



the State Pen

Suicides in Corrections: Paying Attention to Prevention

by Meghan Fay, Internet Reporter
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Suicide is the leading cause of death in US jails, with over 400 inmates taking their life each year. The rate of suicide in a jail is nine times greater than in the community, and in a prison the suicide rate is two to three times greater than in the community. Suicide ranks third as a cause of death in prisons behind natural causes and AIDS, with 150 to 180 prison suicides a year.



Regardless of what type of facility you manage, every facility should have a comprehensive policy with specific procedures to address suicide prevention. Although there are different types of successful prevention programs, the common thread among them is a well-trained

staff with a heightened sensitivity towards the issue and an awareness of warning signs and risks.

Intake Screening

As part of intake, an inmate should undergo screening that includes questions to discover if an inmate is suicidal. "Intake screening is very important to verify or document behavior. If someone admits to prior suicide attempts he is usually telling the truth. Most times inmates will not lie [about suicide attempts], but if in fact they do have a history they will not always admit it," said Lindsay Hayes, Assistant Director, National Center on Institutions and Alternatives (NCIA).

Hayes, a nationally recognized expert in the field of jail and prison suicide and project director for the only three national studies conducted on the subject, recommends using a variety of questions to make an assessment and catch potential high-risk inmates. There is no universal format for intake screening. In some systems the only question that is asked is – 'Does the inmate's behavior suggest suicidal behavior?' Hayes suggests that instead facilities ask the following:

- Are you suicidal?
- Have you ever-attempted suicide?
- Have you ever thought about committing suicide?
- Have you ever been hospitalized for a suicide attempt or a mental illness?
- Has a member of your family or a close friend ever committed suicide?

- Have you recently suffered a close loss?

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A gift certificate, good for \$10 off dues, conferences, regional meetings, or any other CA-NV ACHSA chapter activities will be issued to members who submit articles, news items, or other contributions to *the State Pen* (that's \$10.00 for each contribution!). Get out your pens, fire up the word processors, and send us the latest on your work sites, your accomplishments, case studies, humorous or sad stories (or whatever else you may have). We want your input to make *the State Pen* a networking and outreaching format. Contributions need not be grand or wordy, but please type or print!



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Thanks to Mr. Alan Wild for the use of this logo!

The CA-NV Chapter Board of Directors

Here are the current members of the CA-NV Chapter Board of Directors. Board members serve in an unpaid capacity, with the length of their terms established by the chapter bylaws (interested parties may view these on the chapter web page). Members may be contacted via their e-mail addresses, or by writing them c/o the chapter's mailing address, 2140 Shattuck Avenue, PO Box 2491, Berkeley, CA 94704.

Position	Name	Organization	E-mail
President	Royanne Schissel RN CCHP	San Diego Sheriff's Department	royanne@lanz.com
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Communications Coordinator	Kevin Connor, RN CCHP	San Bernardino Sheriff's Department	Kcnp@earthlink.net
Nevada Representative	Vacant	xxxxx	xxxxx

Additional vacancies exist for immediate past president, as well as for four Members at Large positions. Ballots will be sent to all members in the near future to fill these positions, as well as to confirm the positions of Treasurer and Communications Coordinator.

"It is not only asking the questions and documenting the answers. There is also non-verbal behavior," which includes a lack of eye contact, teary eyes or crying, a sense of hopelessness, talking unrealistically about the future and not appearing to be in contact with reality, said Hayes.

"I think it is important to not get bogged down with identifying a specific type of inmate. Our type of inmate is changing. I think that you do look for behavior changes," said Margaret Severson, Associate Professor of Social Work at the University of Kansas. These include sleeplessness, lack of appetite, suicidal gestures, awaking at odd hours and the giving away of possessions.

Risk

A suicidal inmate is an emergency that requires immediate attention. Most inmates who commit suicide in jail were arrested for non-violent crimes, and 50% of the victims in jails or prison were intoxicated with drugs or alcohol at the time of death, according to the San Francisco Suicide Prevention US Suicide Statistics. The most critical time period in a jail is the first 24 to 48 hours of incarceration, when the influence of drugs and alcohol plagues many inmates and creates a heightened suicide risk.

There are features of the jail environment that magnify suicidal behavior: lack of apparent control over the future, distrust of authoritarian environment, isolation from family and significant others, fear of the unknown, dehumanizing aspects of incarceration and shame of incarceration.

