



# the State Pen

The Newsletter  
of the  
California/Nevada  
Chapter  
of the  
American  
Correctional  
Health Services  
Association

**Volume 10**  
**Number 1**  
**Spring 1999**

## **Self Medication Programs: An Historical Perspective**

By Rebecca Craig



In 1997, the California State Board of Corrections revised Title 15, Section 1216 allowing counties the option of establishing programs for inmates to self administer certain types of medications. This regulation is not included in this article, due to space constraints, but the specific language can be found online at <http://www.bdcorr.ca.gov>. This address will provide you the regulations, guidelines, and inspection report forms for both adult and juvenile facilities. It will also provide you links into other statutes and regulations.

### **Background**

In February 1990, Sheriff Richard K. Rainey of the California State Sheriff's Association (CSSA) requested the CMA Committee review the issue of allowing certain inmates to self-administer prescription medications. The members were reticent, but agreed because the Contra Costa system had a long history of accreditation, and a well organized health delivery system. As a part of this discussion, several physicians who were employed in the prison setting indicated that such a program had been in place for many years, and was working well in that setting.

The CMA went to the Board of Corrections, supporting a proposal that a study be performed to determine the efficacy of self-medication programs in jail settings. The Board agreed, and CMA instituted a system to monitor such programs through on-site reviews. These reviews consisted of structured interviews with custody and health administration, line custody and nursing staff, pharmacists (when applicable) and inmates. Documentation reviewed included written policies and procedures, minutes of pharmacy and Therapeutic meetings, quality improvement studies, administrative health meetings, etc.

continued on page 4

## Message from the President's Desk

### **ACHSA in Crisis**

Royanne Schissel RN

President, CA-NV Chapter

Organizations go through change. There is the first burst of energy and enthusiasm, tremendous growth, a bonding, and reaching out. Things begin to settle, growth slows, and maintenance begins. Age is not kind, and if there is not enough support crises can ensue. CA/NV ACHSA has three out of seven boards of director chairs filled; we are in a crisis of downsizing, not from organizational need or lack of members, but lack of volunteers. We need rebuilding and renewal. We need you to offer your leadership and talents.

ACHSA's goals are:

- To provide members education in correctional health care.
- Support programs that support medical/mental health in corrections.
- To educate non-medical personnel in corrections.
- Provide a networking for all that work in correctional health.

The past few years have been lean in terms of people resources. There have been no elections for four years because of a lack of individuals who were interested or would agree to help. Boards of Director chairs have been vacant for the last four years. Board members put on the last four annual conferences. The number of State Pen newsletters has decreased due to lack of articles. People in board seats have had personal issues resulting in their resignation, and there have been no replacements. The ACHSA Board of Directors is comprised of seven members. We presently have only three: the president, secretary, and communications coordinator.

Recognizing that the situation has to improve, Board members invited some of the founding members to help us review the present and help us with some answers. With your help, we believe we have found some answers.

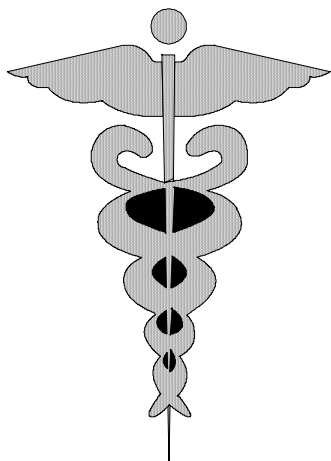
Your help is needed in many ways, big and small. We are reviewing the constitution and by-laws, finding that much of the original language and intentions had been eliminated. We are addressing changes to you as members who need to vote so we can go forward. We also need, by your vote, the option for the president to fill vacancies on the board when vacancies arise. Ballots will be sent to you for voting; please return them on time. Look at YOUR talents, and consider what you are willing (and have time) to do. Some areas of need are:

- Work with a director to contact members who are interested in various committees.
- Committees include membership, conferences, legislation, reviewing the constitution and by-laws, publicity, State Pen, web site maintenance, etc. If you have the talent, we will fill a need!
- Consider joining the Board as a Director or Member at Large.
- Work on the annual conference.
- Education needs for correctional members
- Assist with CE's and CME's.
- Find or write articles for the State Pen.

Working with ACHSA is satisfying and rewarding. Networking with others in our field, developing an understanding of other systems with their rewards/challenges, and passing on information can have a huge impact. Our efforts do make a difference, and there is no better way of achieving a care system we can all be proud of because of our input.

I look forward to meeting you at the annual conference, "As the Century Ends: Corrections for the Future," September 23, 24, and 25 in Costa Mesa. Patty Gonzales and Corinne Callahan have a tremendous speaker roster, and this year's conference will be excellent!

