



University Correctional HealthCare

August 2008

New Jersey Department of Corrections New Agreement with the University of Medicine & Dentistry of New Jersey

With the recent New Jersey Department of Corrections (NJDOC) announcement of their intention to have the University of Medicine & Dentistry of New Jersey (UMDNJ) provide inmate medical services, University Correctional HealthCare (UCHC) has found itself being criticized in the media. Specifically, there have been suggestions that UCHC might drive up costs and reduce quality. Our track record, however, suggests differently. Inmate complaints related to mental health services have been drastically reduced, reliance on Ann Klein Forensic Center (AKFC) for inpatient psychiatric treatment has been cut in half, our pricing is competitive and, through our partnership with NJDOC, there is substantial compliance with the *CF v. Terhune Settlement Agreement*.

UMDNJ Drastically Reduces Inmates Complaints

Mental Health Grievances dropped from 1,384 in 2005 to 687 in 2007, a decrease of approximately 50%. Such a reduction lowers the risk of subsequent mental health related litigation for NJDOC. Medical Grievances, however, increased during this same period about 7% (4,396 to 4,735).

Reduced Reliance upon Ann Klein Forensic Center (State Forensic Hospital)

Since UMDNJ began providing mental health services within NJDOC, we estimated a reduction in 4,488 annual patient bed days per year at AKFC. This is the result of: 1) a reduction in the number of inmate psychiatric crises requiring hospitalization (reduced from 30 to 12 per year) and 2) a reduction in the number of inmates on psychiatric commitment who, after completing their sentence, must transfer to AKFC (reduced from 91 to 41 per year).

Competitive Pricing

The price for UMDNJ mental health clinician services which took effect January 1, 2005, was favorable to the bids received in the 2002 RFP for such services within the NJDOC. With staffing levels for approximately 165 positions, the BHC price was \$20,300,000; United Mental Health was \$22,906,000; MHM Services was \$23,800,000; and CFG was \$25,725,000. Through UMDNJ two years later, the cost for clinician services was \$20,305,249 with 202 staff positions. NJDOC had already included the sex offender services which required additional staffing when they formulated the Agreement with UMDNJ. These figures are all exclusive of nursing, psychiatry, pharmacy and laboratory services.

Substantial Compliance with CF v. Terhune Settlement Agreement

NJDOC, with UMDNJ involvement for just over two years, obtained substantial compliance toward meeting requirements of the *CF v Terhune Settlement Agreement* for male inmates by February 2007. This led to the Second Amendment of the *Settlement Agreement* which allowed women's services to be carved-out. In addition, male class members at all but one of the state prisons were Sunset in the following categories: Disciplinary Process with special needs (SN) inmates; Stabilization (psychiatric crisis) Units, Residential Treatment and Transitional Care Units for inmates with serious need for mental health treatment; Outpatient Mental Health Services for SN inmates in the general population; Construction; Mental Health Policies and Procedures; and Mental Health Staffing.

I continue to be impressed with the high quality of care that our mental health team delivers everyday. Now, I look forward to our expansion, as we further strengthen the effectiveness and efficiency of the medical services to be provided to inmates within the NJDOC.

Jeff Dickert, PhD
Vice President





Test your pager on a routine basis - any problems should be reported to Melody Massa at 609-341-3095



Have You Heard?

Richard Gaudet has accepted the Clinician Supervisor position at SSCF

UCHC has an email mailbox.
You can forward your newsletter articles to:
uchccorectsvcs@umdnj.edu

ADDRESS

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Susan Connor, Occupational Therapist, NJSP wrote the article "Occupational Therapy Month" in the June, 2008 Newsletter and not Kerri Edelman, Clinician Supervisor, NJSP as printed.



Looking Ahead....

