Spring 2026 | Volume 40 | Issue 1

CorrectCare®

The magazine of the National Commission on Correctional Health Care

Aligning Perspectives

Addressing Tension Between Health Care & Mental Health Staff

The Acute Stabilization Unit: Transforming Psychiatric Care

Legal Challenges in Telehealth

Attracting and Retaining Correctional Health Staff

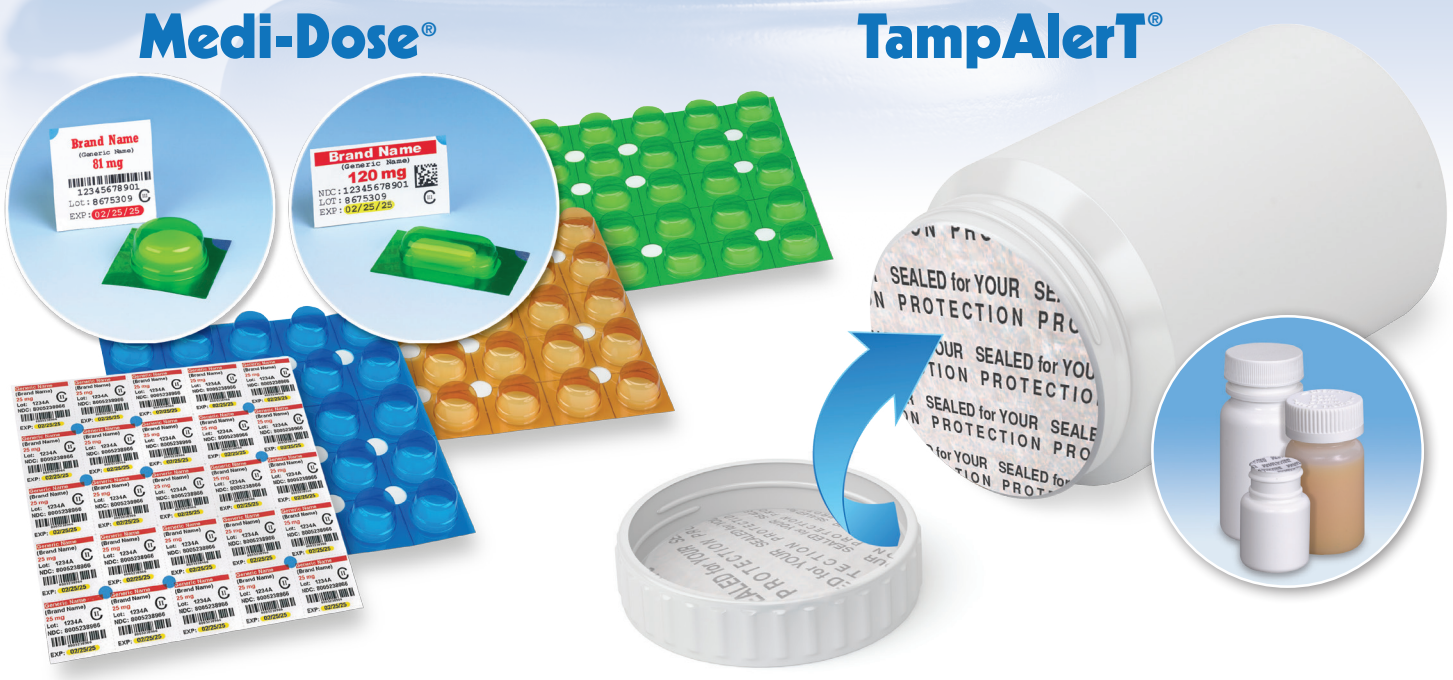
National Commission on Correctional Health Care
1145 W. Diversey Parkway, Chicago, IL 60614

Medi-Dose® EPS®

THE VERDICT IS IN

Still #1 for tamper-evident unit dose in correctional care pharmacies

Unit Dose, Bar Coding, Pharmacy & Nursing Supply Experts!



Simple. Safe. Secure. Since 1971, the Medi-Dose® and TampAlerT® unit dose packaging systems have continued to meet the specific needs of correctional care pharmacies.

Medi-Dose® is the economical answer for packaging and dispensing your solid oral medication. Available in 13 styles, with 6 or 12-month beyond-use dating options, it's moisture and light resistant. No in-service training is required and it's barcode ready. Medi-Dose® uses no metal, glass or machinery…so it's safe to use for both your staff and patient population.

TampAlerT® is the ideal tamper-evident solution for liquids or powders. It's stocked from 15 to 120 mL, in natural or UV inhibitant polyethylene, with regular or child-resistant screw caps. The TampAlerT® seal goes on automatically when you twist on the container cap.

Call or visit our website for samples and more information.

800.523.8966 **MediDose.com**

CorrectCare® is published by the National Commission on Correctional Health Care, a nonprofit organization whose mission is to improve the quality of health care in our nation's jails, prisons, and juvenile confinement facilities. NCCHC is supported by the leading national organizations representing the fields of health, mental health, law, and corrections.

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

FEATURES

DEPARTMENTS

Cover design by Jill Cooper, illustration © Nimfa design/Shutterstock

Our Independence Matters

The National Commission on Correctional Health Care has no membership or dues. NCCHC does not require any affiliation to be considered for accreditation, certification, or employment as a consultant or surveyor, or to serve on committees or the Board of Representatives. NCCHC staff and spouses are not allowed to accept gifts or consulting fees from those we accredit or certify. NCCHC is impartial, unbiased, expert, and dedicated only to recognizing and fostering improvements in the field of correctional health care.

Send correspondence to Barbara Granner, CCHP, Editor
NCCHC, 1145 W. Diversey Pkwy., Chicago, IL 60614
773-880-1460; info@ncchc.org; ncchc.org

New Position Statements Drive Field Forward

Several new NCCHC position statements provide expert guidance on urgent topics in correctional health care.

Telehealth in Correctional Facilities lays out how telehealth can meaningfully enhance access and quality when it is used appropriately and implemented with strong ethical safeguards (see the article on page 17).

Care for People with Sickle Cell Disease in Corrections offers clear guidance and a call to action, addressing patients' unique needs and underscoring the need for structured workflows, sustained monitoring, and patient-centered implementation.

Optimizing Health and Education Outcomes for Youth in Confinement calls for juvenile correctional providers to ensure all youth receive appropriate screening, diagnostic services, health treatment, and referral for educational services to meet their educational needs.

In addition, two revised position statements support women and pregnant people: Nonuse of Restraints for Pregnant and Postpartum Incarcerated Individuals and Obstetric and Gynecologic Health Care in Correctional Settings.

Learn more at **ncchc.org/position-statements.**

New Members Join NCCHC Boards

Brandon De Julius, MBA, CCHP-A, chief executive officer of CFG Health, is the new American College of Healthcare Executives liaison to the NCCHC Board of Representatives.

Sam Wakim, DMD, MPH, joined the board as the American Dental Association liaison. He provides day-to-day guidance, support, and medical management for Horizon Blue Cross Blue Shield of New Jersey.

Pauline Marcussen, DHA, RHIA, CCHP, is the new chair of the NCCHC Foundation Board of Trustees. She recently retired after a 25-year career with the Rhode Island Department of Corrections, most recently as health care services administrator.

Joining the NCCHC Foundation board are Mike Dillman, MSN, RN, CCHP, chief operating officer of CorrHealth; Jeffrey Fetter, MD, assistant professor of psychiatry at Geisel School of Medicine at Dartmouth and chief medical officer at New Hampshire Hospital; and Elizabeth Samson, LMHC, CCHP, vice president of quality improvement at Wellpath.

