UCHC Newsletter

JULY—DECEMBER 2016

11th Annual Statewide Quality Improvement Fair

UCHC held the 11\textsuperscript{th} Annual Statewide Quality Improvement (QI) Fair on Wednesday, November 2, in the Harris Auditorium, Trenton. More than 275 participated with 35 PI Projects on display and 129 staff in attendance.

Mechele Morris, PhD, UCHC Director of Training, acted as MC with remarks offered by Gary Lanigan, Commissioner of the New Jersey Department of Corrections; Kevin Brown, Executive Director of the Juvenile Justice Commission; Frank Ghinassi, PhD, President and CEO of UBHC and UCHC; and Jeff Dickert, PhD, LCSW, UCHC Chief Operating Officer.

As keynote speaker, Dr. Ghinassi, who has led performance measurement, quality improvement, patient safety, and regulatory compliance at Pittsburgh’s Western Psychiatric Institute and Clinic, relayed some of his past QI experience and paralleled health care QI with that of the field of manufacturing especially in regards to reliability, consistency, effectiveness, and safety. When the Institute of Medicine published its renowned quality reports*, healthcare took up the initiative to reduce the numbers of deaths due to hospital-related error (equivalent to the daily crash of a jumbo jet liner each year, he said. Referring to improving health care quality, Ghinassi reminded the audience that if we can’t measure it, we are not going to be able to manage it, and conveyed the significance of our continued work in improving the quality of care in our system.

In closing, Dr. Dickert praised the efforts of all of the staff for their ongoing participation in QI teams, on making contributions to improving our health care system, and providing valuable health care services to the patients at the JJC and the NJDOC.

See pages 2-3 for extended QI Fair coverage!

11th Annual Statewide Quality Improvement Fair

2016 PI Fair Project Summaries can be found on the NJDOC network G-Drive G:\Medical\AllMed\General\UCHC PI Fair and Training\PI FAIRS\PI Fair 2016

Chief Operating Officer Announces Retirement

After 30 years in public service, I have made the decision to retire effective March 1\textsuperscript{st}, 2017.

Over twelve years ago, after 5 years with University Behavioral Health Care’s Acute and Brief Treatment Services, I became employee ‘0001’ with University Correctional Health Care (UCHC). Since then, I have had the privilege of leading an incredibly dedicated team in the provision of specialized services to underserved populations within the New Jersey criminal justice system.

We began with an agreement with the New Jersey Department of Corrections (NJDOC) to provide mental health and sex offender treatment services and, concurrently, became the mental health provider for the Juvenile Justice Commission (JJC). Within a short time, we added sex offender treatment services for state parolees. And in 2008, we assumed responsibility for NJDOC’s physical and dental health services; adding JJC’s physical health services in 2011; and a contract for federal parolee sex offender treatment in 2014.

Our remarkable 3-fold growth since 2005 is not a surprise. It is the direct result of the excellent scope of services provided by our entire UCHC team.

Our president and CEO, Frank Ghinassi, has started a broad search to find the next COO.

It is my expectation that moving forward, you will continue to excel in delivering integrated service encompassing the physical, mental and dental health of our patients. In this, you are second to none.

I do, and always will, take great pride in being part of the Rutgers’ UCHC family.

Thank you.

Jeff Dickert, PhD
Chief Operating Officer
11th Annual Statewide Quality Improvement Fair Winners

**Mental Health Care Team Winners**

Garden State Youth Correctional Facility
“Streamlining the Intoxication and Withdrawal Protocol”

Statewide Team
“Improving Aftercare Planning for Substance Use Disorders”
Team members: Anthony Tamburello, Ifeoma Anwunah-Okoye, Kerri Edelman, and Rusty Reeves.

A.C. Wagner Youth Correctional Facility
“Mind the Gap”
Team members: Samarra Brodbeck, Christine Alfano, Dwayne Brath, Deon Bullard, Adam Cortes, Lauren Cuomo, Wanda Edwards, Tara Lally, Marina Moshkovich, and Markim Shakur Purvis.

**Physical Health Care Team Winners**

Juvenile Justice Commission-Juvenile Medium Secure Facility
“Improving Staff Response and Communication During medical Codes”

Juvenile Justice Commission-Residential Community Homes
“Hit Me with your Best Shot”
Team members: Judy Brilla, Cynthia Brown, Dione McGhee, Cecile McMillon, Harriet Muqwanya, Eberechi Onwutuebe, Jacque Todd, and Carol Vennais.

Albert C. Wagner Youth Correctional Facility
“Don’t Be Ill, Track Your Pills.”
Team members: Sade Bishop, Patricia Collins, Ricardo DeJesus, Jennifer Ferrante, Lisa Johnson, and Danielle Medley.

New Jersey Department of Corrections Health Services Unit
“911: A Costly Clinical Action for the NJDOC: The Follow-up.”
Team members: Peter Plywaczewski and Susan Moore.

