The Biopsychosocial Model of Medicine

Traditional medicine has always dealt with the biomedical and not the psychosocial aspect of health care, and has relegated the latter to the field of psychiatry and mental health. This results in a disjointed healthcare delivery system where the patient is never wholly treated and is left dissatisfied with his/her medical and mental health care.

The majority of patients we treat are not mentally ill, but all patients require that their psychosocial issues be addressed along with their medical issues. It was with this pretext in mind that Dr. George Engel developed the Biopsychosocial Model of Medicine. Its fundamental assumption is that health and illness are consequences of the interplay of biological, psychological and social factors. Dr. Engel states:

The crippling flaw of the (biomedical) model is that it does not include the patient and his attributes as a person, as a human being. The biomedical model can make provision neither for the person as a whole nor for data of a psychological or social nature, for the reductionism and mind-body dualism on which the model is predicated requires that these must first be reduced to physiochemical terms before they can have meaning. Hence, the very essence of medical practice perforce remains “art” and beyond the reach of science.

It is exactly this flaw of the biomedical model that Dr. Marian Stuart and Dr. Joseph Lieberman set out to correct in the field of primary care and more specifically, in the discipline of family medicine as opposed to the discipline of internal medicine, which relies heavily on the biomedical model. Their approach lent itself more favorably to family medicine since the method of training family medicine residents is geared to outpatient treatment, with less emphasis on inpatient treatment on which internal medicine so heavily relies.

Drs. Stuart and Lieberman adapted the biopsychosocial model in their book The Fifteen Minute Hour; readily showing that incorporating this model in primary care medicine would reap many rewards for both the patient and the medical provider. Although it was geared towards training family medicine residents initially, their approach could easily be adopted by all primary care residency training.

The book is replete with helpful techniques aimed at providing care for the patient as a whole. However, one technique in particular, which is the essence of the book, is a method for history-taking called BATHE: B-background, A-affect, T-trouble, H-handling and E-empathy. This technique allows the provider to get a complete history of the patient’s presenting issues in a concise and consistent manner. It addresses the needs of the patient not the wants, making it a more reasonable approach in satisfying both the patient and the provider.

The BATHE technique, based on the biopsychosocial model of medicine, can be easily adapted to correctional health care to fully and completely treat the inmate-patient, thereby improving outcomes and diminishing the number of complaints.

It is sometimes tempting to throw a pill or treatment at the presenting medical issue and demand that the patient take it and get better. However, if the ailment is impacted by psychosocial factors, no amount of treatment or medication will produce the desired effect. Realizing this doesn’t mean an automatic referral to mental health or an implication that the patient has significant psychological needs and you have nothing more to offer him/her. Rather, the utilization of simple mental health techniques to aid in medical management, along with including the patient in his/her treatment plan, is likely go a long way toward achieving a far more successful therapeutic outcome.

The doctor-patient relationship, which has evolved from the paternalistic approach to a partnership with the patient, can be improved by using the biopsychosocial model of medicine, and who better to deliver it than the patient advocate...the primary care provider.


Yasser Soliman, MD
Director Utilization Review Physician
Dear Mechele,

I have a question. What do you think about civilians dating officers? My question isn’t about asking for help in how to pursue or manage such a relationship but more of how you should handle it when dating an officer impacts on how you do your job. Here’s what’s happening. I’ve been working in the prison for some time now and am involved in a situation that I think is becoming a problem. To be specific, my relationship with the officer isn’t a secret among the custody or UCHC staff, even though we’ve tried to keep it out of the workplace. I’m not naïve enough to think that the staff know and the inmates don’t. To complicate things further, this officer has a “no nonsense reputation” in dealing with inmates, which hasn’t won them any popularity contests. But here’s the real situation. I’ve noticed that some, not all, of the inmates I work with have become rather closed mouthed in our sessions as of late. It took awhile to find out why, but finally one of them told me that my relationship with this officer was the reason that some of the inmates had become wary of discussing things with me. They’re afraid that I would share their personal, confidential information with this officer who could use it against them. So what do you think I should do? Should the dating just stop? Or if not, how can I, as a clinician, go about reassuring my inmate/clients that I’m not discussing what they’ve shared during treatment with the officer I’m dating?