August

12 Clinician Supervisor Meeting

September

1 Labor Day - Holiday

Welcome Aboard

June

Meetpal Sandhu, Staff Nurse - Per Diem, NJSP
Anasuya Salem, Physician Specialist, CRAF
Hanny Mabrouk, Physician Specialist, EMCFW
Marlene Weisel, Mental Health Clinician 2, EMCFW
Erin Solana, Occupational Therapist Intern, NJSP
Sarah Zechiel, Occupational Therapist Intern, NJSP
Justina Tartue-Higgins, Staff Nurse, SWSP
Montina Wesley, Mental Health Clinician 3, SWSP
Stacy Kinner, Mental Health Clinician 3, JJC
Susanna Carew, Mental Health Clinician 3, JJC
Louis Castle, Mental Health Clinician 3, JJC
Renee Wojtowicz, Mental Health Clinician 3, JJC
Michael Brady, Program, Development Specialist II, JJC
LaTeisha Callender, Forensic Mental Health Clinician, JJC

July

Amandeep Nagra, Physician Specialist, CRAF
Albert Wu, Physician Specialist, ACWYCF
Mark Famador, Physician Specialist, SWSP
Linda McRae, Staff Nurse, SWSP
Janet Iannucci, Data Control Clerk I, SSCF
Amber Vernon, Psychology Intern, EMCFW
Pamela DiVecchi, Psychology Intern, NSP
Regis Acosta, Physician Specialist, SWSP

Farewell & Good Luck

June

Said Shehadeh	Shoval Gur-Aryeh
Donna Ricca	Patricia Lewis
Tina Bedell	Erin Solana
Sara Zechiel	

July

Sharon Thompson-Smith	Maria Ramundo
Kathleen Rapanaro	Sharon Cunniff



Ask Mechele



Since I have another anonymous question this newsletter, it appears that the column is really catching on. Please keep them coming!

Q: A co-worker regularly shares very personal, explicit information and wants to discuss the same in shared office space. Asking him/her to stop is ineffective. What should I do?

A: This is a tricky question to answer, why? Anyone who knows me personally knows my penchant for entertainment gossip, a good story and that practically no topic is off limits. However, there definitely is such a thing as TMI (too much information). Fortunately, I was alerted early in my orientation to prison life that personal conversations are juicy fodder for inmates, and for that matter, officers and staff too.

As a firm believer in openly asking for what you want, I applaud you for choosing to ask this person to stop. Since that didn't work, let's bump things up a notch with a more assertive, but still respectful, request. Something along the line of, *"You may have forgotten (letting them off the hook), but awhile ago during one of our conversations I mentioned that I'd prefer you keep your personal business...personal."*

If this approach also falls on deaf ears, it's time to look for answers outside the box.

Once during an assessment, a seemingly psychotic inmate told me she passed the time talking in the toilet. Tidy Bowl man aside, I asked her who was on the receiving end of these conversations. While assuring me that she was not crazy, she proceeded to scoop water out of the toilet bowl, knocked on the metal and within a few seconds I could clearly hear the voice of the male inmate locked in the cell above. I say this as a personal reminder that the walls in prison are extremely thin. With significant amounts of time on their hands, inmates are often left to find diversionary activities with which to occupy themselves. And what could be more convenient or accessible than the daily comings and goings of the staff?

While as a rule I don't condone deceit, in this instance stretching the truth a little could prove helpful to a colleague in the long run. Try this on for size, *"You know, just the other day, I overheard a group of inmates discussing the exact same situation. Do you remember who was around when you were telling all of us your story? I hope none of them overheard your conversation, you know how folks love to gossip. You'd better watch what you say in here, cause you never know who's listening. I know I wouldn't want all by business around the prison."*

But, there are those people (you know the ones I'm talking about) oblivious to how they come off, justifying their actions by viewing others as "overly sensitive", or frankly, just not caring about how others might feel. So, a more formal approach may need to be taken.

Your supervisor could prove extremely helpful in this situation. You might want to simply ask for some advice on how to best handle a "hypothetical situation." You could drop an anonymous note recommending the topic be addressed in the next team/staff meeting. Or, you could just dump the issue in the boss' lap and request that they "handle it."