New to the NCCHC Resources Board of Directors are Aynsley Mull, JD, deputy chief legal officer with Centurion Health, and Jeffrey Alvarez, MD, CCHP-CP, CCHP-A, physician executive consultant.

Workforce Development Hub Launched

Individuals entering the correctional health care field can now connect with experienced professionals through the NCCHC Foundation's new Workforce Development Hub, a national initiative designed to support learning, professional development, and workforce growth.

The program provides free access to a searchable online directory of volunteer preceptors who have offered to share their expertise with professionals seeking guidance in correctional health care.

"Access to experienced professionals who can share practical insight and real-world experience is invaluable to those entering or advancing in correctional health care," said Foundation Director Julie Haugland.

The initiative was developed by the NCCHC Foundation's Workforce Development Committee and made possible through the support of CFG Health, a Gold Level NCCHC Foundation Correctional Health Partner.

Learn more about this exciting initiative at **workforcedevelopment.ncchcfoundation.org.**

Overview of 2026 Standards Changes

Now available: Handy transition guides detailing every change and revision to the 2026 jail, prison, and mental health *Standards* manuals, including interpretive guidance, documentation expectations, and compliance indicators. These comprehensive slide decks provide the clarity you need to align with the latest requirements.

Available in print and digital formats at **ncchc.org/online-bookstore.**

The Promise and Peril of AI

By Keith Ivens, MD

In 1996, my first year with the Indiana Department of Correction, I was introduced to the National Commission on Correctional Health Care as an organization that was working to push our field higher. With NCCHC, I was thrilled to find like-minded individuals who wanted to serve incarcerated patients and improve communities by returning those individuals prepared to manage their health needs.

Back then, correctional health care was in a very different place. Some facilities struggled to provide even minimal levels of acceptable care. But over the past three decades, the field has made tremendous progress. We no longer have to rely on court mandates to drive improvement. Today, NCCHC leads the way in setting standards that define and elevate quality care in corrections, and I am deeply honored to serve as the 2026 NCCHC Board chair.

Like so many physicians who are dedicated to serving the underserved, I have found working in jails and prisons to be challenging and deeply fulfilling. As a correctional physician, my philosophy has always been to treat our patients with respect and give them the education and encouragement they need to make better health decisions. Maybe that will help empower them to make better decisions in other parts of their lives as well and avoid reincarceration. That might sounds naïve, but the hope to have a positive impact on patients' lives is the reason I – and many of us – went into medicine in the first place.

Potential Opportunities

In the coming year, the Board and I will be examining the role of artificial intelligence and exploring how this rapidly evolving technology can be leveraged to enhance correctional health care operations and outcomes.

The potential applications are exciting. AI could streamline intake assessments, triage, and health care screenings by helping clinicians identify urgent cases more efficiently. Predictive analytics may enable better tracking of chronic conditions such as diabetes, asthma, and hypertension, ultimately reducing complications and improving patient outcomes. Telehealth could also be strengthened through AI-driven translation and transcription tools, allowing for more effective and accessible remote care.

In the realm of mental health, AI-powered monitoring could help identify individuals at risk for suicide, while digital cognitive-behavioral therapy platforms and other evidence-based tools could supplement traditional counseling.

AI also presents promising opportunities for reentry, an area we know is essential for sustained health and successful reintegration. Personalized AI-driven education platforms could support vocational and academic learning. And intelligent systems could facilitate the secure transfer of health records at release, ensuring continuity of care and connecting individuals with vital health, housing, and employment resources.

As a field, we have both an opportunity and a responsibility to thoughtfully explore how these technologies can advance our mission and improve the lives of those we serve.

I want to be clear: no machine can ever do what you do. It can't build trust, offer empathy, or truly understand the human condition. But as we face growing challenges — staffing shortages, limited budgets, and rising demand — AI can help lift some of the burden. It can give us back time, sharpen our focus, and strengthen our ability to deliver care that changes lives. ●

Keith Ivens, MD, is the 2026 chair of NCCHC's Board of Representatives and board liaison of the American College of Correctional Physicians.

At a Glance: Meet Keith Ivens

Career Highlights

- Chief medical officer, CoreCivic
- President, Correctional Medicine Associates
- Staff physician, Indiana Department of Correction

NCCHC Positions

- Board of Representatives, 2021-present
- Education Committee, 2022-present
- Policy and Research Committee, 2024-2025

Education

- Doctor of Medicine, Stanford University School of Medicine
- Graduate work in Anatomy, Howard University
- Bachelor of Science in Physiology, Michigan State University

Other

- President, American College of Correctional Physicians

Wexford Health
SOURCES INCORPORATED

To learn why Wexford Health should be your correctional health care team, go to **www.wexfordhealth.com** or scan the QR code.

Minimum Age Laws Protect Young Children

By Melissa Goemann, JD, and Elizabeth Barnert, MD, MPH

In the United States, there is no nationally mandated minimum age for arresting and prosecuting children. In fact, many states do not have minimum age laws. Arresting and prosecuting young children is not only inappropriate but deeply traumatizing and can leave lasting scars. It is well past time for every state in the country to join the international community in establishing a reasonable minimum age for arrest and prosecution of children.

Kaia's Story

Before Kaia Rolle, then 6 years old, was arrested in Florida for throwing a temper tantrum, she was a vibrant child who loved to dance. After the police forcibly removed her from school in zip ties, while she desperately screamed, "Help me! Help me!" her personality changed. Her grandmother reported two years later that Kaia was suffering from extreme post-traumatic stress disorder and separation anxiety and rarely smiled anymore.

Unfortunately, Kaia isn't alone. Hundreds of young children across the United States are arrested each year. A 2023 longitudinal study published in Academic Pediatrics found that of the nearly 700,000 minors prosecuted annually, approximately 3.6% are under 12 years old and nearly one in five is under 14.

Negative Consequences

The negative consequences of arresting youth go beyond emotional damage:

Physical harm. While all children in confinement risk physical harm, younger children are at heightened risk of victimization compared to older youth. A study from the National Juvenile Justice Network found that more than one in four confined children under the age of 13 were victims of violence, compared to one in 11 20-year-olds.

Long-term negative effects on health. Researchers led by Elizabeth Barnert found an association between early incarceration (under 14 years old) and worse physical and mental health outcomes in adulthood compared to those first incarcerated at later adolescent and young adult ages.

Harm to public safety. According to the National Juvenile Justice Network, early contact with the system has been found to harm public safety; the likelihood that these children will commit future offenses increases inversely with the age of first justice system contact. These children are also more likely to become chronically involved with the criminal legal system.

Collateral consequences. Juvenile justice system involvement creates a permanent record for a child. While some states try to shield those records, it can be difficult to accomplish and often does not apply to all records. Criminal legal system involvement can result in lasting harm to a child by creating barriers to education, employment, housing, and public benefits.

Finally, the arrest of young children disproportionately affects certain groups of children. A CBS News analysis of data from the U.S. Department of Education's Office for Civil Rights found that of young children arrested, Black school children in grades 5 and below were five times more likely to be arrested at school than their white counterparts. Additionally, children with documented disabilities, such as ADHD and autism, were found to be four times more likely to be arrested at school.