In your favor is the fact that no policy or procedure has been violated by merely dating one of the officers, but you cannot and should not allow your work to be compromised by this relationship. If you are committed to continuing to date this officer, one of you should strongly consider looking into a site transfer. This would offer a fresh start, free of the encumbrance of staff and inmates “knowing your business.” Depending on how many inmates are involved, you could look into approaching a colleague about trading those with concerns, but such an arrangement would warrant supervisory approval and might not be welcomed by the colleague who would, most likely, want an explanation. In the meantime, I would not entertain any inmate questioning along these lines nor would I volunteer any information. I would be firm in my commitment to do my job professionally and encourage the inmates to make use of the time assigned for their treatment. If, however, you choose to end your relationship with the officer, PLEASE, remember the words of a very wise nurse that I’ve quoted in this column before, “Never get your honey where you make your money.” These are words to live by, especially when you work in prison.

Sincerely,
A Tough Question

Dear A Tough Question,

Just the idea of having an inmate in treatment mention my personal relationship on any level makes me cringe. I’ve been able to keep up my clinical skills by running groups for sex offenders out on parole. On more than one occasion, I’ve had to confront an individual who has inquired about my marital/parental status, residence, automobile and whether or not I attended a co-worker’s recent wedding. In no uncertain terms he was immediately made aware of the inappropriateness of his questions, no discussion necessary. Never forget that we work with a population of convicted felons. They are not known for making good choices and are potentially dangerous. Yes, they deserve the best services we have to offer, but they are not, nor have they ever been, entitled to become involved in our personal lives on any level…case closed!

In your favor is the fact that no policy or procedure has been violated by merely dating one of the officers, but you cannot and should not allow your work to be compromised by this relationship. If you are committed to continuing to date this officer, one of you should strongly consider looking into a site transfer. This would offer a fresh start, free of the encumbrance of staff and inmates “knowing your business.” From what you’ve said, to remain where you are will only become more problematic. While limited within the correctional environment, inmate confidentiality is important and questions regarding your integrity, either real or imagined, can make you the ongoing subject of gossip and speculation or at worst, impact your clinical work.

Yours is not a simple question by any means. The easiest thing would be to just stop dating the officer, but I don’t get the impression that you have, so my answer will be based upon the premise that you have, so my answer will be based upon the premise that you’ve chosen not to do so at this time. This situation is problematic on multiple levels. One of the reasons I endorse not being personally involved in the workplace is because it’s really difficult to keep these things private. Typically, when we have issues with our partner, it shows. Knowing how uncomfortable things between couples can sometimes be, imagine the pressure of having to deal with this stress (and the person causing it) at work for 40 hours. Having co-workers ask, “Are you guys doing ok?” is one thing, but inmates…that’s completely different. By nature of having so much down time, many inmates understandably have nothing better to do than feed their natural curiosity about the staff. And what’s juicier than an office romance being played out right in front of their eyes? Sure, some co-workers will get a perverse enjoyment out of our relationship highs and lows, but that’s nothing compared to inmates who may easily see that relationship as a mechanism to be manipulated to improve their situation.

So, I would first recommend that you refuse to discuss your personal relationships with any inmate. Since you feel that this situation has escalated to the point where it is problematic you should immediately involve your supervisor or at the very least, get some advice from EAP. The choice to involve your supervisor at this point, however, would be proactive. If this relationship is common knowledge, as you professed it to be, it’s quite possible that at some point your supervisor might have to approach the matter with you. I always think it’s important to bring situations to light before they blow up so that there’s at least a chance for the bomb to be diffused.
Last fall Suzanne Blizzard, Occupational Therapist (OT) on the SWSP mental health unit, invited inmates to volunteer and create a community project to display at the Quarterly Recognition Ceremony. The Recognition Ceremony is a time for all inmates on the mental health unit to be rewarded for their hard work and consistent group attendance. They are presented with a certificate from their respective group leaders or individual counselor and at the ceremony’s conclusion, there are refreshments in the form of cakes, cookies and/or other treats.

One of the tenets of Occupational Therapy is that the therapeutic media should be purposeful and meaningful to the client or patient. If it is not, then the activity would not be considered a therapeutic occupation. In order to increase the purposefulness of the community origami project, the inmates were told their work would be displayed at the ceremony for all the attendees to see. Custody, staff and fellow inmates were appreciative of the time and effort that was used to create the first ever SWSP Origami Swan. The swan was made of over 600 individual modules folded by the inmates who chose to be part of the project. Each inmate returned for six weeks on Thursday evenings to fold modules and then be part of the assembly team. While all the inmates participated by folding a good number of modules, the natural leaders turned their attention to the assembly of the bird. It took the cooperative efforts of four inmates and the OT to decipher the directions, diagrams and order of construction, as the instructions were written in Chinese, Japanese or Korean.