In my pre-prison administrative life, I was often called upon to discuss really sensitive matters i.e. personal hygiene, aggressive behavior, inappropriate relationships, to name a few. It comes with the territory of being the supervisor. Whenever possible, I would try to position myself in a circumstance where I could experience the behavior firsthand. I also quickly learned that while it might be easy to overlook the concerns of a few colleagues, it is definitely not easy to ignore or dismiss being called in for a "sit down" with the boss.

Finally, while you didn't specify the nature of the "personal, explicit information," please know that there are policies (accessible on line) regarding Sexual Harassment and/or Discrimination which address conversations that could cause a hostile work environment. And if this is the case, you need to report it to your supervisor. If not, simply discussing the policy in the presence of this person could well solve your problem.

Thanks so much for the question and good luck. Feel free to let me know how things worked out.



“How I Lost Almost 50 Pounds Eating In the ODR:”



Like most physicians, it is often my duty to encourage my patients to “diet and exercise.” It is a mantra that few of us enjoy hearing. I was a victim of such counseling not long ago, when I saw a cardiologist (as a patient) for the first time in my life last winter. While I passed my tests with flying colors, he was not happy with my weight.

I joined UCHC in November of 2006. Already not the healthiest soul on the planet, I quickly took to one of the great perks of prison work: the Officer’s Dining Room. There is no doubt about it: I like to eat, and I now had access to free and plentiful lunchtime fare the likes of which I had not seen since the fifth grade cafeteria. There was Salisbury steak, turkey roll, spaghetti in butter, tater tots, the occasional cake (when the kitchen crew was getting creative) and barrels of chocolate pudding. It was not long before I noticed a new “freshman 15.” I went back to the gym, but even after months of exercise, I had not put a dent in my middle.

When my cardiologist asked about my diet, I explained (even sparing some of the better details) the concept of “prison food” to him. He smiled, and with a hint of sadism said, “Good... Good... [pause] You can’t have that anymore.” My heart sunk. I know that some of my co-workers decide to forsake the ODR completely when trying to slim down. I was determined to make a change, but I was not ready for the hassle and inconvenience of eating off-site. As the doc explained what he wanted me to eat, I was busy devising a plan.

Against doctor’s orders (sort of), I kept going to the ODR. From the main line, I took only cooked vegetables. I then made a sandwich with wheat bread and either dry tuna, lunch meat du jour, or the occasional hard-boiled egg, adding mustard if I needed some flavor. For “dessert” I had an apple or whatever fruit was available. Rather than punch, I chose a diet drink from the vending machine.

At home, I continued to eat what I usually ate, but I cut out seconds, thirds, fourths, etc. For snacks, I would eat an apple or a low-fat yogurt. I kept up my work at the gym, trying to go for an hour, two to three times per week, and otherwise stayed as active as possible. I was far from perfect, but I did my best to “contain” cheating to once or twice a week.

What was difficult at first became a habit. To my surprise, I lost those first 15 pounds in about six weeks, and I continued to lose five to ten pounds per month. By my last count, I have lost at least 48 pounds. I still have room to improve, but I am now in the best shape of my adult life. I write this not to brag, but to share my experience with others who find it hard to avoid “prison food.” Next time your doctor hits you with that old “diet and exercise” line, remember that it **is** possible for you to enjoy the benefit of the ODR, and to make it part of a healthy lifestyle.

Tony Tamburello, MD
SWSP Psychiatrist

News from the Office Ethics and Compliance Regarding Attendance at Event Forms

Representatives of the Office of Ethics and Compliance have been visiting campuses to discuss the new Scholarly Capacity Rule and how it affects you. Based on some questions that were raised during these visits, we sought additional clarification from the N.J. State Ethics Commission, as well as from our University's senior management, in order to apply the Rule consistent with its intent. We are happy to announce the following changes:

Scholarly Activity--

NIH - Study Section activity should now be recorded under the Scholarly Capacity Rule, rather than as an Outside Activity. Therefore you must follow the same Scholarly Capacity Rule methodology for these events--notify your department/clinical chair, maintain records and file annual disclosure of compensations and any direct or indirect benefits received from these activities.