Garden State Youth Correctional Facility
“Heart Beats on Time.”
Team members: Francine Pasch, Jennifer Hall, Teresa Marshall, Chenna Reddy, and Inna Vaynberg.
Peoples Choice Award

Garden State Youth Correctional Facility
“Streamlining the Intoxication and Withdrawal Protocol.”

Congratulations to team members: Kerri Edelman, Jane Alderschoff, Carol Ali, Virginia Fineran, Jennifer Hall, Lt. Hollinshead, Kippie Langford, Paul Molnar, Alice O’Shea, Francine Pasch, Chenna Reddy, Beverly Sweeney, Marie Thompson, Kenneth Vaughn, Inna

Attendee Survey Feedback

With an 80% return rate, the 2016 PI Fair attendees rated the overall fair a 4.1! A Very Good Score! Scores for all survey years since 2010 are provided below.

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Rating scale: 1=not good, 2=fair, 3=good, 4=very good, 5=excellent

See you next fair!
Five-Step Challenge to Implement CQI

In CorrectCare www.ncchc.org, Winter 2016
by Lisa DeBilio, PhD, LPC, and Lorraine Steefel, DNP, CTN-A

If you and members of your organization continually ask, “How can we do it better, more efficiently?” then continuous quality improvement is the answer. CQI is a systematic method for continuously finding better ways to provide patient care and services.

At Rutgers University Correctional Health Care, CQI is a core competency that facilitates success in implementing UCHC’s strategic plan to provide mental and physical health services to approximately 21,486 patients within 12 prisons, three secure care facilities and nine juvenile residential community homes across New Jersey. Here, CQI teams work together to identify problems and implement solutions. Charged with a fundamental CQI spirit, UCHC encourages all staff to take up the following five-step challenge, UCHC’s “how-tos” that organizations can follow to implement CQI.

1. Involve New Staff from the Beginning
At UCHC, the new staff orientation period lays the foundation for CQI. Through dialogue, staff learn what CQI is and how it relates to UCHC’s strategic plan, discuss any previous experiences they may have had with CQI and dissect the inner workings of a CQI project that substantially affected the quality of care in the correctional setting. New staff who may ask, “Why do I need to know about this?” or state “I was not hired to do CQI” learn that CQI is a requirement for maintaining NCCHC accreditation, making it an essential practice for all—physicians, psychiatrists, dentists, mental health clinicians, nurses, medical technicians, leaders and support staff. At a half-day class held shortly after orientation, they learn the nuts and bolts of CQI.

2. Support a CQI Culture Through Inclusivity and Team Spirit
To kick off a group-oriented project, UCHC staff of all levels and disciplines form teams of five to eight, including staff involved in the day-to-day operations and at least one who has decision-making responsibility to help facilitate the implementation of proposed interventions. The team brainstorms ideas for possible projects (until ideas are exhausted), without critique from the group, as a scribe writes the ideas on a flip chart. Members vote for their choice of project, which should be related to the mission and values of the organization, involve high-risk or high-volume processes such as medication errors, be based on client needs or staff views of the needs and provide an opportunity for improved clinical outcomes and/or cost savings. With the project chosen, teams categorize the probable causes of the problem, listing them on a cause-and-effect fishbone diagram (so named for its shape); vote on the main causes; and use Pareto charts, vertical bar graphs that clearly show the relative importance of the problem’s causes from highest to lowest. With their newfound team spirit, they then brainstorm interventions and work to develop the final interventions and the pre- and post- measures they will apply, working with those who are closest to the problem. For example, if there is a problem with keep-on-person medication distribution, in addition to those who distribute KOP medication, the team may involve the site administrator, the pharmacist, the nurse manager and custody officers.

3. Use a Framework
There are a variety of ways to conduct CQI studies. NCCHC recommends using a general outline for correctional CQI programs, and encourages facilities to use a structured process to identify areas in need and to develop and implement strategies for improvement. At UCHC, CQI teams follow the four phases of the CQI process: plan and design, measure, assess, and improve, using the resource “Bringing the Gap Between What Is’ and ‘What Should Be’: A Step-by-Step Workbook and Reference Guide,” written by QI directors at UCHC and University Behavioral Health Care (see author information for web address). At the CQI plan-and-design stage, teams flesh out the purpose of the project, how it relates to the organization’s mission and values, who should be involved and the resources needed to implement interventions that address the problem. At the measurement phase, they implement interventions and collect and analyze data to measure their effectiveness.

During the assessment phase, the team reviews the data analysis and the effects of the intervention, comparing the data to other sources of information in the literature, from accrediting organizations such as NCCHC, and the facility’s prior performance as well as that of other facilities within the organization. During this phase, the project is either declared a success with the intent to test the intervention or it is abandoned. If they declare a project successful, they create new or revised processes, educate staff, share the improvements and continually monitor the improvements to ensure continued success. Because the CQI model is circular, it may be necessary to take a step back and work through the previous steps before proceeding. For example, if an intervention is not successful, the team can revisit, revise and then reimplement it.