At the completion of the project, every group member stood back and admired their accomplishment. The most memorable moment came when an inmate known to not show any emotion, broke out into a wide grin that clearly showed his satisfaction with a job well done. All of the inmates were praised for their efforts and responded to the recognition by sharing community praise for their community effort.

The success of this project led to the creation of another bird, a peacock. Although the directions were again in a foreign language, and the diagram was difficult to follow, the group members were eager to tackle this project. This group was different as some of the “swan builders” chose to not participate this time. While they were missed, several other inmates were waiting for their chance to become actively involved in a group project creating something of worth.

The peacock was diagramed in white or black with red spots on the tail. The inmates were encouraged to think outside the box and use colors that they thought the peacock would have, based on the colored paper provided. This time, the inmates were given the opportunity to independently fold paper in their cells which they then brought to group meetings. They folded over 1000 pieces of paper and then the assembly began. Due to some strong personalities in this group of inmates, two separate groups were formed to assemble the peacock. One group worked on the tail section while the other group worked on the body. We soon learned that these kinds of projects must be completed in the order described in the directions because while possible, it was going to prove very difficult to attach the tail to the body. But their persistence paid off and the peacock was finally assembled in time for the Summer Recognition Ceremony. Needless to say, the group members were very proud of their accomplishment. Their enthusiasm was shared by the custody officers and prison staff who were both pleasantly surprised and impressed by this group of mentally ill inmates for their perseverance and achievement.

Late in the fall of 2008, permission was granted to display these community achievements in the trophy case at the entrance to the SWSP lobby for all employees and visitors to see. Additional folded works were provided by the OT in order to fill the display cabinet and provide a visual device to guide the observer’s eye to the information posted on the back of the cabinet. The information was about Occupational Therapy, the use of Origami as a modality and the benefits of using such modalities within the mental health arena. Pictures were generously provided by Tony Davis, Recreation Specialist at SWSP.

Suzanne Blizzard, MSEd, MSOT, OTR/L
Occupational Therapist - SWSP
Email is the primary communication vehicle used by University Correctional HealthCare (UCHC) to notify employees of information necessary to perform their jobs; therefore, it is critical that all employees access their email every workday in order to stay informed. In addition, users of the Department of Corrections Network (DOCNET) and the UMDNJ network are required to login every 60 days to prevent their accounts from being disabled.

The majority of UCHC employees use Sun Java System Communications Express for email service. The service can be accessed using Internet Explorer (IE) from any Personal Computer (PC) with internet access and from all DOCNET computers. To access this system enter mail.umdnj.edu in the address bar of (IE) and you will be directed to the login page. My recommendation is to add this page to your Favorites for easier access. To add the page, click on Favorites and then Add to Favorites when you have the login page displayed. The Favorite will be labeled Sun Java™ System Communications Express by default. You can keep this name or rename the Favorite to any name you prefer. Email can also be accessed from the my.umdnj.edu portal by logging in to this site then clicking on the email icon, followed by clicking on mail.umdnj.edu. Your email password can also be reset from this page. My recommendation is to keep your email and portal password the same.

Be advised that any email left in your in-box or sent folder is deleted after 45 days and cannot be retrieved. If you want to save any email you must move it to a personal folder. To create a personal folder click on your email address on the left side of the page. This will bring you to the Folders page. Click the New button and enter a folder name where you will store your files. You can create different folders and the name and number of files is your choice. Once you have created your folders, go back to your inbox, check any messages you wish to move and the action is to move to the selected folder.

The my.umdnj.edu portal is where you can access your Benefits and Deductions, Pay Information, Tax and Payroll Forms, Current and Past Jobs, Time-Off Current Balances and History. All employees should verify access to this site. If you have difficulty with your my.umdnj.edu login and cannot reset your password for this site please contact the UMDNJ IST Service Center at (732) 743-3200 or email isthelp@umdnj.edu.

Send your questions regarding technology to: agrillle@umdnj.edu

WHO DO I CALL?

If you are unable to login or can login to DOCnet but cannot login to the EMR then you will need to notify the DOC help desk by calling (609) 984-8288 or sending email to HELPDESK@doc.state.nj.us.