In prison, a suicide is usually triggered by other matters such as: re-sentencing, parole rejection, the distance from family members, or inmate on inmate conflict.

More emphasis is often placed upon jail suicides because of the higher suicide rate and that lawsuits are more frequently filed for jail suicides, said Hayes. He attributes the lower number of lawsuits related to prison suicides to the distancing between inmates and their families.

Preventative Training

"The best prevention is in those facilities where

the staff is sensitive to the issue and it is important to have training not only in the academy, but in the facility each year," said Hayes. He credits the National Commission on Correctional Health Care (NCCHC) with having the most comprehensive and practical guidelines for suicide prevention. Their standards not only require a written plan, but provide a guideline of key components to include in the program, which include: training, identification, monitoring, referral evaluation, housing, communication, intervention, notification, reporting, review and critical incident debriefing.

"We dictate that there will be a policy that everyone knows " to obtain accreditation, said Judith Stanley, Director of Accreditation, NCCHC.

There are pockets of good prevention programs, but according to Hayes, there is not one state that is consistent across the board in providing quality prevention programs. Facilities that have not had a suicide are "just very, very fortunate," he said. "You shouldn't look at it like it's a numbers game, you should be looking at each of the suicides and see if any of them could be prevented," said Hayes.

There are still facilities that refuse to implement prevention programs, and they do so for mainly two reasons, "One, a system has not had a suicide, and the second is a negative attitude that suicides are going to occur [regardless]," said Hayes.

Severson, Associate Professor of Social Work at the University of Kansas, feels that not having a prevention program puts staff in a compromising position. "It is like going the wrong way on the highway. The highway is going the direction of predicting and preventing suicides. If the intervention is designed well you can help them decide on the side of life," said Severson.

Controversial Issues in Suicide Prevention

Mental health staff can use no-suicide contracts as therapeutic tools for suicidal inmates. The inmates are encouraged to sign the contract stating that they will not inflict harm on themselves without notifying a staff member. Hayes says that it is more effective with low risk inmates and it doesn't carry much weight to have highly suicidal inmates make a promise to

not hurt themselves.

However, "there are times when a (no-suicide contract) is misused or misunderstood," said Hayes. The word contract sometimes leads officials to believe that it is a legal shield, but it is not a legal document that will hold up in court. According to Stevenson, the contract is used with inmates because, "part of the problem with suicides is isolation and this promise helps make them feel accountable and makes a connection," with the outside or someone, but there is no evidence that the contract is a successful tool.

Some facilities automatically strip potentially suicidal inmates naked regardless of their risk level. "They overreact," said Hayes. The procedure is often used as a punitive measure with manipulative inmates. Hayes believes that it should be used as a last resort and examined on a case by case basis.

Manipulative inmates can be more dangerous than suicidal inmates can because if an inmate is "willing to engage in self-destructive behavior to get something, what turned into a very lethal gesture turns into a very lethal suicide," said Hayes.

Some experts believe that closed circuit television monitoring (CCTV) in lieu of staff observations does little to prevent suicides. If the two methods are used together, the outcome can be positive, "but a lot of suicides have occurred in full view of the camera," said Hayes. The problem with CCTV is that the monitoring is usually done in the control center of a facility, which is an extremely busy area. The officer who monitors the camera usually has other duties and the inmate does not get the constant observation that is required to thwart a suicide attempt.

North Dakota State Penitentiary

The American Correctional Association (ACA) standards require accredited facilities to have a written policy for suicide prevention and intervention, but they offer no guidelines on how to achieve a quality program. However, the Crisis Intervention Team for Suicide Prevention at the North Dakota State Penitentiary was named in the American Correctional Association's Best Practices: Excellence in Corrections.

According to Lynn Koch, a psychiatric social worker at the facility, since 1991, there have been no successful suicides during her tenure. The facility's suicide prevention program was developed in October 1980 after three inmate suicides occurred in less than a year. "We began the program because we knew we needed to provide something for inmates to keep them safe," said Koch.

All staff are trained on suicide risk detection, intervention and prevention, with follow-up training every two years thereafter. "The success of it is a well informed staff and their heightened sensitivity. We have a staff that really watch for these things, are in tune and always have their antennas out looking for this," said Koch.