Check out our website! It offers director's names, information on the conference, registration information (early bird rates are excellent, and it looks like there will be 16-17 CEU's this year), as well as links to other correctional health sites. We hope to hear from you and see you at the conference in September!



### **\$10 Gift Certificates**

A gift certificate, good for \$10 off either 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!

### **Know Your Board**

Presently, these individuals are the Board of Directors for the California-Nevada Chapter:

#### **President**

Royanne Schissel, RN CCHP  
San Diego Sheriff's Department  
royanne@lanz.com

#### **Treasurer**

Vacant

#### **Secretary**

Kandy Heinen, RN CCHP-A  
Contra Costa Sheriff's Department  
Kheinen@aol.com

#### **Communications Coordinator**

Kevin Connor, RN CCHP  
San Bernardino Sheriff's Dept  
kcnp@earthlink.net

Presently, vacancies exist for president-elect, Treasurer, and there is no representative from Nevada. If you or anybody you know is interested in either of these positions, please contact the Board at:

California/Nevada Chapter  
American Correctional Health Services  
Association  
2140 Shattuck, Box 2491  
Berkeley, CA 94704

Alternately, we can be reached at our individual email addresses above, or email [achsa@hotmail.com](mailto:achsa@hotmail.com)



### **Don't Forget, We're on the Web!**

For those members with Internet access, the CA-NV chapter has a small website with conference information, membership applications, and correctional health links. As interest grows, so shall the site!

You can visit it at this address:

<http://members.tripod.com/~achsa/index.htm>

To date, this information has not been published, due in large part to the realization that the results cannot be viewed as a true clinical study. The findings may, however, prove interesting to those of you who are considering implementing such a program. In total, seven counties enrolled and completed the study under the pilot project status provided by the board. These counties were Contra Costa, Santa Clara, Kern, Los Angeles, San Mateo, Orange, and San Joaquin.

The intent of the program was to closely mimic open community standards for medication dispensing and patient education, while recognizing the unique challenges of living in a detention setting. In developing the parameters for the program, the Board and CMA carefully evaluated the following key considerations: cooperation between custody and health administration and line staffs, types of medication excluded from the program, monitoring compliance, education of inmates and line staff, and eligibility issues. The following is a summary of the findings from these reviews.

## **Findings**

Over a six-year period, surveyors found that the most critical component for success was the support and involvement of custody administration and line staff. It was imperative that custody staff be aware of the program's policies and procedures and have a line of authority for reporting any instances of rules violations. The inmates enrolled in the self-medication programs reported two key components that protected them from other inmates. The first, that they would be disciplined if their

medication count was incorrect, and the second was that the nurses would never allow them to have anything that would make someone high. Thus, the pills had limited value to other inmates. Monitoring of inmates took two forms that were equally effective. First, cell searches by custody staff, and second, monitoring at least weekly by nursing or pharmacy staff.

In the instance of custody searches, the officers' awareness of the program and knowledge of allowable medications were paramount. In those instances where there was limited communication, the officers were confiscating the medications, not reporting their actions, and the end result was that inmates were not being medicated. In other instances, inmates found themselves reprimanded, only to be cleared upon review, which resulted in mixed messages that were used by the inmates for a variety of purposes.

In well-operated programs, the custody staffs were trained regarding the program's policies and procedures and the actions to take when medications were found during a cell search. The officers in these programs indicated the procedures were to ask the inmate about the medication, review the written permission sheet, count the number of pills presented, and report to the health administrator (or designee) any violation and file a report to custody administration. These violations were then treated as a rules infraction. In these systems, the rate of compliance was extremely high. Both the inmates and the officers indicated a high degree of comfort with the program. Con't on page 5

**Self-Medication programs (con't from pg. 4)**

Systems where the custody staff left the entire program management to the health staff without any custody involvement were found to have a lower rate of compliance and a higher degree of custody discomfort. The systems that were openly educating staff and inmates regarding the types of medication allowed in the program were successful. In these systems, inmates indicated that medications were not an issue because other inmates were aware of the types of medications allowed and understood that health and custody staff would never allow any medications that were valuable. This belief afforded a protection to inmates with medications on their person.

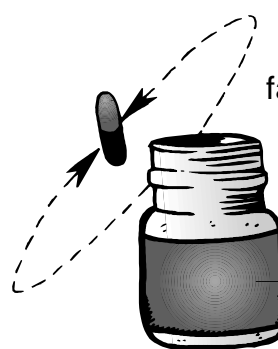
Key issues to ensure cooperation included joint policies regarding inmate monitoring, rules enforcement, and reporting procedures which were incorporated into the quality management process. The exclusion of all narcotics, hypnotics, psychotropics, and injectable medications was found to be reasonable in a living situation that housed individuals with drug abuse problems.