The my.umdnj.edu password can be reset from the login screen by clicking on “Forgot Password?” and following the prompts. If you still cannot login or cannot login mail.umdnj.edu or WEBct then you will need to notify the IST help desk by calling (732) 743-3200 or sending email to isthelp@umdnj.edu.
### Staff Directory

**Updated 8/09**

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<th>Office</th>
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<tr>
<td>Jeff Dickert:</td>
<td>609-341-3093</td>
<td>732-580-1055</td>
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<td>Shirley Lee:</td>
<td>609-341-3093</td>
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<td>Melody Massa:</td>
<td>609-341-3095</td>
<td>201-407-3144</td>
<td>massamk</td>
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<td>Sharry Berzins:</td>
<td>609-341-9382</td>
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<td>berzinsh</td>
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<tr>
<td>Jennifer Storicks:</td>
<td>609-984-6472</td>
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<td>Arthur Brewer:</td>
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<td>609-313-4185</td>
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<td>Rhonda Lyles:</td>
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<td>Hesham Soliman:</td>
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<td>609-238-0513</td>
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<tr>
<td>Jon Hershkowitz:</td>
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<td>732-570-5727</td>
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<td>Johnny Wu:</td>
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<td>201-407-3114</td>
<td>cevascrp</td>
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<td>Mitch Abrams:</td>
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<td>917-887-5206</td>
<td>abramsmsmi</td>
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<td>Marci Masker:</td>
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<td>201-407-3097</td>
<td>mackenma</td>
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<td>Harry Green:</td>
<td>609-298-0500 x1272</td>
<td>732-512-8846</td>
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<td><strong>Psychiatry</strong></td>
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<td>Rusty Reeves:</td>
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<td>973-632-3194</td>
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<tr>
<td>Anthony Tamburello</td>
<td>856-459-8239</td>
<td>609-410-0266</td>
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<td><strong>Nursing Administration</strong></td>
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<td>Magie Conrad:</td>
<td>609-341-3178</td>
<td>908-930-4025</td>
<td>conradmm</td>
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<td>Denise Rahaman:</td>
<td>609-694-4260</td>
<td>609-229-0693</td>
<td>rahamade</td>
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<td>Man Lee:</td>
<td>609-777-1366</td>
<td>609-218-0697</td>
<td>leemp</td>
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<tr>
<td>Thomas Golden:</td>
<td>908-638-6191 x7584</td>
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<td>goldenptf</td>
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| Utilization Review | Email       | Training Team       | |
|--------------------|-------------|---------------------| |
| Christine Bartolomei | bartolch    | Mechele Morris: 609-292-2252 | morrisme |
| Eileen Hooven      | hoovenem    | Stephanie Turner-Jones 609-292-2226 | turnerst |
| Dolcie Sawyer      | sawyerdo    | Denise Gould 609-292-1340 | goulddj |

| Medical Records   | Email           | Infectious Disease | |
|--------------------|-----------------|--------------------| |
| Cindy Romano       | romanoci        | Elliot Famutimi   | famutiel  |

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<td>Elizabeth Topol</td>
<td>topolcl</td>
<td>Leo Agrillo 609-984-1725</td>
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<td></td>
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<td>609-413-6499 cell</td>
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| Quality Improvement | Email | Scheduler       | |
|--------------------|-------|-----------------| |
| Lisa DeBilio:      | debilila | Patti Ford 609-984-1012 | fordpa |
| Debra Crapella:    | crapelda | Jose Torres 609-292-6953 | torresj9 |
| Debbie Pavlovsky:  | pavolsde | Patti Reed 609-777-1510 | reedp1 |
|                    |           | Rebecca Cozzens 856-459-8034 | cozzensra |
|                    |           | Samantha Pezzella 856-459-8453 | pezzelsa |
Accessing the DOC INTRA net

“How am I supposed to write-up a verbal medication order?” “Am I supposed to give this inmate approved but non-emergency forced medications after hours?” “Who moved the call schedule?” Questions like these that are critical to your work will arise from time to time. But there’s no need to worry about who can answer these questions for you in the middle of the night. You can find this information on the DOC intranet, which is available to anyone with access to a DOC computer. If you use the Electronic Medical Record (EMR), you have access to the intranet.

Note that we are talking about the INTRA net, not the INTERnet. The difference is that INTERnet sites are publicly available to anyone with a computer and an internet connection. In contrast, INTRA net is limited to a specific network of computers (like those in a particular company), and usually cannot be accessed from other places like an airport, coffee shop, or your home.