The unique aspect of this program is inmate involvement during the most serious of the suicidal stages. "We have the normal kind of checks, but we added the extra component of giving them someone to talk to if they want to," said Koch. In addition to staff observation every 15 minutes and camera surveillance, an inmate who is a member of the crisis intervention team (CIT) is called to sit with the suicidal inmate, outside the cell, to offer him/her suggestions or support when indicated.

The CIT members are given six days of good time for a three-month stint of service. "It's really beneficial," for the inmates, said Koch; "it gets them back into the mode of caring for other individuals."

Resources

Lindsay Hayes, Assistant Director, National Center on Institutions and Alternatives: (508) 337-8806

Lynn Koch, North Dakota State Penitentiary, Treatment Department:
(701) 328-6372

Margaret Severson, Associate Professor of Social Work, University of Kansas:
(785) 864-4720

Judith Stanley, Director of Accreditation, National Commission on Correctional Health Care: (773) 880-1460

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SCOPE and STANDARDS of Nursing Practice in Correctional Facilities

American Nurses Association

Editor's note: due to space constraints, the introduction and table of contents for this document have been omitted.

Nursing is a dynamic, independent profession. In corrections, the nurse is frequently employed in an isolated environment where there is constant pressure to expand his or her scope of practice to meet new needs and demands. This unique environment be stressful and antagonistic, and it may limit the range of available interventions. It may also require nurses to acknowledge their responsibility for providing only those services that fall within their legal practice parameters.

Nurses in correctional facilities provide health care to individuals incarcerated in jails, prisons, juvenile detention facilities, and similar settings. The populations incarcerated vary from youths to aged adults and include both women and men, from the healthy through the chronically ill, the mentally ill, and the developmentally disabled. In some settings, long term care access to inmates facilitates planned care as well as the development of trusting professional relationships that enable nurses to do more than maintain the inmate's general health through screening and emergency interventions.

Nurses practicing in correctional facilities provide health care services as their sole responsibility, and matters of nurses judgment are solely their province. Therefore, it is inappropriate for nurses to be involved in the security aspects of the facility and registered nurses would not participate in procedures performed solely for correctional purposes. It is also inappropriate for nurses to participate in disciplinary decisions or committees or to participate directly or indirectly in executions by lethal injection. However, security regulations applicable to facility personnel also apply to health personnel.

Historical Perspectives and Trends

ANA/American Correctional Health Services Association Organizational Units

ANA councils are organizational units through which individual members of state nurses associations participate in improving or advancing the profession in an area of nursing practice or interest. The councils provide a community of peers and a principal source of expertise in the areas of interest and serve as a forum for discussing relevant issues and concerns. They develop standards, positions, and policies for recommendation to the Congress of Nursing Practice. The councils propose the establishment of certification offerings and recommend specific certification requirements in an area of interest to the appropriate governing structures. Currently, there are six councils, which are as follows:

1. Council for Acute Care Nursing Practice
2. Council for Advanced Nursing Practice
3. Council for Community, Primary, and Long Term Care
4. Council for Nursing Research
5. Council for Nursing Systems and Administration
6. Council for Professional Nursing Education and Development

The ANA Council on Community, Primary, and Long Term Nursing Practice affiliates includes nurses involved in caring for the community and for individuals who are well, at risk for health problems, or in need of long term care (e.g., in the home, schools, public health agencies, community health clinics or other community-based agencies, work sites, or correctional facilities, ambulatory care clinics, provider offices, or nursing homes).

The American Correctional Health Services Association (ACHSA) is the membership organization for all correctional health care professionals. It serves as a forum for current issues and needs confronting correctional health care. It provides education, skill

development, and support for personnel, organizations, and decision makers involved in correctional health services, thus contributing to a sense of community and creating positive health changes for detained and incarcerated individuals. The *Scope and Standards of Nursing Practice in Correctional Facilities* published by the American Nurses Association is adopted as ACHSA policy.

Changes in Population and Services

Over 1.3 million persons are incarcerated in the United States, and approximately 1 in every 428 adults was in jail on June 30, 1992. According to Bureau of Justice statistics, the inmate population has doubled over the past decade and is currently growing at the rate of 14 percent yearly. During the same 10 years, the number of incarcerated women tripled in state and federal prisons and doubled in jails.