Non-Scholarly Activity--

When attending training events as a participant (e.g., receiving CE or CME), which are sponsored by UMDNJ, or when all expenses are paid by UMDNJ or the attendee, OEC no longer requires you to submit an Attendance at Events Form for approval. You must still submit your TA and any other administrative documentation required by your school or department.

If there is any "mixed payment", where you or UMDNJ pays a portion of your expenses for the training event, and the sponsor pays a portion, directly or indirectly (e.g., waiver of fees), then you are required to submit an Attendance at Events Form to the Ethics Liaison Officer for review and approval.

Please review the matrix and obtain the new Attendance at Event form for use at: www.umdj.edu/complweb

OCCUPATIONAL THERAPY STUDENTS AT NJSP

The Educational process of Occupational therapy (OT) students includes completion of two types of fieldwork/internships. Level I fieldwork enriches coursework through direct observation and participation in selected aspects of the OT process. The focus is not on independent performance. At Level II, fieldwork is focused on developing competent, entry-level generalists. These students will have an in-depth experience delivering OT services to clients [American Occupational Therapy Association (AOTA), 2008a].

While Level I students can be supervised by qualified personnel including, but not limited to, certified OT practitioners, psychologists, social workers and nurses, Level II students must be supervised by an occupational therapist who, "meets state regulations and has a minimum of 1 year of practice experience subsequent to the requisite initial certification" (AOTA, 2008b).

This June, I supervised New Jersey State Prison's first OT students. Erin Solana and Sarah Zechiel, entry-level masters' students in the Occupational Therapy Program at Temple University in Philadelphia, PA, completed a 40 hour Level I fieldwork experience. In addition to OT groups, they had the opportunity to observe music, art, and recreation therapy, psychology, and social work groups, review charts and classi-

fication files, tour the facility, and enjoy "delicious" meals in the ODR. These experiences were shared back at their institution in the form of case studies and reflection papers. As for the students themselves, did they think their time in corrections was well spent? The answer lies in the feedback, which described their experiences as, "very educational, unique and thoroughly enjoyed."

Susan Connor OTR/L
Occupational Therapist
NJSP

For more information about OT programs across the country, visit :

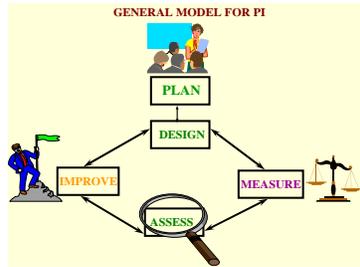
<http://www.aota.org/Students/Schools.aspx>

American Occupational Therapy Association (2008a). *Most Frequently Asked Fieldwork Questions*. Retrieved June 24, 2008, from

<http://www.aota.org/Educate/EdRes/Fieldwork/NewPrograms/38242.aspx>

American Occupational Therapy Association (2008b). *Fieldwork FAQs*. Retrieved June 24, 2008, from

<http://www.aota.org/Students/Current/Fieldwork/FAQs/39570.aspx>



The Third Annual Performance Improvement Fair

On June 19, 2008, 182 staff from the New Jersey Department of Corrections (NJDOC), University Correctional HealthCare (UCHC) and Correctional Medical Services (CMS) attended the Third Annual Performance Improvement (PI) Fair where 30 statewide projects were put on display. While all the projects were winners, the top three selected by judges Carl Ausfahl (CMS), Linda Adler (NJDOC), and Mari Masker (UCHC) were as follows:

1st Prize - Carlos Martinez, Maria Delgado, Andrea Zawadzky, Peter Martindale, Mike Lawrence, Sue Bolton, Carla Jackson, Pierre Thomas, and Bernice Frinch of Northern State Prison. Project: *Compliance In Administering Psychotropic Injections.*

2nd Prize - Sabrina Brown-Oliver, Christopher Lucca, Pamela Zamel, Cindy Zetye, Carmen Hodges, Alice Gladkowski-Gottesfeld, and Chenna Reddy of Albert C. Wagner Youth Correctional Facility. Project: *The Use of Patient Education and Mental Health Counseling to Lower Diabetic Indicators Among Prison Inmates.*

3rd Prize - Kerri Edelman, Jordan Lieberman, Scott Parker, Sam Bailey, Don Gibbons, Carol Lawton, Soba Abiona, and Maggie Patterson of New Jersey State Prison. Project: *Improving the Continuity Between Group Therapy Progress Notes and Individual Patient Treatment Plans.*

Planning for the Future?

When planning your next PI initiative, consider the following: focus on the role of substance abuse in the overall treatment of inmates, encourage custody personnel to participate in the PI process, use the expertise of your peers and the PI staff in carrying out your projects and if there were any projects presented at this year's PI Fair that can be replicated at your site, do not hesitate to reach out any of the team members for assistance.

If you have any additional ideas on how to make the PI Fair better, more relevant and interesting please let us know.

Congratulations everyone!

Lisa DeBilio, PhD
Manager, Quality Assurance
Central Office

RELATIONAL THEORY AND THE PRACTICE OF PSYCHOTHERAPY

“Not everyone who has been nourished by Freud has swallowed him whole.” Paul Wachtel.

A pioneer of integrating schools of therapy, whose groundbreaking work in the 70's explored the intersection between behavioral and psychoanalytic techniques, Paul Wachtel, Ph.D. conducted a workshop, on June 27th, where he contrasted Relational Theory with traditional Psychoanalytic Theory.

He first rejects the traditional concept of therapeutic neutrality and objectivity as a myth, replacing it with the idea of “intersubjectivity”, which acknowledges that we are all embedded in a relational matrix and that the therapist and patient are involved in a current relationship.

When this is recognized, transference, the idea that a patient projects his view of his parents on the therapist, is viewed more accurately as an “enactment,” where patients live out with other people the problem pattern of their lives. Rather than a neutral observer, the therapist becomes part of the process he is observing. The therapist almost inevitably becomes an “accomplice” in the patient's pathological interactions. Ultimately, this is not a limitation. When it is recognized it can become an advantage in treating a patient from within his experience.

Dr. Wachtel used these paradigm shifts to discuss how to provide therapeutic interpretations that leave the patient feeling that he has more room for his experiences rather than feeling attacked and diminished. Psychoanalytic interpretations can be intellectualized and accusatory while cognitive interpretations, where the patient is told that her assumptions about life are irrational, are no better.

Dr. Wachtel discussed a blunder he made in a case where a difficult patient made a reasonable request for a schedule change and, instead of granting it, Dr. Wachtel questioned the request, then interpreted the request in light of transference. He ignored the difference between the patient seeing the therapist as his father and the patient drawing the therapist in to act like his father (which, in fact, the therapist did. Dr. Wachtel refused the request because he was angry at the patient for being so difficult.) He discussed how childhood issues perpetuate themselves in patterns of vicious cycles that start in childhood but are no longer primarily about childhood. Using this case, he illustrated the above ideas, noting the false dichotomies between past and present, between internal and external and between transference and “realistic perception” propagated by many therapies.