Monitoring of inmates by health staff for compliance was another critical component. The health staff may be the designated component for actually counting the number of pills and determining compliance, but there must be custody support through the discipline process to ensure the self-medication rules are enforced. The actual staff used to perform this function varied between the programs. For Contra Costa, Los Angeles, Orange and San Mateo counties, the nursing staff was responsible for the monitoring process. They called inmates to the

clinic or the pill line and checked the medication containers to determine compliance. In Kern, Santa Clara, and San Joaquin counties, the pharmacist was responsible for the program. The pharmacist, in the same manner as in the open community, provided medication regarding timing, dosage, side effects, etc., directly in a one on one discussion with the inmate. The pharmacist or his/her designee performed pill count audits to determine compliance and maintain statistical data.

Time has shown both methods to be effective. The pharmacy staff indicated a high degree of satisfaction in performing what they view as their role in patient education. The systems that relied on the nursing staff also indicated satisfaction with being able to talk with inmate patients regarding the type of medication, its importance, and in general providing inmates with health education. The inmate interviews and the degree of compliance found did not seem to indicate a difference between either approach.

Of the medications with the highest degree for completion, heart and high blood pressure medications were rated the best, with antibiotics being rated as second. The degree of success with high blood pressure and heart medications was related to two factors.



Con't on page 6

Con't from page 4

First was the seriousness of the illness, and the second was the age of the inmate taking the medications. These factors were so interlinked that it was impossible to determine which had the greatest effect on compliance. Of interest to the surveyors was the number of inmates who indicated that the jail staff provided better education than their physician or clinic in the open community.

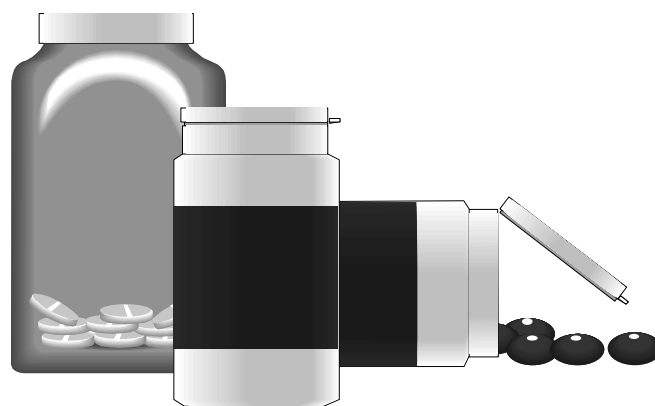
Of the antibiotics, those provided for dental conditions rated higher than those given for other reasons did. In many instances the inmates directly linked pain reduction to taking medication to decrease infection and thus compliance was quite high. Again, the surveyors found that patient education regarding the reasons for medication seemed to directly affect compliance.

Another factor was the ability of the inmate to either keep the medication on his/her person, or have the ability to lock the medication in some type of secure area. In one system, the inmates were afforded a personal basket for belongings, which was locked with a combination lock. In this facility, the inmates reported no instances of medication losses, and the monitoring log indicated 100% compliance with all cell and medication checks. In another system, the inmate locked his/her room, and again, the compliance rate was 100%.

In other systems where the inmate was directed to carry the medication on his/her person, the rate of compliance was slightly less and in several instances the inmate reported the

medications had been stolen either while showering or when in the exercise yard. The surveyors and inmates indicated a greater degree of comfort with the programs where the inmates had the ability to lock their medications in a secure environment. Again, it should be stressed that this was a degree of comfort and not proven through rules infractions or reports of altercations.

I hope this information was beneficial. Always feel free to contact me at (415) 882-5132 or via e-mail at [rcraig@calmed.org](mailto:rcraig@calmed.org).

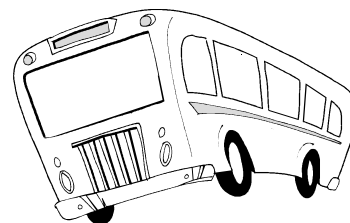


*Editor's note: San Bernardino County recently initiated a program similar to the ones mentioned in this article, and has found it to be quite successful. Many thanks to Rebecca Craig for providing this article for the newsletter.*

## California State Department of Corrections Introduces Tuberculosis Alert Codes

Everybody who works the intake area in a local detention center in California has experienced this scenario: A line of state prisoners is transferred to the jail, and noted on their transfer summary is the rather cryptic message "TB code 22," or some such. For those who were wondering what this means, a couple of years ago the Department Of Corrections adopted a set of codes to notify staff of individual inmates' TB status. A summary of each code and what it represents follows:

### **Tuberculosis Alert Codes**



- Code 11:** PPD skin test administered but not yet read and/or interpreted.
- Inmates with unknown TB status shall not be transported.
- Code 21:** Inmate requires diagnostic TB testing.
- Inmates with Code 21 shall not be transported.
- Code 22:** PPD skin test is not significant and no follow-up treatment is required.
- Inmates with Code 22 shall be transported/moved by regular transportation.
- Code 31:** Inmate is suspected of having infectious TB.
- Inmate shall not be transported. A medical hold may be placed on the inmate until the culture reports are received.
- Code 32:** PPD skin test significant from PRIOR infection/disease.
- Inmate shall be evaluated annually (during birth month) for signs/symptoms of TB disease with baseline CXR and as warranted. Inmate shall be transported/moved by regular transportation.
- Code 33:** Inmate has diagnosis of TB infection and is receiving prophylactic treatment.
- Inmate shall be transported/moved by regular transportation.
- Code 34:** Inmate has diagnosis of TB infection and either:
- Refuses medication.
  - Is non-compliant with medication.
  - Medication is contraindicated.
  - Inmate is HIV positive, refuses prophylactic medication.
  - Inmate shall be evaluated annually (during birth month) for signs/symptoms of TB disease with baseline CXR and as warranted. Inmate shall be transported/moved by regular transportation.
- Code 43:** Inmate is currently under treatment for confirmed TB disease (non-infectious). Inmates remain code 43 through the entire treatment period for this episode of TB disease.
- Code 51:** Inmate has infectious TB disease and is resistant to two or more first line drugs.
- Inmates shall not be transported.
- Code 52:** Inmate had PRIOR TB disease resistant to two or more first line drugs.
- Inmate shall be transported/moved by regular transportation.
- Code 53:** Inmate has multidrug resistant TB disease that is under treatment and is no longer infectious.
- Inmate shall be transported/moved by regular transportation



**Code of Ethics**  
Adopted February 1995  
Revised August 1996

**Preface**

A code of ethics is a set of principles, which guide the conduct of a group of professionals and establishes moral duties and obligations in relation to clients, institutions and society. One of the characteristics of a professional association is the development and adoption of a code of ethics.

The American Correctional Health Services Association (ACHSA) undertook the development of a code of ethics through a consultative process which included a membership survey, workshops, and adoption of a provisional set of principles in 1990. The objectives of the process were to identify fundamental values of correctional health professional and ethical conflicts in the correctional health care setting.

Distinctive features about a code of ethics for correctional health professionals became apparent. Correctional health professionals represent many health care disciplines: doctors, nurses, mid-level practitioners, psychologists, social workers, nutritionists, health information specialists, administrators. Codes of ethics are, in most cases, developed for a single professional discipline. Nonetheless, there are fundamental values that extend across health professional disciplines, especially in relation to duties and obligations towards patients.

It is the correctional institution that creates the need for a unique code of ethics for correctional health professionals. The fundamental values of correctional health professionals in relation to the institution do not arise from the culture and experience of health professionals. The duties and obligations toward the institution generated much discussion and debate during the consultation.

The ACHSA code of ethics does not emerge in a vacuum. There are the codes of ethics of the professional disciplines. There are also international principles of law and ethics, such as the World Medical Association Declaration of Tokyo, the United Nations Principles of Medical Ethics, the United Nations Standard Minimum Rules for the Treatment of Prisoners, and the International Council of Nurses Statement on the Role of the Nurse in the Care of Detainees and Prisoners.

**Preamble**

Correctional health professionals are obligated to respect human dignity and act in ways that merit trust and prevent harm. They must ensure autonomy in decisions about their inmate patients and promote a safe environment. The following principles adopted by the American Correctional Health Services Association are not laws, but a code of conduct that defines the essentials of honorable behavior for correctional health professionals.

**Principles**

The correctional health professional shall:

1. Respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
2. Evaluate the inmate as a patient or client in each and every health care encounter.
3. Render medical treatment only when it is justified by an accepted medical diagnosis. Treatment and invasive procedures shall be rendered after informed medical consent.
4. Afford inmates the right to refuse care and treatment. Involuntary treatment shall be reserved for emergency situations in which there is grave disability or immediate threat of danger to the inmate or others.
5. Provide sound privacy during health care services in all cases and sight privacy whenever possible.
6. Provide health care to all inmates regardless of custody status.
7. Identify themselves to their patients and not represent themselves as other than their professional license or certification permit.
8. Collect and analyze specimens only for diagnostic testing based on sound medical principles.
9. Perform body cavity searches only after training in proper techniques and when they are not in a patient-provider relationship with the inmate.
10. Not be involved in any aspect of execution of the death penalty.
11. Ensure that all medical information is confidential and health care records shall be maintained and transported in a confidential manner.
12. Honor custody functions but not participate in such functions as escorting inmates, forced transfers, security supervision, strip searches or witnessing use of force.
13. Undertake biomedical research on prisoners only when the research methods meet all requirements for experimentation on human subjects and individual prisoners or prison populations are expected to derive benefits from the results of the research.

## 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  
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 Berkeley, CA 94704