Minimum Age Laws

Some progress is being made, but more needs to be done. Twenty-eight states now have a minimum age for prosecution, but many of those mandated ages are very young. In Florida, the minimum age is only 7 years old, and in Arizona and Washington state it is 8 years old. Most states with a minimum have set it at 10 years old (Arkansas, Colorado, Connecticut, Kansas, Louisiana, Mississippi, Nevada, North Carolina, North Dakota, Pennsylvania, South Dakota, Texas, and Wisconsin). Maine and Nebraska have a minimum age of 11 years old. Seven states now have a minimum age of 12 years old (California, Delaware, Hawaii, Massachusetts, New York, Utah, and Vermont) and three have a minimum of 13 years old (Maryland, Minnesota, and New Hampshire). In the meantime, 22 states have yet to establish a minimum age.

The practice of arresting and prosecuting young children makes the United States an outlier throughout the world. The most common minimum age of criminal responsibility is 14 years old, and the United Nations has urged nations to set their minimum age of criminal responsibility to 14 years old at the youngest.

What Can You Do?

We urge those in states with no – or very low – minimum ages to advocate for vital human rights legislation that

Continued on page 21

Aligning Perspectives

Addressing Tension Between Health Care & Mental Health Staff

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

Correctional health sits at the intersection of health care, mental health services, and custody – three demanding disciplines that must function together even when their priorities do not always align. Among the many challenges this creates, few are more persistent – or more disruptive – than the tension between health care and mental health teams. If unaddressed, that tension can strain relationships, weaken patient care, and worsen the very conditions those involved are trying to treat.

The Problem

Tension often arises from contrasting philosophies, competing priorities, and daily operational differences. Medical teams tend to focus on physical stability, diagnostic results, and infection control, while mental health professionals concentrate on behavioral management, crisis intervention, and long-term psychological wellness.

Both areas of focus are equally important and valid, but their differing approaches can lead to misaligned treatment goals, including disagreements over medication adherence, isolation precautions, the interpretation of somatic complaints, and risk assessments related to self-harm or behavioral escalation. When coordination lapses, critical details can be missed and care can become fragmented, shifting from unified planning to parallel decision-making.

Limited resources and constant time pressure only amplify the divide. Health staff sometimes view mental health interventions as secondary to physical health needs. Conversely, mental health clinicians may see their medical colleagues as dismissive or lacking empathy. Over time, those perceptions can harden, breeding mistrust and professional resentment and ultimately fracturing what should be a unified patient-care team.

Adverse Effects on Patient Care

When tension between teams goes unaddressed, communication becomes transactional instead of collaborative, and patient outcomes suffer. Poor coordination leads to inconsistent care plans, delayed interventions, and a higher risk of missed or inaccurate diagnoses – both medical and psychiatric.

Psychotic symptoms illustrate why collaboration is essential. Before labeling psychotic symptoms as psychiatric (primary), clinicians must first rule out organic (secondary) causes such as medical conditions, substance intoxication or withdrawal, and neurocognitive disorders (see box).

For example, a patient arrived at one of our facilities appearing paranoid, disoriented, and agitated. He was initially referred for a psychiatric evaluation. Further

Psychosis: Differential Diagnosis

Psychotic symptoms often present a complex diagnostic challenge, particularly in settings where multiple contributing factors may coexist. Differentiating between primary psychiatric disorders and secondary organic causes of psychosis requires a systematic, medically informed approach. In corrections – where patients frequently have overlapping medical, neurological, and substance-related conditions – this distinction is even more essential. Adhering to the differential diagnosis for psychosis can greatly reduce a source of conflict between health care and mental health teams.

It is important to understand that psychosis is a symptom – not a diagnosis. Before concluding that a patient's psychosis is due to a psychiatric disorder, clinicians must carefully evaluate for organic causes. In correctional settings, where medical comorbidities, substance use, and limited diagnostic resources are common, this step is especially critical.

Medical causes. A wide range of medical conditions can produce psychotic symptoms. Those include infections affecting the central nervous system, metabolic and endocrine disorders such as thyroid disease, hypoglycemia, or adrenal dysfunction, and systemic illnesses like lupus or hepatic encephalopathy. Delirium from acute medical instability is another frequent and reversible cause.

Drugs, medications, and toxins. Substance use or withdrawal remains a leading cause of secondary psychosis. Stimulants such as cocaine and methamphetamine, hallucinogens, synthetic cannabinoids, and alcohol or benzodiazepine withdrawal can all induce hallucinations or paranoia. Certain prescribed medications – including corticosteroids, anticholinergics, dopaminergic agents, and some anticonvulsants – may also trigger psychotic symptoms. Toxic exposures, such as heavy metals or carbon monoxide, should be considered when the history suggests environmental risk.

Neurocognitive disorders. Dementias, traumatic brain injury, autism spectrum disorders, and other neurodegenerative or structural brain conditions can alter perception and behavior. Psychotic features may emerge as part of the disease process or as a reaction to cognitive decline and disorientation.

Taken together, these categories remind us that what may appear to be a psychiatric problem may, in fact, reflect an underlying medical or neurological condition. A disciplined, collaborative approach – grounded in communication among staff – helps ensure accurate diagnosis, timely treatment, and better patient outcomes.

assessment revealed tremors, diaphoresis, and elevated vital signs consistent with delirium tremens, a severe form of alcohol withdrawal. Prompt medical intervention stabilized the patient within hours.

Similar pitfalls occur in less-acute presentations. In another case, a middle-aged patient repeatedly complained of fatigue, sluggishness, and poor concentration. Medical staff, noting her flat affect and vague complaints, suspected depression and referred her to mental health. The mental health professional, however, questioned the extent of the patient's cognitive slowing. Laboratory testing revealed significant hypothyroidism. Treatment of her hypothyroidism led to noticeable improvements in mood and energy.

Cases like those demonstrate how easily each team can rely too heavily on its own framework for understanding symptoms. When health care and mental health staff work together to review both physiological and psychological factors, they can more accurately determine whether distress is emotional, physical, or both – leading to more effective and compassionate treatment.

In correctional settings, where patients already face barriers to continuity of care and may distrust facility staff, visible disagreement among providers can further erode the therapeutic relationship. Inconsistent documentation, incomplete handoffs, and parallel treatment plans without shared decision-making diminish quality of care and increase liability risk. The most vulnerable patients – those with co-occurring disorders – are often the ones that fall through the gaps.

The effects of poor interdisciplinary communication extend far beyond clinical metrics – they directly shape how patients experience care. Incarcerated patients already live with isolation, distrust, and limited access to services. When providers disagree or cling to narrow disciplinary views, necessary interventions are delayed.

As a result, patients may feel anxious, dismissed, or unsafe. Misunderstood symptoms can lead to unnecessary restrictions or inappropriate medications, compounding stress and worsening both mental and physical health.

Conversely, when teams collaborate effectively, patients experience more consistent and compassionate care. Their trust in the entire health staff improves, and they are more likely to adhere to treatment plans and engage actively in their own recovery – advancing the larger goal of humane and effective care.

Strategies to Reduce Tension

Effective integration does not happen by accident – it takes deliberate effort from both leadership and frontline staff from all disciplines. The following strategies can help reduce tension and improve patient care.

Prioritize structured collaborations. One effective approach is to establish regularly scheduled interdisciplinary

Continued on page 20

The Acute Stabilization Unit: Transforming Psychiatric Care in the San Mateo County Jail

By Mark Delucchi, PhD, CCHP-MH

The Acute Stabilization Unit (ASU) at the Maguire Correctional Facility in Redwood City, Cali., represents a pioneering approach to addressing severe psychiatric illnesses and co-occurring substance use disorders among incarcerated individuals. Operated by Liberty Healthcare Corporation in partnership with San Mateo County Behavioral Health and Recovery Services, Correctional Health Services, and Sheriff's Office, the ASU has been a cornerstone of acute psychiatric care since its inception in October 2018, providing high-quality care in a safe environment.