Accessing and using the DOC intranet is easy. If you’ve opened Internet Explorer at work, you’ve probably already seen the intranet. It’s the default “home page” on all DOC computers. If you’ve been using internet sites, clicking the Home button (the picture of the house to the left of “Favorites”) will get you back to this page. You may also enter the intranet address into your browser:
http://highpoint.state.nj.us/intranets/doc/

If you see a photo of Commissioner Hayman, you’re there (or on the receiving end of a very special visit). You’ll notice several links on the left side of the DOC intranet home page. Most of what we find useful is concentrated in the “Health Service Unit” link. When you click it, links to the medical and mental health on-call schedules are available on the left hand side beneath “Health Service Unit.” If you click for example, Medical On-Call, you will be asked, “Do you want to open or save this file?” Click open, and you will be able to see the information.

Back under the “Health Service Unit” page, scroll down. Under the heading “Forms and Documents,” there are links to the EMR Work Flow Manual and the Index to Health Services Documents. Use the Work Flow Manual for instructions to complete a task that perhaps you do less often (like documenting medical guardianship – see p. 122), or to clarify how common work is supposed to be done. The Index to Health Services Documents gives you access to useful forms such as Antipsychotic Informed Consent (MR-072) and the UCHC Healthcare Records Release to help you obtain inmates’ outside medical records. On the right side of the “Health Service Unit” page you can access applicable DOC policies with the links, “Medical Procedures,” “Mental Health Procedures,” “Pharmacy Procedures,” etc.

As you explore the intranet, you may discover other gems, like messages from the Commissioner, the DOC Telephone Directory, and the ever popular menu for the Mates Inn Restaurant (located on the grounds of the DOC Central Office). The intranet is an indispensable resource that helps us get the job done. And by the way, I didn’t move the call schedule. For any the other answers, find them on the intranet!

Anthony Tamburello, MD
Associate Director of Psychiatry

On July 2nd, the Adult Diagnostic and Treatment Center (ADTC) initiated a large scale scabies treatment program for the entire facility. Both Kathleen Gill and I would like to commend all the staff involved in preparing and implementing the plan. We watched as various staff from the Medical Units of ADTC, East Jersey State Prison (EJSP) and the Special Treatment Unit (STU) come together and performed as a team. Ancillary staff, dental staff and even our physician actively participated in the program. Those involved in observation and application were divided into two teams and sent out onto the housing units. Along with an LPN, ancillary staff manned the Nurse’s station, answering phones, directing supplies and relaying information.

With prison movements being coordinated and facilitated by the Administrator, Mr. Bernard Goodwin, and Chief Cathy Buchanan, along with exceptional assistance from the Department of Corrections custody staff, we were able to complete the entire program within a few hours. We are extremely grateful for their cooperation and coordination.

Even though this was a necessary task, the medical staff worked competently and efficiently as a team. It was impressive to witness personnel from the three sites come together to complete this treatment program. They all did a great job and we thank them.

Dolores Guida, RN
Regional Nurse Manager - ADTC, EJSP, STU Annex, Kearney
Disease Control and Prevention Have No Price Tag

Disease prevention encompasses three levels, primary, secondary and tertiary. In primary prevention we make our environment immune to the agent of disease through cleanliness and education, which entails personal hygiene, hand-washing, nutritional education, immunization and healthy life style. Typically, primary prevention, the simplest and most effective method in preventing diseases, is greatly under appreciated. Why? Speculation is that it has no control with which to compare its cost effectiveness. However, when primary prevention is lacking, the outcome carries devastating financial loss, morbidity, impairment and mortality.

Secondary prevention involves the early detection of disease and prevention of its progression. In secondary prevention treatment is initiated early to prevent clinical manifestation of disease. Tertiary prevention deals with rehabilitation. Here efforts are made to prevent death in the presence of impairment.

Hypothesis

Healthcare costs can be mitigated through implementation of disease control and prevention. While it’s true that disease prevention may increase health care costs initially, this view is short sighted. In the long run, interventions such as education, immunization, vaccination and screening tests, say for cardiovascular disease, can provide very economical long-term costs when taking a longsighted approach.