Overall, inmates are poor and undereducated, and ethnic minority populations are disproportionately represented. Before incarceration, the inmate's lower socioeconomic status tends to limit access to health care services, thereby contributing to higher than average risk for heart disease, hypertension, diabetes, and mental illness. Because of a significant history of substance abuse, inmates have rates of infection for human immunodeficiency virus (HIV), tuberculosis, hepatitis B, and sexually transmitted diseases that far exceed those of other populations.

Beliefs

The basic philosophy underlying these standards is that health care provided in the correctional facility should be equivalent to that available in the community and subject to the same regulations. The Supreme Court of the United States recognizes that detainees in correctional facilities are totally dependent on the employees of the institution for their health care. This increases the nurse's responsibility for assisting the incarcerated persons with their health care problems.

Ensuring inmates' human rights is of major importance in the controlled environment of

correctional facilities. Justice, a cardinal concept guiding the nursing profession, mandates that all persons receive nursing services that are equitable in terms of accessibility, availability, and quality.

Nursing shares in the belief that learning is a lifelong process and demonstrates such through certification of continued education and competency.

Nursing Practice in Correctional Facilities

The major thrust of nursing care in correctional settings is the provision of primary care services for the population. Primary health services in this field include screening activities, providing direct health care services, analyzing individual health behaviors, teaching, counseling, and assisting individuals in assuming responsibility for their own health to the best of their ability, knowledge, and circumstances.

Basic Nursing Practice

Nursing care may be provided in collaboration with other nurses or health professionals, or independently, which is often the case in a small or rural facility. The practice includes providing a full range of nursing services emphasizing disease prevention and health promotion activities, recognizing and treating illnesses and injuries, counseling, and evaluating the effectiveness of planned care.

Advanced Nursing Practice

Advanced nursing practice in correctional facilities is characterized by depth and breadth of knowledge in a nursing specialty and the ability to incorporate knowledge of the correctional field in planning, implementing, and managing health care. The advanced practice nurse guides the practice and critical thinking of nursing and other health care personnel; carries out direct advanced clinical practice; manages one or more clinical practice settings; incorporates scientific knowledge from other disciplines into practice and management, and evaluates the health care provided in those settings.



Standards of Care

Standard I. Assessment

The Nurse Collects Health Data

Rationale

Correctional nursing practice is characterized by a high degree of autonomy and requires a broad-base of subjective and objective data.

Measurement Criteria

1. The priority of data collection is determined by the client's immediate condition or needs.
2. Pertinent data are collected by using appropriate assessment techniques, adapted to ensure security and provider safety.
3. Data collection involves the client, significant others, health care providers, and other criminal justice system personnel, when appropriate.
4. The data collection process is systematic and ongoing.
5. Relevant data are documented in a retrievable form.

Standard II. Diagnosis

The nurse analyzes the assessment data in determining diagnoses.

Rationale

The nurse in a correctional facility uses independent judgment and available data to formulate diagnoses.

Measurement Criteria

1. Diagnoses are derived from assessment data.
2. Diagnoses are validated with the client, significant others, health care providers, and records maintained by other institutions, when possible.
3. Diagnoses are documented in a manner that facilitates the determination of expected outcomes and care plan.

Standard III. Outcome Identification

The nurse identifies expected outcomes individualized to the client.

Rationale

The nurse in the correctional facility identifies outcomes based on unique factors (such as length of stay, overall safety, and a lack of information about the prior health status of clients) that affect the nurse's ability to provide services.

Measurement Criteria

1. Outcomes are derived from the diagnoses.
2. Outcomes are documented as measurable goals.
3. Outcomes are mutually formulated with the client and health care providers, when possible.
4. Outcomes are realistic in relation to the client's present and potential capabilities.
5. Outcomes are attainable in relation to resources available to the client.
6. Outcomes include a time estimate for attainment.
7. Outcomes provide direction for continuity of care.

Standard IV. Planning

The nurse develops a care plan that prescribes interventions to attain expected outcomes.

Rationale

Effective planning is essential for appropriate interventions.

Measurement Criteria

1. The plan is individualized to the client's condition or needs.
2. The plan is developed with the client, significant others, health care providers, and other criminal justice personnel, when appropriate.
3. The plan reflects current nursing practice.
4. The plan is documented.
5. The plan provides for continuity of care from the time of entry into the system, through transfers to other institutions, to final release from custody, when appropriate.
6. The plan provides for discharge follow-up based on the client's need for health care, when appropriate.