4. Share the Results and Network
In collaboration with the New Jersey Department of Corrections, UCHC hosts an annual performance improvement fair for all employees as a forum for staff to share information about their CQI initiatives and achievements. Teams present posters and project summaries while attendees have the opportunity to view each poster and net-work with the teams, which drives staff to consider projects for their facilities.

An expert panel of judges representing the NJDOC, the Juvenile Justice Commission and UBHC evaluates the projects for their clarity of purpose and strong improvement focus; potentially strong impact on quality of care; evidence of consistent, comprehensive planning; and the application of the CQI process.

The top three projects from the mental health and medi-cal divisions receive plaques, and all participants receive certificates of appreciation. Winning projects are considered for submission to the annual statewide QI fair cohosted by the New Jersey Department of Human Services, the New Jersey Department of Children and Families and UBHC. Since the PI fair’s inception in 2006, the number of projects has increased from 30 to more than 40, and more than 300 staff members participated in 2014.

5. Sustain CQI
Rather than an endpoint, CQI is a journey that includes accountability and the continuous review of processes. Built into their performance reviews, UCHC leaders are held accountable to guide the development of at least one CQI project per unit that will be submitted to the PI fair and accomplished during the year. Every Friday, clinical leaders track NJDOC specific objec-tive performance indicators, which are based on NCCHC standards and other sources, in day-to-day operations such as intake assessments, chronic care visits, dental visits and mental health encounters. Positive OPIs show that the CQI process is working. One example of a major improvement achieved through the CQI program is the increase in overall patient satisfaction with mental health services, as shown by patient satisfaction surveys that have trended upward from 3.7 in 2005 to 4.0 in 2015.

Overcoming the Challenge
Providing quality of care is especially challenging in a complex organizational structure. In the New Jersey DOC, following the five-step challenge to implement CQI has made a difference in looking at “what is” and changing it to “what should be.”

Lisa DeBilio, PhD, LPC, is director of quality improvement and Lorraine Steefel, DNP, CTN-A, is nurse educator and clinical coordinator with Rutgers University Correctional Health Care, Trenton, NJ.


To read about the first UCHC PI fair, see Staff Health Fair Celebrates Quality Improvement in the Summer 2007 issue of CorrectCare*, available from the online archive at: http://www.ncchc.org/ correctcare-archive.
Joint Medical-Mental Health Training on Motivational Interviewing

On December 6, 2016, UCHC facilitated a joint medical and mental health training on Motivational Interviewing. This topic was selected because Motivational Interviewing has been found to:

- Encourage patients to set and achieve goals for health maintenance and disease management
- Engage patients in active (non-pharmacological) management of chronic pain
- Address issues of problematic alcohol, opiate, and other drug use
- Improve patient's medication adherence
- Promote engagement in other evidence-based behavior change approaches, such as Cognitive-Behavioral Therapy

Meta-analysis motivational interviewing, has been found to outperform traditional advice given in the treatment of a broad range of behavioral problems and diseases.


Eighty-four UCHC staff attended the training at the Hamilton Technology Center. Training was arranged through the Northeast/Caribbean AIDS Education and Training Center.

Trainers were:

Perry “Rusty” Chambliss, BS, Vice President of Training/Director of the Leadership Training Institute at Cicatelli Associates Inc. (CAI). Rusty oversees oversees and supervises the content and quality of all training provided for the past 20+ years.

Melanie Stileen, RN, BSN, ACRN, Co-Director Clinical Division, Director of Nursing Education and Senior Clinical Trainer for Cicatelli Associates Inc. (CAI), NYC and Co-Director and Clinical Faculty for CAI’s Northeast/Caribbean AETC.

Feedback from training was very positive.

Jeff Dickert, PhD
Chief Operating Officer

World Suicide Prevention Day at Rutgers

On September 9th World Suicide Prevention Day was recognized at Rutgers University Behavioral Health Care (UCHC). Host and new UBHC President and CEO Frank A Ghinassi, PhD, shared current statistics about the unfortunate rise of suicides nationwide and introduced New Jersey Department of Corrections (NJDOC) Commissioner Gary Lannigan, along with Commissioners, Allison Blake, Department of Children & Families, Elizabeth Connolly, Acting Commissioner Department of Human Services and Raymond Zawacki, Deputy Commissioner for Veterans Affairs. Commissioner Lannigan acknowledged that both inmates and correctional officers are vulnerable to suicide and shared efforts being made to impact change. Among them is the research of Dr. Rusty Reeves, MD, Director of Psychiatry, UCHC, which has significantly impacted the number of inmate suicides.

A video presentation from Mark A Graham, Major General, US Army (retired), Senior Director, Rutgers UBHC National Call Center, spoke about the personal impact of losing his son Kevin to suicide. Major Graham said the experience moved his niece to speak up when a 7th grade classmate said he wanted to kill himself. While fellow classmates took the comments as a joke, the suicide in their family moved her to take action. She got excused from class and called her mother who then told someone in authority at the school. This eventually led the boy’s parents to discover a loaded weapon in his bedroom that same day.

