regulating heavy, long, and painful periods. Make sure that clinicians in the facility are comfortable identifying indications and contraindications for these medications and can refer for specialty gynecology care if needed. Non-narcotic pain medications can also help ease pain, and specialty care may be warranted if pain is not successfully managed. Poor exercise, sleep, and diet habits can also contribute to the length, amount, and frequency of bleeding.

Increasing access to menstrual health education can improve health outcomes among your residents. Consider partnering with a local provider or nonprofit in your area to provide menstrual health education or have health staff provide these training.

What Can Your Facility Do?

- Provide a range of period products – types and absorbencies
- Make additional pads available for postpartum people
- Spell out procedures for securing period products in the resident handbook
- Screen for menstrual disorders at intake and thereafter
- Provide health education to residents and staff

Regan Moss, MPH, is a doctoral student in the Social, Behavioral, and Population Sciences Department at Tulane University. Ann Grace Morgan, MD, MPH, is an obstetrics/gynecology resident at the University of Alabama at Birmingham. Haley Fenn, MS, is a project manager with Nurse Family Partnership of Central Alabama. Silvia Vilches, PhD, is an associate professor at Auburn University's College of Human Sciences.

FOR MORE INFORMATION

American College of Obstetricians and Gynecologists: ACOG.org

NCCHC Women's Health Care in Correctional Settings position statement: ncchc.org/position-statements

Periods in Prisons curriculum: PERIOD.com

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NCCHC Keeps Growing! Meet the New Staff Members

To keep up with growing demand for NCCHC's services, the organization has added five professionals to its staff.

Sandra Violette, MSW, CCHP, has joined NCCHC as manager of accreditation for Opioid Treatment Programs and mental health. She is an addictions counselor with 20 years of experience with the Connecticut Department of Corrections, where as director of addiction treatment she oversaw statewide addiction programming and was instrumental in starting MOUD services within the state.

Sandra Violette

Liz Catalano

The Accreditation Department also has two new accreditation coordinators.

Accreditation Coordinator Liz Catalano's experience includes providing consultation, training, and technical assistance to corrections and community-based recipients of Second Chance Act grants.

Janet Pimentel

Janet Pimentel, post-survey accreditation coordinator, comes to the organization from The Joint Commission, where she held a number of relevant positions over a 19-year tenure.

Leah Fucile

Leah Fucile, CCHP, has joined NCCHC Resources, Inc., the organization's consulting arm, as project manager. She recently retired as director of administrative operations for the Las Vegas Metropolitan Police Department/Clark County Detention Center, where she managed medical and mental health contracts and was instrumental in obtaining and maintaining NCCHC accreditation.

Ana Olivares is NCCHC's new education manager, focusing on webinars and virtual conferences. Previously, she was senior manager for global health education with NCCHC supporting organization the American Academy of Pediatrics.

Ana Oliveras

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Expert Advice on the NCCHC Standards

By Wendy Habert, MBA, CCHP-A

CQI Study Sample Sizes

Q Does the National Commission on Correctional Health Care require a minimum sample size for CQI studies?

A NCCHC does not dictate a specific number or percentage of the overall population when identifying CQI study sample size. Determining sample size can be challenging and is usually dependent on the topic being studied and potential of occurrences. For example, when studying a topic related to pregnancy, the population size may be small, as it is limited to the total number of pregnant patients within a facility, and the sample may inevitably include all of the pregnant patients; however, when studying a topic related to timeliness of receiving screenings or health assessments, the sample size could be much larger, so an identified sample size may be established (for example, a random selection of 20 charts of those booked into custody in an identified month).

The CQI committee should identify a large enough sample size so that results are representative of what is happening in the facility. When doing surveys, NCCHC surveyors most commonly see facilities using a range of sample sizes, from 20-25 charts/patients up to the entire population (such as the pregnant population example above).

Family Notification of Death or Hospitalization

Q What is the best practice for notifying a family member of an in-custody death or when an incarcerated individual is hospitalized?

A NCCHC's standards do not include specific information pertaining to notifications of family/loved ones in relation to death or hospitalization, as these notifications are most commonly a function of custody staff and therefore fall under the purview of custody policies and procedures. Whether in person or via telephone call, many facilities engage a chaplain when a notification to next of kin is necessary. For safety and security reasons, many facilities do not notify family members/loved ones of the transport to the hospital and may only do so when death is imminent; again, that is a custody-related policy.

To learn more, we encourage you to reach out to other law enforcement agencies within your state; many may be willing to share their death notification policies and procedures to assist you and your agency.

Constant Observation

Q What does "constant observation" mean in relation to suicide watch monitoring?

A Constant observation refers to direct line-of-sight observation not obstructed by a wall, cell door, or other obstruction limiting the ability to observe the individual on a continuous, uninterrupted basis. Closed-circuit television or incarcerated individuals cannot be used in any way (for example, as companions or suicide prevention aides) as a substitute for staff observation of individuals being monitored for safety precaution purposes. Facility policies guide the frequency of documentation of the constant observation; however, documentation is recommended at least every 15 minutes. ●

Wendy Habert, MBA, CCHP-A, is NCCHC's director of accreditation. Send your standards-related questions to accreditation@ncchc.org.

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