In some instances, health care systems are devoted to treating acute illness, testing, diagnosing, relieving symptoms and curing ailments. Prevention and disease control are the proactive measures that by preventing illness and disability, actually cut costs. We are aware of the exorbitant health care costs in the treatment of cardiovascular disease, HIV/AIDS, cancer, diabetes, chronic respiratory disease and MRSA. However, primary prevention in the form of: education focused on tobacco cessation, safe sex practices, healthy diet/nutrition, moderate alcohol ingestion, physical activity, personal hygiene- hand washing and good environmental sanitation, can aid in significantly averting these costs.

Without a doubt, we are the product of our environment. Most diseases are exogenous, meaning they come from our environment. Therefore, the inability to adapt to our environment can bring about illness. The prevention and control of disease is the entity that modifies our environment for physical, psychological and social adaptation and as such, is very cost effective.

Elliot O. Famutimi, MPH, PhD
Infectious Diseases Control and Prevention Program Manager/Epidemiologist

MEETING WITH OUR PRESIDENT

I had the opportunity to attend an Open Forum with our newly installed UMDNJ President, William F. Owen, Jr., MD, on July 30th. I came away with a lot of insight on UMDNJ; where we currently stand, and the vision for our future direction. There appeared to be representatives from every department (secretarial support, environmental specialists, mental health clinicians, nursing, etc). My first impression was that our President is someone who is both experienced and comfortable dealing with line staff. His unique philosophy of leadership was described as choosing to, "lead by touring." This was thought to reference that in spite of a relatively brief tenure as President, he has made it a point to make the rounds, including a tour of Northern State Prison and the Environmental Plant in Newark, NJ. Historically, previous UMDNJ presidents have not seized such opportunities.

I was really struck by how he addressed the concerns of a member of the supportive secretarial staff. This 55 year old stated that she had been in her current UMDNJ position for 20 years. As a single parent working two jobs to support her children, she emotionally lamented her concerns over the lack of advancement opportunities which have caused her to remain stagnant at the University. President Owen comfortably sat back and responded in a manner that was both sincere and concerned, not just to this staff member, but to everyone who had issues to share. He spoke about upcoming changes, changes that will incorporate a total restructuring. The goal will be to provide job enhancement skills, techniques and vocational training aimed at increasing opportunities for individuals like the 55 year old women referenced above, who exhibit a desire to move up within the University.

My question, driven by my NJSP staff, was as follows. “Should staff be concerned about cut backs or tuition reimbursement allowances?” President Owen offered me a direct, elaborate explanation of how satisfied the New Jersey Department of Corrections has been with the services provided by our UCHC team. He described the University’s budgetary status as a "balanced state," and further stated that his vision is to not cut employees or tuition reimbursement, but to look at areas that could assist UMDNJ to economize, such as hiring contractual services from WITHIN UMDNJ, rather than going outside.

I left the meeting with President Owen with a greater appreciation for our shared UCHC/UMDNJ mission. It also solidified for me that we have a great Central Office team that continues to support our individual areas of expertise, ensuring that we have the necessary tools to provide excellent services.

Wanda Broach-Butts, RN
Department Nurse Manager - NJSP
WHAT NOT TO WEAR....

“This article was directed to staff working in The Community Supervision for Life Program, a treatment program designed to assist parolees understand the circumstances in their lives that led them to commit sexual offenses, thereby avoiding a recurrence of harmful behaviors. The article was included in the UCHC newsletter because the information easily relates to anyone working in a correctional setting.

“What Not To Wear” is the title of a popular reality television program and we are going to steal it to discuss an important issue regarding the “dress code” for women working with sex offenders.

On the TV show, the poor subject of the program is critiqued for her horrible fashion sense and taught how to dress to look years younger and pounds thinner. The dowdy dowager is turned into the sexy vixen. I don't know about you, but I love shows like this and many times have seen things that I want to run out and buy, but soon realize that I just couldn't wear them to work.

In the CSL program, we don’t want people to think that they have to dress like the “before” picture of a wardrobe makeover, but we do want to make a few suggestions.

Some of our male clients have difficulty listening to what they need to hear from their female therapists. They don’t call it therapeutic resistance for nothing and we know our clients have a great deal of shameful information about their past that they would like to resist. Other clients have learning and attention difficulties and negative associations with anything that resembles an education type activity.

Most worrisome for the purposes of this discussion, is the fact that many of our clients have a history of misperceiving sexual cues from women, which has resulted in their sexual offense history. So, throw in a little ADHD, a hefty dose of hyper-sexuality, some therapeutic resistance, and the guys are focusing on you and what you’re wearing, rather than the therapeutic issue at hand.