The program ended with a candle lighting ceremony and musical interlude where all who were impacted by suicide, which was the entire room, stood for a moment of silent reflection.

Ethical Challenges in Correctional Mental Health Care

On October 20th 2016 a conference entitled, Recovering Inside? Ethical Challenges in Correctional Mental Health Care was held in Philadelphia. Among the interdisciplinary panel of presenters was Stephanie Procell (pictured second from right), Clinical Psychology Doctoral Intern at Edna Mahan Correctional Facility for Women (EMCFW). Ms. Procell is a graduate of John Jay College of Criminal Justice, with a Masters in Forensic Psychology and Forensic Mental Health Counseling. She also completed a clinical practicum at Rikers Island New York City Jail.

Ms. Procell’s panel responded to the question, Can a Correctional Facility Be a Therapeutic Space? She said that approximately 40% of the offenders at Rikers were mentally ill with 13% having serious mental illness. One of the charges of Rikers mental health staff was to determine malingering, which in and of itself is difficult, however, this was compounded by the existing culture that did not respect mental health treatment. She described inadequate space, which for example forced staff to do assessments in hallways and treatment in a TV room with other inmates in close proximity. Pharmacy technicians were scared to go onto units to give medications since they were expected to distribute them to the inmates without the assistance of custody staff. This set the stage for high levels of medication noncompliance and misuse. In stark comparison Ms. Procell described her experience at EMCFW which in her words was, “the best run facility ever.” She extolled the program where correctional officers were cooperative and dedicated to providing safety, as well as therapeutic space where treatment was both supported and valued. Her presentation was extremely well received.

Michele Morris, PhD, Director of Training
The Reintegration of Sex Offenders into the Community: Some Observations from the Front Lines

Jackson Tay Bosley, Psy.D., Rutgers University & Philip H. Witt, Ph.D., A.B.P.P., Associates in Psychological Services, Somerville, NJ

In the Forum Newsletter, Association for the Treatment of Sexual Abusers, September 21, 2016.

The Problem

Much of what we have learned about individuals who have committed sex offenses has emerged from the veritable boom (bloom?) of research since the 1990s. We can thank our Canadian friends for generating much of this new information, including how to better assess recidivism risk (e.g., Hanson, Harris and colleagues) and how to better allocate limited intervention resources (Risk-Need-Responsivity; Bonta, Andrews and colleagues).

The 1990s also brought with them some less beneficial changes, including special sentencing provisions, such as community registration and notification laws, commonly called Megan’s Law(s). Not only has there been no research support for the notion that the registration and notification laws have added to community safety (Zgoba, Witt, Dalessandro, & Veyesy, 2008), but the added attention to, and stigmatization of, our clientele has made their reintegration back into the community all the more difficult. As a manager of a large community-based program for sex offenders, I have observed an overarching problem that occupies the attention of most of my clients and much of the professional staff: how do our clients find employment, a safe place to live and non-criminal social network? The challenges facing a client recently released are many (Schneider & McBride, 2015):

- Housing
- Employment
- Maintaining prosocial support networks
- Drug and alcohol treatment
- Physical and mental health problems
- Sex offender specific treatment

Our focus in this article will be the more concrete, immediate challenges, such as housing and employment. Far less has been written about these critical areas of reintegration than about providing sex offender specific treatment.

We as clinicians and our colleagues who provide legal supervision, each have our own responsibilities. We clinicians address the psychological issues that lead to dysfunctional behaviors, while our law-enforcement colleagues provide supervision and monitoring. Although we can refer clients to available community resources for services such as drug treatment or vocational assistance, stability in other basic life domains are outside of their control. Both clinical and legal professionals deal with the effects on our clients of the limited job and housing opportunities. A condition of parole is typically that the offender remains gainfully employed, so if the individual is unemployed, the parole officer and the offender have a potential source of ongoing conflict. For the therapist, an offender’s unemployment also causes problems. If an offender is unemployed, struggling to make ends meet, the focus of therapy is unlikely to be on understanding or managing risk factors, but rather on how to meet basic needs. Although much can be learned from focusing on meeting basic needs, if unemployment and housing problems persist, treatment may never progress to other issues, and the constant stress of unemployment itself can serve as an ongoing risk factor.

In therapy, our clients complain that they can’t find a job or enough hours at their minimum-wage job to support themselves in the community. The parole officers (POs) are faced with their supervisees living in environments that are rife with illegal drugs and petty criminal activity (e.g. theft and prostitution). All of which undermines the efforts of men who are struggling to learn to live the productive, prosocial life that we support and that the POs require. The impact of these limitations varies geographically, with some areas more accepting of this population than others. For example, many of our clients migrate to the inner-city areas, where there traditionally have been more post-prison resources available through social service organizations. Clients who have families with no children at home are incredibly lucky, in that they may have a place to stay. Unfortunately, some of our clients have alienated their families—in some cases having victimized family members—and are no longer welcome in the home.