Solving for Better Psychiatric Care

Before the ASU opened, people in custody requiring involuntary psychiatric hospitalizations were temporarily transferred to the county hospital. This practice was disruptive to all involved. Patients had to navigate an unfamiliar environment in orange, jail-issued clothes while mingling with civilian psychiatric patients. Deputies had to accompany patients and remain with them, resulting in program disruption at the hospital, safety issues in transport and hospitalization, and potential staff shortfalls at the jail. Hospital staff had to manage the unit milieu with both custody and civilian patients, along with the accompanying sworn staff.

The result was often a short hospital stay with minimal psychiatric stabilization for the patient, while other incarcerated people languished in jail without adequate mental health care, as the jail facility lacked the clinical resources to truly address this critical psychiatric need.

The ASU was created to ensure that all individuals in custody experiencing acute psychiatric symptoms received the necessary and clinically appropriate care within the existing jail system.

Creating a Safe Space

The ASU is a 10-bed unit certified by the State of California Department of Health Care Services as a Jail Inpatient Unit; it serves as the county receiving facility for incarcerated individuals placed on involuntary psychiatric holds, known as 5150s in the State of California. The unit has admitted and discharged more than 300 patients in its first five years, maintaining an average daily census of 7.3 and an average length of stay of 50.5 days. This extended length of stay is often due to the need for temporary conservatorship, which helps the patient be found competent to stand trial and ultimately address their criminal case while receiving psychiatric care for their symptoms.

ASU staff perform frequent safety checks and suicide assessments upon patient admission and throughout the patient's stay. These assessments are critical for identifying patients at risk and assist the staff in implementing appropriate interventions to reduce risk. The ASU's focus on safety has contributed to creating a therapeutic clinical environment in which staff have performed fewer than 50 emergency involuntary medication administrations and experienced only one staff assault incident in more than six years of operation.

Photo © True Touch Lifestyle/Shutterstock

Collaborating for Results

The ASU provides comprehensive care through a multidisciplinary team approach. The treatment team includes psychiatrists, nurses, mental health workers, a recreational therapist, program clinical director, and the program director. The team collaborates daily to review patient progress, adjust treatment plans, and address any emerging clinical and safety issues, thereby ensuring continuity of care through regular communication. The ASU team provides thorough psychiatric assessments tailored to each patient's

needs, forming the basis of individualized treatment plans aimed at achieving psychiatric stability as quickly as possible. The ASU's trauma-informed, recovery-oriented approach ensures that patients receive psychotropic medications and treatments in a supportive environment.

The unit offers 24-hour care, with nurses addressing the patient's medical needs, administering medications, collecting blood samples, providing wound care, and offering health education. Mental health workers, similar to psychiatric technicians, observe the patients' safety throughout the day at least every 15 minutes, more frequently as necessary, resulting in more than 1.6 million observations since 2018. They also provide recreational activities consistent with patients' treatment plans.

The program's board-certified psychiatrist leads the treatment team, meeting with each patient daily, adjusting psychotropic medications, working to stabilize the patient quickly, and providing consistent psychiatric care and monitoring. A board-certified recreational therapist develops clinical activities tailored to each patient's needs, both individual and group treatment, designed to engage patients and promote their mental health and ultimate recovery. The clinical director is a licensed therapist who provides individual and group therapy on the unit and ensures that all patients receive a supportive transition back to the most appropriate jail housing or to community-based care. The ASU director oversees the unit and represents the ASU at most judicial court hearings related to the patient's involuntary psychiatric hospitalization.

The ASU has also provided more than 100 hours of clinical mental health training for sworn staff. With their greater understanding of mental health symptoms and diagnoses, custody staff show patience and commitment to the population and help reduce the need for seclusion, restraint, and other less therapeutic interventions.

Satisfaction and Success

Patient satisfaction is a key indicator of the program's success. The patients complete a satisfaction survey prior to discharge. This feedback, with scores averaging 4.5 on a 5-point Likert scale, highlights the positive impact of the ASU's comprehensive care and supportive environment on patient recovery. Patients also have shown a 99.3% compliance rate with psychotropic medications.

The ASU has significantly impacted the San Mateo County jail system as a whole. The unit has saved the Sheriff's Office nearly 34,000 deputy shifts at the hospital that would have been required while patients were admitted on a psychiatric hold. The ASU's presence has also supported the transition of those individuals incarcerated with significant mental illness from segregated housing to more supportive environments. In 2018, 100% of ASU admissions came from segregated housing and approximately one-third of the discharges were returned to segregated housing units. Today, approximately 40% of admissions come from segregated housing and no discharges to segregated housing have occurred for the past 15 months.

The ASU at Maguire Correctional Facility exemplifies how innovative, collaborative approaches can transform mental health care for those in acute psychiatric crises in correctional settings. The ASU stands as a model for other correctional facilities, demonstrating the profound impact of dedicated psychiatric care on the health of the incarcerated population and the overall jail system. By providing specialized, in-custody treatment, the ASU not only improves clinical patient outcomes but also alleviates the strain on sworn staff and the broader county health care system. This model offers a promising blueprint for other correctional facilities seeking to enhance their mental health services. ●

Mark Delucchi, PhD, CCHP-MH, is a clinical psychologist and executive clinical director at the HOPE Program, a California-wide company that provides clinical treatment to registered sex offenders and other parolees. He was formerly executive director of the Acute Stabilization Unit at San Mateo County Jail.

The Art and Science of Attracting and Retaining Correctional Health Professionals

By Danielle Byrn, MA, LPC, CCHP

"You work where?!"

Most correctional health professionals routinely encounter that question. And for good reason: many students studying nursing, medicine, psychology, or counseling have never considered the possibility of working in a jail, prison, or other kind of carceral setting. While those environments certainly are not for everyone, there is no doubt that health care professionals are an integral part of corrections, which is now one of the main providers of health services, especially mental health care, in the country.

As a mental health professional, I have had the good fortune to work in a variety of correctional settings and with a variety of patient populations. I have found that many patients are very appreciative of the services we provide and receptive to the education, guidance, and encouragement we share. Often, this is the first time they have received such care.

Illustration © Macrovector/Shutterstock

Working in this field offers plenty of opportunities for reward and fulfillment. However, we may struggle to build and maintain a stable, qualified workforce due to the unique pressures of the job.

Recruitment: Change the Narrative

While health staff may have a limited role in human resources' recruitment process, we can have a big impact on attracting people to the field. Community engagement is a valuable tool for finding qualified staff. Many correctional institutions are situated in or near major cities and near institutions of higher learning. Reaching out to nursing, psychology, counseling, social work, and medicine and psychiatry residency programs at nearby universities can produce a wealth of potential candidates. Social media, used in accordance with agency policies, can also be a tremendous tool in recruitment.

Another strategy is to develop a strong student internship, clinical rotation, or practicum program within your agency. Many of my colleagues gained exposure to our organization through working as student interns. This can be a powerful tool for developing a strong network of future professionals as well as creating valuable community connections. It can also help to destigmatize this career path among early professionals.

Offering competitive compensation packages, student loan repayment, tuition reimbursement, retention bonuses, and/or schedule flexibility can help enhance the desirability of the field.

A crucial component of recruitment is changing the narrative. Public perception of working in corrections is generally not flattering to the field. I personally recall, during my graduate school days, seeing my fellow students visibly cringe when I spoke of my excitement at securing a practicum spot at a federal prison. Talk about deflating my enthusiasm!