Standard V. Implementation

The nurse implements the interventions identified in the care plan.

Rationale

The nurse is the most appropriate health care provider in the correctional setting for ensuring that actions are taken to meet the physical, mental, and health education needs of the client.

Measurement Criteria

1. Interventions are consistent with the established care plan.
2. Interventions are implemented in a safe, appropriate, and timely manner.
3. Interventions are documented.

Standard VI. Evaluation

The nurse evaluates the client's progress toward attainment of outcomes.

Rationale

The nurse in the correctional setting uses the nursing process to evaluate the outcome of nursing actions, interventions, and client education. The nurse may alter the care plan, expand the database, introduce new interventions, and develop client education activities.

Measurement Criteria

1. Evaluation is systematic and ongoing.
2. The client's responses to interventions are documented.
3. The effectiveness of interventions is evaluated in relation to outcomes.
4. Ongoing assessment data are used to revise diagnoses, outcomes, and the care plan, as needed.
5. Revisions in diagnoses, outcomes, and the care plan are documented.
6. The client, significant others, health care providers, and other criminal justice system

personnel are involved in the evaluation process, when appropriate.

Standards of Professional Performance

Standard I. Quality of Care

The nurse systematically evaluates the quality and effectiveness of nursing practice.

Rationale

The nurse in the correctional setting ensures that quality nursing care meets measurable community standards.

Measurement Criteria

1. The nurse participates in quality-of-care activities as appropriate to the individual's position, education, and practice environment. Such activities may include the following:
 - a. Identifying aspects of care important for quality monitoring.
 - b. Identifying indicators used to monitor the quality and effectiveness of nursing care.
 - c. Collecting data to monitor the quality and effectiveness of nursing care.
 - d. Analyzing quality data to identify opportunities for improving care.
 - e. Formulating recommendations to improve nursing practice or client outcomes.
 - f. Implementing activities to enhance the quality of nursing practice.
 - g. Participating in the work of interdisciplinary teams that evaluate clinical practice or health services.
 - h. Developing policies and procedures to improve the quality of care.
2. The nurse uses the results of quality-of-care activities to initiate changes in practice.
3. The nurse uses the results of quality-of-care activities to initiate changes throughout the health care delivery system, as appropriate.

Standard II. Performance Appraisal

The nurse evaluates his/her own nursing practice in relation to professional practice standards and relevant statutes and regulations.

Rationale

The nurse in the correctional setting balances professional performance with the maintenance of safety and security.

Measurement Criteria

1. The nurse regularly engages in performance appraisal, identifying areas of strength as well as areas for professional and practice development.
2. The nurse seeks constructive feedback regarding his/her own practice.

3. The nurse takes action to achieve goals identified during performance appraisal.
4. The nurse participates in peer review as appropriate.

Standard III. Education

The nurse acquires and maintains current knowledge in nursing practice.

Rationale

The diverse health care needs in the correctional facility and the attendant need for nursing autonomy require the nurse to engage in ongoing education.

Measurement Criteria

1. The nurse participates in ongoing educational activities related to clinical knowledge and professional issues.
2. The nurse seeks experiences to maintain clinical skills.
3. The nurse seeks knowledge and skills appropriate to the practice setting.

Standard IV. Collegiality

The nurse contributes to the professional development of peers, colleagues, and others.

Rationale

The nurse in the correctional facility has the responsibility and opportunity to positively influence peers, colleagues, and others regarding health care issues, education, and practice.

Measurement Criteria

1. The nurse shares knowledge, skills, and information with peers, colleagues (including other criminal justice system personnel), and others.
2. The nurse provides peers with constructive feedback regarding their practice.
3. The nurse contributes to an environment that is conducive to the clinical education of nursing students, as appropriate.

Standard V. Ethics

The nurse's decisions and actions on behalf of clients are determined in an ethical manner.

Rationale

The nurse in the correctional setting has an ethical commitment to the client and the nursing profession that must not be compromised.

Measurement Criteria

1. The nurse's practice is guided by *The Code for Nurses* and related ANA position statements, such as the *Position Statement on Nurses' Participation in Capital Punishment*.
2. The nurse maintains patient confidentiality.
3. The nurse acts as a client advocate.
4. The nurse delivers care in a nonjudgmental and nondiscriminatory manner that is sensitive to client diversity.
5. The nurse delivers care in a manner that preserves and protects client autonomy, dignity, and rights.
6. The nurse seeks available resources to help formulate ethical decisions.