I am repeatedly reminded that any client who has a steady and sufficient income can (usually) find an apartment or room to rent. However, obtaining such employment is not easy with a felony sex offense on one’s record. Many places that usually hire workers with criminal records will not hire sex offenders, or the work is unskilled or temporary. I prefer to see this as an obstacle that can be overcome, because despite this impediment, the majority of our clients find work, with encouragement from their POs and direct clinical help in the form of increasing job interview skills. At least some of the anxiety is anticipatory, in that many of our clients struggle with how to present their sex offender status, fearing that it will mean an automatic refusal of employment. Sometimes, that is the case, although they are rarely told that they are not being hired because of their sexual offense. Usually, the employer simply tells them that someone else was hired.

One of the ways that therapists can help is to assist the clients in disclosing their status in such a way that they can maintain their composure, present honestly, and establish some kind of rapport with the potential employers. This composure can be practiced through in-group role play exercises and some therapeutic scripting. Notwithstanding arguments about the relationship between denial and risk, we note that effusive protestations of innocence do not seem to

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“Reintegration of Sex Offenders into the Community…” cont’d

(Continued from page 6)

convince potential employers. We have no hard evidence, but we suspect that such declarations merely accentuate potential employers’ suspicions.

We are reminded of some of the lessons of our undergraduate psychology classes in the early 70’s. Maslow noted that it’s hard to focus on higher level needs, such as self-actualization, when unable to satisfy even basic needs, such as where we will be laying our head (or finding something to eat). We know, for example, that unstable housing is a robust predictor of re-arrest (Meredith, Speir, & Johnson, 2007) and absconding (Levenson, Ackerman, & Harris, 2014). Unstable employment and lack of social support also predict re-offense (Willis & Grace, 2008, 2009). There are some homeless men’s shelters that accept sex offenders, but these are rare and, at least in New Jersey, all sex offenders are required to have a residence approved by the State Parole Board. This places a burden on the state (in that they are under legal supervision), but ensures that clients cannot be homeless or living on the street. New Jersey has also (narrowly) avoided the mess that occurs when residency restrictions are implemented. As it is, most offenders are under Community or Parole “supervision for life” (which can be released by court order after 15 years), and a successful reintegration weighs heavily towards being released from this long-term supervision.

**Toward a Solution**

Our overarching point is that successful “treatment” for our clients involves a reintegration process that includes not only dealing with the psychological issues that led to sexual offending behaviors, but also includes solving practical problems, such as finding and maintaining employment, which is required to live a self-supporting, crime-free life. We, as therapists, can help this process by making sure that these practical issues are also a focus of our rehabilitative efforts. By now, we know that dynamic risk factors have a bearing on likelihood of re-offense, and it is these dynamic risk factors that present a reintegration challenge (Schneider & McClure, 2015), including:

- Unstable employment (Hanson & Morton-Bourgon, 2005)
- Fewer positive peer influences (Hanson & Harris, 2000; Hepburn & Griffin, 2004)
- Unstable living situation (e.g., HCR-20: Douglas, Hart, Webster, & Belfrage, 2013; LSI-R: Andrews & Bonta, 1995)

By way of example, the social work staff for New Jersey’s Special Treatment Unit (STU; facility for civilly committed sex offenders) has done an excellent job creating a release preparation process for the many residents that are transitioning back into the community. This process involves extensive examination of the resident’s resources and skills, graduated (supervised) community furloughs and extensive therapeutic processing of the resident’s experiences during these furloughs. The STU staff, in conjunction with the client, develops a comprehensive release plan focusing on (Schneider & McClure, 2015):
- Furloughs
- Housing
- Employment
- Sex offender treatment
- Substance abuse treatment
- Social supports
- Spiritual supports
- Recreational interests

These furloughs, in particular, allow the offender to acquire basic skills, such as using public transportation and meeting future community-based therapists. In addition, once released, the STU appoints “Keep Safe Buddies,” who are, vetted and approved residents with whom the discharged resident is required to maintain regular contact. These “Keep Safe Buddies” provide both a healthy peer influence on the released client, as well as a model for learning how the released client is adjusting (Schneider & McClure, 2015).

Obviously, furloughs and “Keep Safe Buddies” are resource-intensive and may not be practical for the large numbers of sex offenders who are released into the community from state prisons. However, there are clear lessons to be learned and some recommendations that follow.

1. All sex offenders need to be assessed prior to leaving the correctional or commitment facility not only for the risk that they pose to the community, but for their ability to live a crime-free lifestyle. From this pre-release assessment, a comprehensive reintegration plan should be developed. Research indicates that a clear, comprehensive reintegration plan guides both client and service providers; in fact, a coherent discharge and reintegration plan has been found to reduce recidivism (Willis & Grace, 2008; 2009). An offender’s ability to live a productive, crime-free lifestyle once released affects the risk of future sexual offending. Additionally, those sexual offenders with limited resources released into the community pose an administrative burden to their legal supervisors and occupy considerable treatment time with issues that relate to their inability to get their most basic needs met.