In this particular environment, what might be acceptable and fashionable anywhere else (open toe sandals, button down shirt with a bit of cleavage showing) becomes an opportunity for a misperceived sexual cue. Jeans can be fine, but when they’re too tight or too low, it’s like wearing a neon sign saying “available sex object.” Particularly for offenders with a history of violence against women, this can be an invitation for trouble.

Other offenders take the point-of-view that women, by making themselves attractive, are doing so “for them.” We've seen this lead to offenders targeting particularly vulnerable therapists and seeing them as potential sex partners. Sometimes, this leads to groups becoming unmanageable and disrespectful of the therapist. In short, while it’s nice to feel sexually attractive, it is important that we not do this at work around our clients. And we have to remember that even on a day when we are not scheduled to see clients, if we’re in the parole offices, they see us.

Much of our socialization and the clothes marketed to us set the stage for us to present ourselves as attractive. But if we are not aware, it can negatively influence the provision of therapy and make rapport difficult, if not impossible. Our clients are labeled sex offenders because they didn't recognize or respect sexual boundaries. The tendency to see members of the preferred gender as sexual objects hampers their ability to recognize important messages.

So, while those strappy sandals, low cut shirts and spaghetti strapped sundresses may look adorable on you, you can’t and shouldn't want to wear them here.

Merrill Berger, PhD
Clinician Supervisor - CSL

CSL NEEDS YOU...

We are looking for a few good (wo)men.

If anyone is interested in picking up some per diem work running groups for sex offenders on parole in the community, please let me know. We have slots available across the state at various parole offices. Excellent supervision provided.

Call Sharry Berzins at 609-341-9382 for additional information or to sign-up.

Merrill Berger, PhD
Clinician Supervisor - CSL
There are two announcements at the Business Manager’s meeting that will impact UCHC: 1) effective October 1st, the remaining petty cash funds will be eliminated with the exception of payments for subject fees. All expenses to be reimbursed to staff must be done via check request. 2) effective the same period, all employee reimbursements done through a check request will be included in the employees pay check; accounts payable will no longer issue a separate check. Payroll will identify this reimbursement with a separate earnings code in order to ensure that this will identified as non taxable.

Need help with Discharge Planning? Go to [http://findahealthcenter.hrsa.gov](http://findahealthcenter.hrsa.gov) to search for agencies anywhere. This link was forwarded to us by John Jacobs, LCSW, MHCIII at South Woods State Prison.

From *This Week at UMDNJ*: Ombuds Corner

Surprise, surprise! Over 68% of the concerns brought to the Ombuds Office thus far fall into the broad categories of Evaluative Relationship (Supervisor/Subordinate, Faculty/Student; 52%) and Peer Relationship (16%) problems. If one were to analyze the concerns in more detail, many of the issues are caused by poor communication, lack of respect and general insensitivity by some (and over-sensitivity by others), towards one another. Keep in mind that communication issues tend to be a “two-way street.” As an organization, we need to try to get along better. That is not to say that we shouldn’t be truthful with one another—either those of us in evaluative relationships, or with our peers. Communication, especially those that may be critical in nature, should be non-personal and constructive. We are in a high stress business, so let’s not put unnecessary pressure on each other. Watch for work-relationship tips in the weeks to come.

*Neil Schorr* is the University Ombuds.

Submit your articles by September 28th for the October newsletter

Articles submitted for publication in the UCHC newsletter may be held for subsequent newsletters at the discretion of the Editorial Board
This form must be completed for the timeframe covering January 1, 2009 - July 1, 2009 and returned to the UCHC Central Office by August 30, 2009. Also, provide a copy of the completed form to your Data Control Clerk or Secretary to be maintained on site and made available for NCCHC inspectors.

Name: _____________________________  Title: _____________________________

### Continuing Education/Licensure/Certification Log for 2009

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License Renewal Needed: Yes: ____  No: ____  If Yes Date of Completed Renewal: _____________________________

Type of License: ____________________________________________________________

CPR Certification Needed: Yes: ____  No: ____  If Yes Date of Completed Renewal: _____________________________

This form was designed to make tracking your CEUs, CPR Certification and Licensure easier. While it will be included in each newsletter, feel free to make as many copies as you need. Send any recommendations to improve the form to Mechele Morris at morrisme@umdnj.edu.
What is Staphylococcus aureus or Staph?