Standard VI. Collaboration

The nurse collaborates with the client, significant others, other criminal justice system personnel, and health care providers in providing patient care.

Rationale

The nurse in the correctional facility collaborates with public and private health care providers to ensure comprehensive continuity of services.

Measurement Criteria

1. The nurse communicates with the client, significant others, criminal justice system personnel, and health care providers regarding client care and nursing's role in the provision of such care.
2. The nurse consults with health care providers for client care, as needed.
3. The nurse makes referrals, including provisions for continuity of care, as needed.

Standard VII. Research

The nurse uses research findings in practice.

Rationale

Utilization and practice of research activities within the correctional setting promotes the professional development and knowledge base within this unique setting. The nurse is expected to adhere to research method guidelines.

Measurement Criteria

1. The nurse uses interventions substantiated by research as appropriate to the individual's position, education, and practice environment.
2. The nurse participates in research activities as appropriate to the individual's position, education, and practice environment. Such activities may include the following:
 - a. Identifying clinical problems suitable for nursing research.
 - b. Participating in data collection.
 - c. Participating in a unit, organization, or community research committee or program.
 - d. Sharing research activities with others.
 - e. Conducting research within the guidelines of the individual facility, statutes, and regulations.
 - f. Critiquing research for application to practice.
 - g. Using research findings in the development of policies, procedures, and guidelines for client care.

Standard VIII. Resource Utilization

The nurse considers factors related to safety, effectiveness, and cost in planning and delivering client care.

Rationale

The nurse in the correctional facility is uniquely positioned to determine the priority, availability, and appropriateness of resources required to meet the client's health care needs.

Measurement Criteria

1. The nurse evaluates factors related to safety, effectiveness, efficiency, and cost when two or more practice options would result in the same expected client outcome.
2. The nurse assigns tasks or delegates care based on the needs of the client and on the knowledge and skill of the provider selected.
3. The nurse assists the client and significant others in identifying and securing appropriate, available services to address health-related needs.



Happy Holidays

From the

California-Nevada Chapter

Of the

American Correctional

Health Services Association!

Conference '99: A Big Success!

Approximately 120 correctional health care professionals (and one administrator) attended the CA-NV Chapter's annual conference at the Wyndham Gardens Hotel in Costa Mesa. The impression was overwhelmingly positive, due to the hard work of the committee members, who communicated largely via e-mail and telephone. Some members didn't even meet until the first day of the conference, which is remarkable considering the outstanding quality of the speakers and the agenda they put together.

A wide variety of topics were presented, including Title 15 updates for juvenile facilities, criminalization of the mentally ill, the management of communicable diseases in corrections, and the Nurse Practice Act and diversion program presented by the Board of Registered Nursing. Also included was a history of medicine in corrections, delivered by Dr. John Clark, of the Los Angeles County Sheriff's Department. There were also several other excellent presentations delivered, providing information of interest to everyone present, regardless of their respective area of licensure.

Special thanks to Dr. Ken Byrd of the Fresno County Sheriff's Department, and Rebecca Craig, from the Institute for Medical Quality, for making it possible to provide CMEs for the physicians in attendance for the first time in many years.

Prison Listserver Available

Correctional health care professionals have a free listserver available to them, allowing communications with others throughout the country on important topics related to our rather unique profession. Recent topics include hepatitis (a hot topic throughout corrections), HIV, co-pay, privatization, standards of care, etc.

To subscribe, you'll need a computer with a modem and an Internet service provider capable of sending e-mail by the internet. To subscribe to the listserver, send a message via e-mail to:

majordomo@hypoxia.uchsc.edu

In the body of the message (not the subject) just type in the words:

Subscribe prison

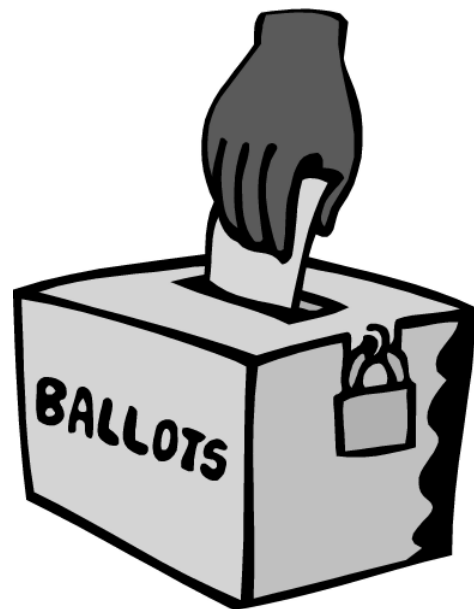
Then send. You will receive a notification back via e-mail within a few hours, which will also provide instructions on how to access and use it.