It's true that corrections is not exactly a "warm and fuzzy" field. But hiring managers need to balance that reality with discussions of the very rewarding aspects of the work. Most people's perceptions of corrections are based on riveting, but often overdramatized, movies and TV shows. Emphasizing the role health care professionals play in improving lives, enhancing safety, and contributing to social justice can appeal to values-driven candidates.

People are often quite surprised when they find that correctional clinics, infirmaries, and therapeutic spaces mirror those found in community health care settings, and

that patients are seen in a professional manner utilizing the tools of our trade. They are also surprised when they hear how grateful and appreciative our patients often are.

We ideally should work closely with human resources and our facility's policies to choose candidates who will be a good fit within our agency. There are a few important questions to consider.

First, does the candidate appear relatively comfortable in the correctional environment? I strongly recommend bringing candidates on-site for job interviews whenever possible. While your candidate does not have to be comfortable to the point of skipping down the hallway, you want to see that there is a level of inquisitiveness, resilience, and desire to do the job.

I remember feeling nervous walking through the unit during my interview and jumping at the sound of crash gates closing, but I knew this was something I could acclimate to. There is a marked difference between someone unaccustomed but adaptable to the environment, and someone who is fearful to be there. It is unfair to the candidate, the agency, and the patients to hire someone whose fear and worry would preclude them from fulfilling their job duties.

Second, does the candidate possess situational awareness and a basic understanding of the realities of working in a correctional setting? This is something you can learn – my own levels of situational awareness and "gut instinct" have certainly been honed over the years – but you want to ensure that your candidate has a good foundation of resilience and teachability in place.

Onboarding: Set Them Up to Thrive

Onboarding is a critical step in ensuring that good candidates, once selected, are set up to thrive. Once your candidate has been discovered, interviewed, and selected, there can be a lengthy pathway to getting them hired and on your unit. If your agency allows, it is good practice to maintain communication throughout this process. This can lay a valuable foundation of encouragement and support from their new employer. Clear communication at this stage can help minimize confusion and fear of the unknown. Arming your new hire with clear, concise instructions reduces anxiety and helps build trust. Letting them know basic logistics, such as pre-hire requirements, start date, work schedule, dress code, prohibited belongings, and even where to park, goes a long way in setting up those building blocks for success.

The stark differences between community work and corrections can definitely be jarring. Having to leave those precious cell phones and other devices in the car during the workday may initially be difficult for new hires. Allowing reasonable break times and communication channels with family members can be helpful in easing the transition to correctional work.

Development and Retention

Years ago, there was a saying heard around the unit: "Eight for the state, then I'm out the gate." This catchy (but cynical) phrase expressed the expectation that an employee would put in their eight-hour shift and go home with no thought to career investment or growth.

I believe this mindset was erroneously developed to minimize burnout and prevent employees from "taking work home with them." We no doubt see and hear stressful things on the job, and proper support is vital. But I believe we need to develop our workforce with an eye toward longevity, retention, and growth. So how can we do that while also encouraging our workforce to stay healthy and avoid the dreaded "B" word: burnout?

The people in your agency are your greatest asset in this quest. Helping your new hire build their professional network, introducing them to colleagues and mentors, and encouraging them to join committees are all effective strategies. A health professional in isolation, particularly within the confines of a jail or prison, can be in dangerous territory. Developing a strong mentorship system is crucial in providing support, guidance, and encouragement, as well as valuable safety lessons. Allowing new hires to shadow seasoned workers is very effective in helping them gain confidence in their clinical skills, documentation, and boundary-setting. Peer consultation, case reviews, access to supervision, and regular team meetings can all help mitigate burnout, promote resilience, and build community.

Corrections can be a very high-stress environment, and because health staff provide such essential care to potentially difficult patients, they need to know they are supported and heard. When a new hire starts, ensure that they not only have clear expectations of duties, but that they have a direct communication line to assistance.

Development of the health professional can also be accomplished through encouragement to attain professional licensure, earning credentials and certifications (such as the CCHP), attending workshops and conferences (such as NCCHC's), and taking advantage of tuition reimbursement programs for continuing education. Reimbursement of CEU expenses is an investment in long-term staff retention.

Final Thoughts

The challenge of attracting and retaining qualified, invested health professionals belongs to all of us. By prioritizing recruitment and retention strategies, correctional systems can build a more resilient, skilled, and compassionate workforce that ultimately benefits individuals, institutions, and communities. ●

Danielle Byrn, MA, LPC, CCHP, is the Mental Health Therapeutic Diversion Program manager at the University of Texas Medical Branch (UTMB).

The Right Ingredients: Nutrition for Detained Youth

Photo © LanaSweet/Shutterstock

By Michelle Staples-Horne, MD, MPH, CCHP, Barbara Wakeen MA, RDN, CCHP, and Paula Braverman, MD

Providing adequate nutrition to youth in custody can be a challenge. Consider the broad picture of food inequity outside the walls. Many young people come from situations where fast food, food deserts, and strong food preferences – "pickiness" – make it difficult for them to get the nutrition they need. They may be accustomed to determining their own food choices and have limited exposure to healthy options.

In a juvenile detention or confinement setting, the conflict is even stronger. Among many other choices that have been removed from their control, youth who are detained have limited food choices, if any at all. This dynamic frequently creates situations where it is difficult to provide food that is both appropriately nutritious and agreeable to them.

A healthy diet is a balanced diet: adequate nutrients and calories based on age, gender, and activity levels. Youth require more calories, protein, calcium, phosphorus, iron, zinc, folate, and vitamin D than most adults. Assuming a common age of 16 years and an average daily activity level of an hour or less of moderate-intensity exercise, the target goal for youth in correctional facilities is between 2,600 and 3,000 calories a day.

The Vital Role of the RDN

In custodial settings, a registered dietitian nutritionist (RDN) works with the facility/governing agency food services staff to produce menus that should be both nutritious and relevant to the demographics of the population. The RDN may be on staff or work in a consulting capacity and is a direct liaison to the facility food services department or staff.

RDNs write and approve menus based on many considerations including population, state standards, accreditation standards, facility policy, contracts, and other guidelines such as the USDA Child Nutrition Program. Youth should also be surveyed to provide input into creation of the menus.

In building these nutrition programs, it's critical for RDNs to consider states' varying definitions of "youth." Typically, "youth" means younger than 18 years old, but in some states, it can be as young as 16 or as old as 24. Those housed in adult facilities should be served the adult menus augmented with milk and one or two snacks per day.

Honoring Specific Dietary Requirements

Some youth require special diets due to allergies; medical, dental, or behavioral health needs; or religious practices. Diets are ordered by the appropriate health authority (clinician, nurse practitioner, or authorized medical personnnel) or religious authority based on governing agency policies. In most settings, diets ordered due to religious practices are approved through the chaplaincy service, planned and/or reviewed by the RDN, and then provided to food services staff for compliance.

Other special dietary needs include soft diets to accommodate dental appliances such as braces; autistic youth who may require food that is more, less, or differently textured; youth on suicide precautions requiring finger foods; and youth who are pregnant requiring more calories and nutrients.

All medical diets are created by the RDN with appropriate preparation by food services staff. Typically, correctional facilities have a standardized medical diet program that encompasses common medical diagnoses. For those diet needs outside of the standard diets, the RDN should be contacted for guidance.