2. Preparing incarcerated or committed sex offenders for release to the community pays off in the short- and long-run. I hear it from the POs when one of their charges shows up in the District Office waiting room with all of his possessions in a large plastic bag because he has nowhere to go. It falls on the PO (who is forced to take on the role of social worker) to arrange for the individual to stay at one of the available homeless men’s shelters. Preparation also involves increasing offenders’ productivity. Productivity can be increased through education and vocational training while incarcerated, and most correctional and commitment facilities offer both. The more an offender takes advantage of education and vocational training while incarcerated, and the more credible and valuable he will be (and hopefully will appear to be) to a potential employer. But therapy itself can potentially increase an offender’s productivity by helping him to express himself assertively and make more mature decisions, characteristics that may be apparent in a job interview.

3. Some of our adult clients have never been self-supporting despite years of living in the community prior to incarceration. Some have cognitive deficits that limit their ability to function in any setting except on the fringes of society. Others simply grew up in environments where criminality was the norm, and their exposure to self-supporting individuals was limited. The more limited an offender, judging from prior impaired social functioning, the higher level of support and structure he is likely to need upon release. For these men, we recommend that a mentoring system be developed. The mentoring can take a number of forms. As we discuss more below, successfully discharged offenders can serve as mentors, returning to the institution for their own aftercare to advise clients who are approaching release. Sometimes discharged offenders who are successfully employed can serve as potential employment contacts, introducing an offender to a prospective employer (who has presumably had a good working relationship with one discharged offender). It is important that frequent aftercare be provided to support the client through the difficult transition to life in the community, especially if the offender has been incarcerated or committed for many years. The more that can be done to increase positive social bonds between incarcerated offenders and supportive members of the community, such as friends, family, or even selected released offenders, the better the offender’s chance of succeeding upon release, since these

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“Reintegration of Sex Offenders into the Community…” cont’d

(Continued from page 7)

reoffenses. Level issues can occur, making for more good lives and fewer matters form the foundation upon which treatment of higher level issues can occur, making for more good lives and fewer reoffenses.

4. The availability of public transportation is important. One of the onerous effects of residency restrictions is that it severely limits where our clients can live. If our clients are pushed to the literal as well as figurative fringes of society, their ability to work and involve themselves in society is limited. Work (and treatment) reduces recidivism. Our clients are safer in the community if they are given access to as many needed services, and something as basic as access to public transportation has an impact on the offender’s ability to work and receive social services. Supervised furloughs for offenders while still incarcerated, but approaching release, can help the client learn the ropes regarding how to use basic services, such as public transportation.

5. Avoid scheduling treatment during normal work hours. By doing so we are limiting our client’s work opportunities, which can have the cascading effect of limiting many other areas of their lives. Thus, late afternoon and evening treatment groups should be available.

6. A list of employers who have knowingly hired registered sex offenders is helpful. One of the POs suggested a program reminiscent of the Civilian Conservation Corps to ensure that these men have jobs and income to support themselves, rather than turning to welfare assistance. Consider inviting these employers to the institution to conduct job interviews. Familiarity with the institution and the individuals whom the employers may potentially hire can go a long way toward eliminating negative stereotypes of offenders, thus allowing an offender to get his foot in the door on a job.

7. Allowing released, but successfully employed offenders to come back to the correctional facility and describe the issues involved in becoming self-sufficient would be helpful to educate offenders who are soon to be released. It also shows that success in community reintegration is possible.

Conclusion

It is clear to us that if we want our clients to make a successful reintegration into the community, we have to assess their ability to live independently early in their correctional sentence, provide them with (adequately functional) vocational assistance and couple these efforts with effective services once they get out. Smoothing the process of community reintegration will go a long way to helping our clients remain offense-free once they return to the community. As therapists, we are trained to focus on high level issues: What risk factors led to the offenses? How can the client communicate his needs assertively? Is the client empathic, taking others’ needs and feelings into account? Sometimes, however, we need to shift our focus to more basic needs, such as housing. The client’s success in these concrete matters form the foundation upon which treatment of higher level issues can occur, making for more good lives and fewer reoffenses.

• Schneider, J. E., & McBride, J. (2015). The role of support networks in “keeping safe” in the community. Presentation at the 34th Conference of the Association for the Treatment of Sexual Abusers, October 2015, Montreal, Quebec, Canada.

Philip Witt, Ph.D., specializes in forensic psychology— that is, psychology as applied to legal cases. He is a diplomat in forensic psychology of the American Board of Forensic Psychology, where he previously served on the examination panel, and a Past President of the American Academy of Forensic Psychology. He serves on the clinical faculty of Rutgers Medical School. A past president of the American Academy of Forensic Psychology, he was the 2001 recipient of that organization’s Psychologist of the Year award. He is on the editorial board of the Open Access Journal of Forensic Psychology.