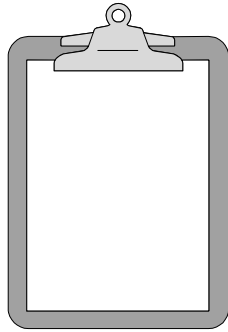
The listserver is maintained by the University of Colorado Health Sciences Center, and is administered by Rod Gottula, MD, who is nationally known in the field of correctional health.

Vote, Shmote

Chapter members will be receiving ballots in the near future for the election of board members. Among the positions being formally voted upon are those of Treasurer, Communications Coordinator, President-elect, as well as for four (4) member-at-large positions.

Please be sure to return your ballots as quickly as possible once you receive them!





Survey Time...!

Once again, chapter members attending the annual conference were afforded the opportunity to participate in a survey. Questions were primarily geared to determine the demographics of those attending. A total of 59 forms were turned in. Here are the results, as well as some comments:

Profession	Med Dir	MD	DDS	Admin	Nrs Mgr	RN	BSN	LVN	PA	Psych
Number	3	5	2	2	7	48	7	3	2	2

Obviously, these do not total 59; several respondents fell into more than one category.

All types of facilities and agencies were represented:

Type of Facility	Juvenile	Jail	Prison	INS	County	City	DHS	State
Number	12	27	17	3	22	1	2	3

Represented facilities came in all sizes:

Population	<500	500-1,000	1,000-3,000	3,000-5,000	5,000-1,000	>15,000
Number	11	10	10	16	8	4

Experience in correctional health varied widely:

Years	<1	1-5	5-10	10-15	>20
Number	1	16	20	15	7

Conference information obtained from attendees is as follows:

Company Reimburse	Yes	No	
	30	24	
Best Locale	Northern CA	Southern CA	
	8	40	
Preference of Days	1	2	3
	3	25	29

The number of people who were not reimbursed for their attendance, yet decided to attend anyway impressed me. I also must confess surprise at the number who preferred Southern CA over Northern CA.

Attendees were also given the opportunity to comment on a few areas. Here is a sampling of their replies:

Primary Job Satisfaction: "Providing care and counseling to an underprivileged community," "Independence," "Seeing the evolution...over the past 25 years," "Knowing our inmates get good care."

Primary Job Concern: "Lawsuits," "Services may be contracted in the future," "Adequate resources," "Nursing duties vs. custody behavior towards inmates," "Incongruity in providing some medical care: Hepatitis C," "Facility not in compliance with many Title 15 standards."

Additionally, topics were submitted which attendees would like to learn more about. These will be presented to the conference committee for consideration when creating the agenda for next year's conference. Thanks to all for their input!

Application For the California/Nevada Chapter of the ACHSA

Name _____
Mailing Address _____
Name of Organization/Institution _____
Address _____
Work Telephone No. _____
Specialty/Discipline _____
Position _____

Are you a member of ...

ACA? Yes No

National ACHSA? Yes No

The American Correctional Health Services Association (ACHSA) is an affiliate of the American Correctional Association (ACA). Although not mandatory for ACHSA membership, please indicate if you are a member of the ACA on application.

In order to be a member of the California/Nevada Chapter of the ACHSA, you must be a member of the national ACHSA; please indicate if you are a member of the national ACHSA on application.

Annual dues for ACHSA are: \$45.00 (National) and \$25.00 (State). Total due = \$70.00

Please make check payable to: ACHSA, California/Nevada Chapter, and send to: Treasurer, 2140 Shattuck Ave., Box 2491, Berkeley, CA 94704.

Membership is open to all individuals interested in correctional health services

California/Nevada Chapter
American Correctional Health Services Association
2140 Shattuck, Box 2491
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