Facilities should have a protocol in place for youth reporting food allergies, although sometimes an "allergy" is actually a dislike of that food or a gang restriction to not eat that type of food. If a youth arrives stating a food allergy, the health staff (or health-trained custody staff if no health staff is on duty) should notify food services immediately via phone and written communication so food services can provide a meal avoiding the allergen. Food services should notify the RDN for guidance as needed.

Then, as soon as possible, the parent or guardian should be contacted to verify the food allergy. Many times, the parent or guardian will explain that the youth is not in fact allergic to the food item. This information should be documented in the medical record and the diet order rescinded.

If the parent or guardian does attest to the food allergy, health records may be requested from the young person's primary care physician or a blood test can be ordered to confirm the patient's reaction to the food when ingested. If the test is positive and/or correlates with the history, the diet can be continued. This information should be provided to the RDN to create a diet eliminating the food allergen. Once the diet is created, food services staff should prepare the meals as directed, and custody staff should ensure the youth receives and eats only the diet meal prepared.

Incorporating Behavioral Health Care

Further evaluation may be indicated for youth presenting to the facility with restrictive diets unrelated to food availability or culturally sanctioned practices to assess for an eating disorder such as anorexia nervosa or avoidant/restrictive food intake disorder (ARFID).

Both disorders place youth at risk for significant malnutrition and require close medical monitoring as well as intervention by a behavioral health professional. Unlike anorexia nervosa, which involves purposeful food restriction related to distorted body image and fear of gaining weight, individuals with ARFID do not have a disturbed body image. Rather, ARFID can present with a lack of interest in eating or food avoidance based on sensory issues or concern about potential negative consequences associated with eating such as choking or abdominal pain. There is a strong correlation between ARFID and autism. A 2025 article in the International Journal of Eating Disorders reported significant rates of co-occurrence between autism and ARFID.

Complying with Policy

The Child Nutrition and WIC Reauthorization Act of 2004 requires educational agencies and correctional facilities in the Child Nutrition Program to establish a school wellness policy for all youth.

To meet the requirements, juvenile correctional facilities can offer education or educational materials via classes, handouts, or one-on-one counseling during the time the federally funded after-school snack is provided. Most often, this education is provided by medical or educational staff. It is a golden opportunity to provide health and wellness education that might be new to the audience. Incorporating daily physical activity and/or structured exercise can also offer positive results for some kids at risk.

Taking the Next Bites

There are immediate steps juvenile facilities can take to improve their nutrition programs:

- There should be policy for youth participating in hunger strikes. Close monitoring by all staff is required to accurately monitor and document food and fluid intake.
- Behavioral and medical staff should have clear procedures in place for young people on strike, including counseling and medical monitoring. Youth have the right to refuse food until the refusal becomes life-threatening requiring medical intervention.
- Most juvenile facilities do not offer commissary or have vending machines available. However, if there is a commissary or vending machines, items should be reviewed and selected for food quality and allergens with input from the RDN.
- Just like at home, food can be a source of comfort and support in appropriate types and amounts. Youth populations can be offered food to celebrate positive behaviors. These treats should be vetted by the RDN for nutritional value. A party with a veggie pizza will be appreciated as much as one with a meat lover's special!
- Deter well-meaning community organizations that want to bring in food as gifts. The quality, safety, and nutritional content of items from outside. is unknown and may be prohibited.

Nutrition plays a critical role in the health and development of youth in custody. With careful planning, professional guidance, and coordinated policies, facilities can ensure that meals support both immediate health needs and long-term well-being. ●

Michelle Staples-Horne, MD, MPH, CCHP, is medical director with the Georgia Department of Juvenile Justice. Barbara Wakeen MA, RDN, CCHP, is a correctional dietitian consultant with Correctional Nutrition Consultants, Ltd. Paula Braverman, MD, is chief of adolescent medicine at Baystate Medical Center. The authors are members of NCCHC's Juvenile Health Committee.

RELEVANT NCCHC STANDARDS

Standard Y-B-01 Healthy Lifestyle Promotion: Health care policies, procedures, and practices emphasize health promotion, wellness, and recovery.

Standard Y-D-05 Medical Diets: Medical diets are provided that enhance patients' health.

NCCHC Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022

Individuals depicted are models used for illustrative purposes only.

Addressing the opioid epidemic takes a team-based approach. **INDIVIOR WAS BUILT TO DO JUST THAT.**

Opioid use significantly increases a person's chances of involvement with the criminal justice system.[1] Based on a 2025 report, of the estimated **2 million** individuals in jails or prisons in the US between 2019 and 2025, **1 in 5** were incarcerated for drug-related offenses.[2] Certain medications for opioid use disorder (MOUD) are associated with improvements in reducing criminal activity, decreasing drug cravings, and lowering illicit opioid use.[1]

References:

1. Substance Abuse and Mental Health Services Administration (SAMHSA). *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*. SAMHSA; 2019. Accessed March 6, 2025. https://store.samhsa.gov/sites/default/files/medication-assisted-treatment-opioid-use-disorder-criminal-justice-settings-pep19-matusecjs.pdf
2. Sawyer W, Wagner P. *Mass Incarceration: The Whole Pie 2025*. Prison Policy Initiative. Updated March 11, 2025. Accessed March 28, 2025. https://www.prisonpolicy.org/reports/pie2025.html

INDIVIOR®

NP-NBD-US-01389 Apr 2025

Navigating Legal Challenges in Telehealth

By Allison Becker, JD, and Kendra Stark, JD

Telehealth has revolutionized health care delivery across the United States, and correctional facilities are increasingly adopting this technology to improve access to care. Telehealth reduces logistical hurdles, such as transporting patients to outside clinics, which often involves security risks and high costs. It also helps address provider shortages, particularly in rural areas where many prisons are located.

Implementing telehealth in correctional settings, however, raises legal and regulatory challenges, including complying with federal and state laws, maintaining patient privacy, and upholding ethical standards. Administrators and health care professionals need practical guidance for navigating this new technology.

Privacy, Security, Informed Consent, and More

Telehealth in correctional facilities must comply with HIPAA standards for privacy and security. Platforms should use encryption, secure transmission, and proper data storage. Noncompliance can lead to severe penalties and fines. State laws add complexity, particularly around licensure and scope of practice. For example, some states require providers to hold a license in the patient's state, creating hurdles for multi-jurisdictional systems. The Ryan Haight Online Pharmacy Consumer Protection Act also impacts telehealth prescribing practices, requiring at least one in-person evaluation before prescribing controlled substances. Correctional facilities must work closely with legal counsel to ensure compliance with these overlapping regulations.

Informed consent is a cornerstone of ethical health care delivery. Incarcerated individuals must understand the nature, benefits, and limitations of telehealth services before participating. That includes understanding potential privacy risks, especially in environments where confidentiality can be compromised by surveillance or facility protocols. Written consent, documented and securely stored, is essential to demonstrate compliance and protect against future disputes. When obtaining consent, facilities should also consider language barriers and literacy levels and provide interpreters or simplified materials as needed.

Correctional environments often conflict with health care privacy requirements. Surveillance cameras, staff presence during sessions, and institutional monitoring policies may inadvertently expose sensitive health information. Facilities should implement clear protocols to minimize those risks, such as restricting audio/video recording and training staff on HIPAA obligations.

Cybersecurity is another critical concern. Electronic health records and telehealth platforms are prime targets for cyberattacks. Providers should conduct risk assessments, implement multifactor authentication, and maintain Business Associate Agreements with technology vendors to ensure compliance. Regular audits and penetration testing can further strengthen security measures.