Jackson Tay Bosley was raised in Kamakura, Japan, Bangkok, Thailand, and Hong Kong. He completed his BA degree in Religion and Psychology from the University of Hawaii in 1978 and his MA degree in Psychology from Antioch University (Hawaii) in 1982. He earned his Doctorate in Clinical Psychology (PsyD) from Rutgers University in 1999. Dr. Bosley has worked to reduce interpersonal violence by developing specialized treatment programs in prisons, hospitals and in the community for over 35 years. He currently works for Rutgers University Behavioral Health Care and administers community-based treatment programs for about 1000 high-risk adult sexual offenders. He supervises clinicians, conducts research, testifies in court cases and provides direct clinical services including group therapy and sexual offender risk assessments.

[1] When the pronoun “I” is used, the article refers to JTB. Link to original article: http://newsmanager.compartners.com/atsa/issues/2016-09-14/3.html

Rutgers, The State University of New Jersey—UCHC Newsletter: July-December 2016 Page 8
Rusty Reeves, MD, is now an APA Distinguished Fellow. Excellent news!

Distinguished Fellowship is awarded to outstanding psychiatrists who have made significant contributions to the psychiatric profession in at least five of the following areas: administration, teaching, scientific and scholarly publications, volunteering in mental health and medical activities of social significance, community involvement, as well as for clinical excellence.

Michelle Corker, Art Therapist (NSP) is now a Licensed Professional Counselor (LPC). Congratulations!

Dr. Lorraine Steefel, Nurse Educator (Central Office) was selected to represent the American Nurses Association (ANA) as a content expert and member of the Technical Development Work Group (TDW) to update the Centers for Disease Control and Prevention website and educational materials on Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) in Atlanta in September 2016 and to work ongoing with the group remotely. The TDW is comprised of clinicians with ME/CFS expertise, representatives of healthcare professional organizations, medical educators, and researchers, and ME/CFS patients and advocates. Great job!

RE: Employee Recognition

The UCHC Executive Leadership team encourages the use of “Shout Outs” in the newsletter as a form of Employee Recognition.

The Leadership Team understands there are many achievements and day-to-day activities contributing to successful operations and deserving department recognition.

Newsletter editing staff are happy to provide assistance in drafting “Shout Out” wording. Please indicate such in your email request.

Send “Shout Out” via email to UCHCnews@ubhc.rutgers.edu with the subject “Shout Out”

“Shout Out” criteria:
- The person(s) being recognized must be part of Rutgers-UCHC
- Event/situation must be directly related to current work responsibilities; or
- Achievement in current profession and/or educational area of study (i.e. promotion, presentation, publication, licensure, advanced degree, etc.); or
- A Rutgers University, NJDOC, JJC, Parole or other client related event; or
- An act of heroism or bravery; rendering life-saving aid such as a Good Samaritan.

Certified Correctional Health Care (CCHP) announcements
New CCHP:
Harriet Mugwanya, RN, CCHP (JJC)
Diane Baca, LPN, CCHP (NJSP)
New Surveyor:
Sue Spingler, RN, CCHP-A (NJSP)
Way to go!

Rebecca Lopatin, PsyD (BSP) passed the Examination for Professional Practice of Psychology (EPPP).
Great work!

Arthur Brewer, MD, statewide medical director for University Correctional Health Care, has been selected as one of the directors of the Board of the Academic Consortium on Criminal Justice Health (ACCIH).

The mission of ACCIH is to advance the science and practice of health care for individuals and populations within the criminal justice system. ACCIH serves as the academic home for criminal justice health researchers, educators, clinicians, scholars and administrators. ACCIH represents 10 founding institutions, including Rutgers.

For the past 9 years, ACCIH hosts annual Academic and Health Policy Conference on Correctional Health which continues to be among the most successful criminal justice health conferences in the nation. It attracts approximately 300 attendees yearly, with participants from 27 states, 9 countries, and, over 130 institutions.
If your legal name changes, you must notify the UCHC Central Office as well as make the change online at http://my.rutgers.edu.

if you relocate, change your residence, go walkabout, move on up to the east side, or simply decide to live in a different location; you must notify the UCHC Central Office as well as make the change online at http://my.rutgers.edu.

By the way, congratulations on your new digs!

Steps to Change Your Name/Address on the portal:
1. On the Welcome screen find the Banner Self-Service tab.
2. In the new window find “Personal Information” in the left menu.
3. Find and click on “Name Change Information” or “Update Addresses/Phones”.
4. Follow remaining prompts on website.

Note: You must notify both the UCHC Central Office AND complete the change online. Notifying one does not update the other.

Mileage
Mileage reimbursement rate for CY 2017 is 53.5 cents per mile (x .535)
Mileage reimbursement rate for CY 2016 was 54 cents per mile (x .54)

Problems with UCHC
Pagers/Cell Phones
Report all problems to Lisa Chaszar,
UCHC Central Office,
(609) 292-4036 x5211
or email Lisa.Chaszar@rutgers.edu
Remember to check your pager on a routine basis.