Staph is a type of BACTERIA that may cause skin infections that look like PIMPLES, BOILS or insect BITES. Skin infections caused by Staph may be red, swollen, painful, have pus or other drainage. Some Staph, known as METHICILLIN-Resistant STAPHYLOCOCCUS AUREUS or MRSA, are RESISTANT to certain antibiotics, making it much harder to treat.

Who gets Staph infections?

Anyone can get a STAPH infection. People are more likely to get a Staph infection if they have:

- SKIN-to-skin CONTACT with someone who has a Staph infection
- Contact with items and SURFACES that have Staph on them
- Openings in the skin such as CUTS or SCRAPE
- Crowded living conditions
- Poor HYGIENE

How serious are Staph infections?

Most Staph skin infections are minor and can be easily treated. However, Staph also may cause more serious infections, such as infections of the BLOODSTREAM, SURGICAL sites or PNEUMONIA. Sometimes a Staph infection that starts as a skin infection may worsen. It is important to contact your doctor if your infection does not get better.

What are the signs and symptoms of Staph infections?

Staph or MRSA infection may appear as a red or SWOLLEN pimple, boil or insect bite that may be PAINFUL and/or WARM to the touch. The site may be full of pus or other DRAINAGE and/or accompanied by a FEVER.

How are Staph infections treated?

TREATMENT for a Staph skin infection may include taking an antibiotic or having a doctor drain the infection. If you are given an antibiotic, be sure to take all of the doses even if the INFECTION is getting better, unless your DOCTOR tells you to stop taking it. Do not share ANTIBIOTICS with other people or save them to use later.

How do I prevent or keep Staph infections from spreading?

- Know the signs of Staph infections and get TREATED early.
- Practice good hygiene and WASH your hands often or use an alcohol-based HAND SANITIZER.
- Keep your cuts and scrapes CLEAN and cover them with bandages.
- Do not touch other people’s cuts or BANDAGES.
Special events are planned across the country on September 16, 2009 to increase awareness of the effects of too heavy or improperly worn backpacks on health. Did you know that more than 79 million students in the United States carry backpacks to school? Or that more than 23,000 backpack-related injuries were treated at emergency rooms, doctor’s offices, and clinics in 2007? Pain and strain on your child’s back, neck, and shoulders can be reduced or even avoided by following the loading and wearing recommendations provided in the attached handout.

Submitted by:
Susan Connor
Occupational Therapist - EMCFW

Backpack Strategies for Parents and Students

Aching backs and shoulders? Tingling arms? Weakened muscles? Stooped posture? Does your child have these symptoms after wearing a heavy school backpack? Carrying too much weight in a pack or wearing it the wrong way can lead to pain and strain. Parents can take steps to help children load and wear backpacks the correct way to avoid health problems.

Loading a pack
- A child’s backpack should weigh no more than about 15% of his or her body weight. This means a student weighing 100 pounds shouldn’t wear a loaded school backpack heavier than about 15 pounds.
- Load heaviest items closest to the child’s back (the back of the pack).
- Arrange books and materials so they won’t slide around in the backpack.
- Check what your child carries to school and brings home. Make sure the items are necessary for the day’s activities.
- If the backpack is too heavy or tightly packed, your child can hand carry a book or other item outside the pack.
- If the backpack is too heavy on a regular basis, consider using a book bag on wheels if your child’s school allows it.

Wearing a pack
- Distribute weight evenly by using both straps. Wearing a pack slung over one shoulder can cause a child to lean to one side, curving the spine and causing pain or discomfort.
- Select a pack with well-padded shoulder straps. Shoulders and necks have many blood vessels and nerves that can cause pain and tingling in the neck, arms, and hands when too much pressure is applied.
- Adjust the shoulder straps so that the pack fits snugly on the child’s back. A pack that hangs loosely from the back can pull the child backwards and strain muscles.
- Wear the waist belt if the backpack has one. This helps distribute the pack’s weight more evenly.
- The bottom of the pack should rest in the curve of the lower back. It should never rest more than four inches below the child’s waistline.
- School backpacks come in different sizes for different ages. Choose the right size pack for your child’s back as well as one with enough room for necessary school items.

Need More Information?
For more facts on backpack safety, see “Backpack Facts: What’s All the Flap About?”

If you would like to consult an occupational therapy practitioner about an ergonomic evaluation regarding backpacks, computer use, or other learning-related issues, talk to your child’s teacher about whether a referral to occupational therapy is appropriate. Your physician, other health professionals, and your school district’s director of special education may also be able to recommend an occupational therapy practitioner.

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