Telehealth introduces new dimensions of professional liability. Providers must confirm that their malpractice insurance covers telehealth services, including those delivered across state lines. Additionally, correctional facilities should establish clear protocols for emergency situations, such as when a telehealth consultation reveals an urgent medical need that cannot be addressed remotely. Failure to act promptly could expose both providers and institutions to claims of deliberate indifference under the Eighth and 14th amendments. Case law such as *Estelle v. Gamble* (1976) outlines the constitutional obligation to provide adequate medical care to incarcerated individuals, and providers should work with legal counsel to determine how telehealth services fit into that standard.

Funding telehealth in correctional settings also raises legal questions about reimbursement and cost-sharing. Federal programs like Medicaid generally do not cover services for incarcerated individuals, though recent policy shifts allow limited prerelease coverage for substance use disorder treatment. Facilities must understand state-specific rules on billing and cost recovery to avoid violations of reimbursement regulations. Some states have introduced pilot programs to expand telehealth funding in correctional settings, but those remain limited and require careful navigation.

Operating Legally and Ethically

Telehealth often relies on specialists located outside the facility's state, creating licensure challenges. While some states offer reciprocity or telemedicine-specific licenses, others require full licensure. Noncompliance can result in disciplinary action and invalidate malpractice coverage. Correctional systems should develop strategies for credentialing providers across multiple jurisdictions or consider contracting with telehealth vendors experienced in navigating these requirements.

Beyond legal compliance, ethical considerations loom large. Telehealth should enhance – not diminish – patient autonomy and quality of care. Facilities must guard against using telehealth as a cost-cutting substitute for necessary in-person care. Additionally, technology deployment should not exacerbate inequities; for example, by limiting access for individuals with disabilities or language barriers. Best practices include providing assistive technologies, ensuring interpreter services, and monitoring patient satisfaction to maintain high standards of care.

Putting It All Together

Telehealth offers tremendous promise for improving health

Continued on page 21

Illustration © Shaeva/Shutterstock

YesCare

Say Yes To Exceptional Care

Caring with Compassion.
Treating with Dignity.
Leading with Integrity.
Responding with Urgency.

WE'RE HIRING NURSES & LBHPs IN ALABAMA!

Careers.YesCareCorp.com

Why I Became a CCHP-Advanced

By Richard Forbus, MBA-HCM, CCHP-A

I have always loved a challenge. Maybe that explains why I joined the Marine Corps and, when my deployment ended, pursued a career in law enforcement. I enjoy tackling tough assignments and demanding tasks.

The desire to understand the complexities of correctional health care was a significant factor in my decision to pursue my current position with NCCHC. I know we face many challenges in delivering effective, efficient, and collaborative care to the people in our nation's jails, prisons, and juvenile facilities – and I want to be part of the solution.

That desire (and my persistent love of a challenge) is also why I chose to pursue certification as a CCHP-A (Advanced). I wanted to demonstrate my commitment to moving the correctional health care field forward.

Correctional health professionals tend to focus on the NCCHC *Standards* as the foundation of knowledge necessary to deliver high-quality health care and achieve good outcomes. That is true and important to understand. Earning certification as a CCHP demonstrates an individual's mastery of the standards and is an important measure of the knowledge, skills, and abilities that are specific to correctional health care.

But it is the collective effort of health care professionals and custody staff working together, with the same foundation of knowledge and toward the same goals, that ultimately makes quality health care and good outcomes a reality.

I suspected that earning advanced certification would be a significant challenge for me, coming as I do from a law enforcement and custody background rather than a clinical one. But I am dedicated to self-improvement, lifelong learning, whatever you want to call the force that makes us want to do more and learn more. I knew that facing the CCHP-A challenge was necessary for me in order to continue learning and growing.

The process itself was a challenge. From the application through the written examination, I admit that I sometimes doubted myself. The application is extensive, requiring details about the applicant's experience and contributions to the field of correctional health care. The study topics for the exam are wide-reaching. The test itself is a four-hour examination consisting of eight essay questions.

As I prepared for the exam, I found myself asking questions: Have I done enough to qualify for the test? How will it look, as an NCCHC employee, if I fail? Is this even worth the effort? I am sure everyone who has applied and taken the exam has asked themselves the same questions. But I knew I would never advance and improve myself, personally or professionally, without making the effort and putting in the work.

I view becoming a CCHP-A as more than just demonstrating knowledge of NCCHC standards. Becoming a CCHP-A recognizes me for my career accomplishments and contributions to the field, with the expectation that those contributions and efforts will continue and grow.

What I did not realize as I was studying for the exam is that there are relatively few individuals with advanced certification. I am as proud of earning my CCHP-A as of anything I have accomplished in my career, including earning my MBA.

If you are a current CCHP and you're wondering about the next step to advance your career and demonstrate your commitment to correctional health care, I highly recommend pursuing advanced certification when you are eligible to do so (after being certified as a CCHP for three years).

I feel honored to have joined the group of professionals who possess advanced certification with NCCHC, and I invite you to join us too. ●

Richard Forbus, MBA-HCM, CCHP-A, is NCCHC's vice president of program development.

Nurses: New CCHP-N Certification

Recognizing the shared core knowledge required across all levels of nursing practice, NCCHC has expanded its nursing specialty certification program to include all licensed nurses.

The new CCHP-N credential, formerly known as CCHP-RN, reflects the increasingly essential role that licensed practical nurses (LPNs) and licensed vocational nurses (LVNs) play in correctional settings – and in health care more broadly. The change also aligns with NCCHC's mission to elevate quality and professional practice across the field.

All CCHP-N exam questions have been thoroughly reviewed to confirm they are appropriate for all levels of nursing licensure and within scope of practice.

rounds, bringing together diverse health care professionals to discuss and develop comprehensive strategies for patients with complex needs. By promoting communication and mutual understanding, interdisciplinary meetings foster integrated treatment planning. With consistent organization and leadership support, they can address time constraints and role conflicts, ultimately enhancing decision-making and building a cohesive, team-based approach to care.

Develop clear communication protocols to strengthen how information is shared. Consistent, accurate information exchange among team members is vital. Shared electronic documentation and standardized handoff forms promote transparency and reduce miscommunication during transitions of care. Establishing clear expectations – through structured shift reports or interdisciplinary updates – helps maintain continuity and accountability. Integrating such practices into daily workflows improves efficiency, minimizes errors, and ensures every team member has access to the same up-to-date patient information.

Invest in shared learning, including cross-training and education. Joint training on common issues – such as substance use disorders, suicide risk assessments, and somatic symptom presentations – builds mutual respect and a shared professional language. Joint sessions allow health professionals to understand each other's roles and approaches. Fostering insight into overlapping responsibilities and complementary skills can reduce misconceptions and improve coordination. Incorporating case studies, simulations, and cross-disciplinary discussions further reinforces teamwork and consistent decision-making.

Encourage leadership commitment and modeling. Supervisors shape the culture in any professional setting. When leaders model cooperation and highlight the strengths of different disciplines, they set the tone for respect and teamwork across the facility. Their example not only reinforces shared responsibility but also encourages open communication and problem-solving. Leaders who consistently demonstrate accountability – acknowledging errors, giving constructive feedback, and supporting joint decision-making – signal that collaborative practices are valued and expected. Mentorship from leadership helps newer or less confident staff navigate interdisciplinary dynamics effectively. Recognizing and celebrating collaborative efforts builds trust, promotes a workplace culture centered on integrated, patient-focused care, and directly influences how teams handle challenging clinical situations, ultimately improving patient outcomes.