Most importantly, he discussed how to generate interpretations which “do not confront, unmask or rip the veil from the patient's eyes” but help “the patient feels less anxious about his feelings and desires and to be more accepting of those desires.” Therapists tend to approach the patient with suspicion about his “false consciousness,” but should move toward “an attitude of acceptance, encouragement (including the quite literal meaning of encourage), and of inviting the patient's conflicted desire or emotion.” The therapist can create positive interpretations by acknowledging the patient's difficult affective experience, and conflicts (instead of attributing her actions to avoidance or stubbornness. An example is instead of saying “You're a lot angrier at your mother than you realize,” where a therapist is showing a patient what she is missing, say, “I have the sense that you're angry at your mother but think it's awful of you to feel that.” Rather than observing, this interpretation approaches inquiry from within the patient's subjective frame of reference. Interpretations should also point to strengths and positive adaptations the patient is making.

Dave Wasser, PhD
Forensic Mental Health Clinician
RFSP



THE INJECTIONS PERFORMANCE IMPROVEMENT PROJECT AT NSP

It was around April 2007 that mental health staff became concerned that Northern State Prison SN inmates were not receiving their injectable medications. Some of these inmates were noted to have been admitted to the Stabilization Unit (SU) because they had either become acutely symptomatic (possibly due to not receiving their medication) or they had received charges for violating institutional policies. One inmate was even found to have gone several months without receiving his injection. It was also discovered that in addition to having no central system in place to monitor compliance of the injections, there was no record of exactly where the meds were being housed within the prison.

Faced with this dilemma, The Injections Performance Improvement (PI) Project team at NSP chose to focus on insuring that every special needs (SN) inmate prescribed an injectable psychotropic medication (Haldol, Prolixin, or Risperdal Consta) would receive that medication on the date it was scheduled to be given. While there were many factors that could have been responsible for the inmates not receiving their injections (meds not ordered, orders not routed to the transcription nurse, etc.), the PI team decided to focus exclusively on nurses not issuing the injectable medication and inmates refusing the injection.

Baseline data was obtained by reviewing the Electronic Medical Record (EMR) for all SN inmates (January 2007 through June 2007) prescribed an injectable psychotropic medication to see if they had received their injection according to the order of frequency. A missed dose was defined as one not issued during the month it was scheduled. The goal of the project was to increase the compliance of issuing injections to those scheduled by at least 5%. We also thought it was important that every inmate receive their injection when scheduled.

The intervention began July 2007 and is scheduled to continue until demonstration of three consecutive months of compliance at a level of at least 95%. A point person from CMS supervised compliance among outpatient inmates with a UCHC counterpart doing the same with inpa-

tient inmates. Also, beginning July 2007, every two weeks the UCHC point person audited the charts of all inmates prescribed an injectable psychotropic medication to see if they received it as prescribed. If an inmate had not received their scheduled injection, the CMS point person or the inpatient unit nurse where the inmate was housed would be informed, so they could issue the injection. In addition to the monitoring of inmate compliance and receiving their scheduled injections, other factors were examined such as lateness of receiving injections, inmates on injections entering/leaving the prison, and those on the forced medication protocol.

From January 2007 to April 2008 on any given month, the number of inmates on psychotropic injections at NSP ranged from 29 to 44. The results indicated that of the 417 scheduled doses of injections from January 2007 through August 2007, there were 61 missed doses which meant that 85% of the inmates had received their injections. Of the 429 scheduled doses of injections from September 2007 through April 2008, there were 43 missed doses which meant that 90% of inmates had received their injections. A month-by-month comparison from January 2007 to April 2007 (37 missed doses) compared with January 2008 to April 2008 (23 missed doses) indicates a 38% reduction. Of the total number (104) of missed injection doses, 49% occurred on C100, 21% occurred on the RTU, 21% occurred in Administrative Segregation (AdSeg), and 9% occurred in other locations.

Future recommendations are: 1) Invite nursing staff from C100, RTU, and AdSeg to a PI team meeting to gather additional ideas of how compliance could be further improved, 2) Provide C100, RTU, and AdSeg with a list of the scheduled dates of upcoming injections, 3) Assure that the staff responsible for providing injections on C100, RTU, and AdSeg have backup coverage.

Carlos Martinez, LCSW
Clinician Supervisor
NJSP