Extend collaboration to the policy level. Policies governing chronic care management, behavioral emergencies, and restraint use should be developed collaboratively, with input from both health care and mental health staff. An inclusive process helps ensure that policies are balanced, practical, and reflective of each patient's unique needs. Shared ownership aligns ethical and clinical standards while helping to prevent gaps or conflicts in care. Regular policy reviews and interdisciplinary feedback sessions sustain consistency, compliance, and quality across all levels of care.

The Takeaway

In the demanding world of correctional health care, collaboration is not a luxury – it's a lifeline. When handled with honesty and respect, tension between health care and mental health teams can spark development instead of division. Communication, mutual education, and shared patient-care goals can transform interprofessional friction into a foundation for more holistic and humane care. What presents initially as a divide between teams leaves room for everyone to grow together. ●

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

Guest Editorial: Minimum Age *continued from page 7*

protect young children from being arrested and prosecuted in the juvenile court. Where there is not yet the political will to enact such laws, advocating for legislation to establish minimum ages of confinement, meaning an age below which children are deemed to young to be locked up in a juvenile detention or confinement facility, is helpful as well.

Until we end childhood incarceration, it is essential to remember that children in custody have likely been traumatized and may have special medical and mental health needs. They need to be treated in a developmentally appropriate way, assessed for medical and therapeutic needs, and provided with appropriate interventions to address those issues and to keep them safe.

Additionally, it is important to remember that Black children are often viewed as older than their age, creating inappropriate expectations. Finally, the behavior of children who are disabled may be misunderstood as intentionality rather than a result of their challenges. It is important to assess children for disabilities, as not all types of disability are easily recognizable.

Finally, whether in custody settings or in the community, it is critical to recognize that any young child who comes to the attention of law enforcement is likely a child needing support. Offering support in community settings, through education, health, and sometimes through the child welfare system, may do more to enhance public safety and set the child on a healing path. But if the child is detained and under your care, please recognize the significant trauma the child is likely experiencing, the harmful conditions that might have led to their incarceration, and the supports needed. Addressing those issues will encourage children to grow positively so that they can have their next birthdays with their classmates and family, in the community, growing into healthy adolescents and healthy, productive adults. ●

Melissa Goemann, JD, is a social justice advocacy consultant with Next Generation Justice Consulting. Elizabeth Barnert, MD, MPH, is associate professor of pediatrics at the David Geffen School of Medicine at UCLA and chair of NCCHC's Juvenile Health Committee.

Telehealth *continued from page 17*

care in correctional settings, but its implementation requires careful attention to legal and regulatory concerns. By prioritizing HIPAA compliance, informed consent, cybersecurity, and licensure requirements, correctional facilities can harness telehealth's benefits while minimizing risk. Collaboration among legal counsel, health care providers, and correctional administrators is essential to creating policies that uphold patient rights and meet evolving standards. As telehealth continues to expand, proactive planning and adherence to best practices will be key to success. ●

Allison Becker, JD, is managing partner of the North Carolina offices of Gordon Rees Scully Mansukhani, co-chair of the firm's national Healthcare Practice Group, and co-chair of the Correctional Healthcare Practice Group. Kendra Stark, JD, is a partner and co-chair of the firm's Correctional Healthcare Practice Group.

FOR MORE INFORMATION

NCCHC Position Statement: Telehealth in Correctional Facilities (2025)

ABOUT CORRECTCARE®

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

Subscriptions: *CorrectCare* is mailed free of charge to CCHPs, key personnel at accredited facilities, and other recipients at our discretion. The magazine is posted at ncchc.org and sent out digitally to all individuals in the NCCHC database.

Change of Address: Update your account at ncchc.org or email info@ncchc.org.

Editorial Submissions: Submitted articles may be published at our discretion. Manuscripts must be original and unpublished elsewhere.

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-A

Constant Observation of Suicide Risk

Q Monitoring those with acute risk of suicide via constant observation can be labor intensive. How common is this level of monitoring?

A NCCHC recognizes that correctional facilities vary in custody staffing levels, average daily population, and patient acuity. When developing custody and health care policies and procedures related to safety precaution monitoring, facilities should apply the 2026 *Standards*' definition of acute risk of suicide to determine when constant observation is required versus when safety checks at unpredictable, irregular intervals not exceeding 15 minutes are appropriate.

Under the 2026 *Standards for Health Services* in jails and prisons, as well as 2026 *Standards for Mental Health Services in Correctional Facilities*, acute risk of suicide refers to individuals who are actively engaging in suicidal or self-injurious behavior and/or expressing thoughts of suicide with a specific plan and the means to carry it out, indicating imminent risk. Individuals without a specific plan or without access to the means to harm themselves in their identified plan do not meet this definition and should be classified as nonacute risk of suicide.

Most patients fall under the nonacute risk of suicide classification once access to means has been removed. In these cases, compliance with Standard B-05 Suicide Prevention and Intervention requires direct observation monitoring at unpredictable, irregular intervals not exceeding 15 minutes, rather than constant observation, which is reserved for those at acute risk.

Reaccreditation Under 2026 *Standards*

Q We have a reaccreditation survey coming up in 2026. How will you review our documentation under the new jail and prison *Standards* manuals?

A The new items in the 2026 *Standards* manuals are effective beginning in 2026. NCCHC recognizes that some of the new requirements in the 2026 manuals will take time to fully implement. With reaccreditation surveys reviewing the 36-month period preceding your 2026 survey, those conducted under the new 2026 jail or prison *Standards* will be approached with appropriate grace and flexibility as facilities transition to the updated compliance indicators.

Facilities are not expected to demonstrate 36 months of compliance with these new requirements. Instead, surveyors will assess the steps taken toward implementation as of January 2026, rather than expecting full historical compliance with the new elements. Evidence of implementation may include, but is not limited to: updates to policies and procedures; training or education provided to health staff; revisions to forms or operational processes; changes in health record documentation practices; and updates to orientation materials and custody-related training documents

Lead surveyors will document their observations during the survey process. Some new elements may already be Fully Met, while others may be scored as Partially Met to reflect ongoing implementation efforts. This approach ensures that facilities are recognized for meaningful progress while continuing to work toward full compliance. ●

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

CORRECTIONAL MENTAL HEALTH CARE CONFERENCE

JULY 18-20, 2026 • AUSTIN MARRIOTT DOWNTOWN

Care that changes outcomes—inside and beyond the walls

Join peers from across the country at the **Correctional Mental Health Care Conference** — the nation's leading event dedicated to advancing mental health care in correctional settings.

This year's agenda centers on high-impact topics clinicians and administrators need most, including suicide prevention, serious mental illness, and risk reduction — all with a focus on improving patient outcomes and supporting staff well-being.

Who Should Attend

Learn alongside clinicians, administrators, and leaders working to improve mental health care in correctional environments.

Sessions are designed for:

- **Frontline staff** seeking effective ways to connect with patients and enhance care
- **Managers and administrators** working to deliver strong mental health services with limited resources
- **Leaders and decision-makers** focused on strengthening systems, morale, and policy

Why Attend

- Stay current on emerging practices and policy
- Gain **continuing education (CE)** credits
- Be part of a national community committed to better care

Learn more at
ncchc.org/mental-health-conference

Interested in exhibiting?
Booths and sponsorship opportunities are available.

Contact Mary Mac Kinnon at **sales@ncchc.org.**

45 Years of Service.
1 Mission.

We're proud to celebrate 45 years of Centurion Health! Founded as MHM Services in 1981, 2026 marks 45 years of providing care, building strong partnerships, and growing TeamCenturion in service to communities nationwide.

centurion™