To Resolve Payroll Issues...
1. Contact your payroll timekeeper. In most departments this is the unit support staff.
2. If your payroll timekeeper is unable to assist, contact your supervisor, or in their absence, the regional manager/administrator.

Educational Assistance Program
The Educational Assistance Program application must be submitted to Campus Human Resources Benefits Services Office after the course is completed. Course pre-approval forms are no longer required.

The application and required documentation for reimbursement for college courses, non-college courses and seminars must be received in the Campus HR Benefits Services Office within 90 business days after the completion of the course(s), seminar(s) or conference(s).

Applications submitted without the required documents will not be accepted. See application for list of required documentation.

Educational Assistance Program Information and Eligibility Criteria:
http://uhr.rutgers.edu/benefits/non-state-benefits-legacy-umdnj-positions/educational-assistance-ex-program

Educational Assistance Application:
http://uhr.rutgers.edu/sites/default/files/form_applications/EducationalAssistanceProgramApplication_0.pdf

Tuition Assistance Policy 60.9.46
(Use link below and scroll down to policy 60.9.46):
http://policies.rutgers.edu/view-policies/human-resources-60-9-46-section-4036/60-9-46

All UCHC Staff,

Litigation, unfortunately, is commonplace in prisons. Most litigation against staff comes to naught, however, all requires attention.

In such matters you would be directly served a summons or complaint. Supervisors, peers and support staff are not authorized to accept service/sign off on an Affidavit of Service on behalf of another employee. However, supervisors should assist to arrange a meeting with the individual being served a summons or complaint.

If you are asked to sign a litigation or claim for the name “University Correctional Health Care” and no specific staff name is assigned – DO NOT SIGN OR ACCEPT. This type of claim/litigation must be served upon the Office of the Secretary to the Board of Governors as follows:

Rutgers, The State University of New Jersey,
Office Secretary of the University
7 College Ave, Room 111
New Brunswick, 08901-1280

If you receive notice you are named in a lawsuit or other legal action, immediately do the following:

Fax the legal papers, along with the attached, updated letter template requesting legal representation, to the attention of Chief Operating Officer at (609) 341-9380.

The UCHC Central Office will forward the complaint to Risk & Claims and the Rutgers Legal Department. They will contact you to inform you which attorney will represent you.

Call the assigned lawyer, explain the case and make sure you understand what you are directed to do. Denial or nonchalance will not serve you well in such a situation. Educate yourself about the case. Do not assume the attorney knows the case as you do, and don’t be afraid to suggest strategy to the attorney.

If you have questions or wish to speak about ongoing litigation, you may contact the Chief Operating Officer by phone at (609) 292-4036 x5228.

Problem With Your Paycheck

I've Been Served!!
What should I do?

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Employee Assistance Program
1-866-EAP-UBHC (1-866-327-8242)
http://ubhc.rutgers.edu/eap/

Don’t be shy!
Have an idea for a future publication, one time article or interested in becoming a regular contributor to the UCHC Newsletter? Please let us know!

Send all news correspondence to: UCHCnews@ubhc.rutgers.edu

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Mechele.Morris@rutgers.edu

Production Editors: Jennifer VanEmburgh
Jenn.VanE@rutgers.edu
Shirley Lee
Shirley.Lee@rutgers.edu

Suggestions? Ideas? Leadership Wants to Know!

The UCHC Leadership Team created ImproveUCHC@ubhc.rutgers.edu as an avenue to communicate with UCHC Central Office Leadership. This electronic communication method is available for you to send your ideas any time, day or night. All suggestions are monitored and forwarded to the UCHC Leadership Team for review, without revealing your identity unless you direct us otherwise.

Your valued input will help us better manage our programs and become better managers ourselves, so we invite you to use this Performance Improvement initiative. We hope to hear from you soon!

UCHC Leadership Team

EAP is just a phone call away...

Did you know that anyone in your household is eligible to use the EAP?

All services are provided by your employer and free to you and the members of your household.

All services are confidential.

No information is shared with anyone without a written release from you.

Individuals and couples are seen for a variety of reasons such as: personal difficulties, relationship concerns, anxiety, depression, grief, stress and substance abuse.

We can help with family issues such as: parenting, single parenting, blended families and elder care.

Whatever your concerns, we are here for you.

Submit articles for the next Newsletter to UCHCnews@ubhc.rutgers.edu
Ongoing UCHC Continuing Education Log

Year: _________

Name: _____________________________   Site: _____________________

Position: ___________________________

*** PLEASE PRINT CLEARLY***

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Once you complete this form submit a copy to your site Data Control Clerk/Secretary for entry into the UCHC Database.

Keep a copy (along with attendance verification for each activity) for your personal records.

Note: Staff meetings can be included as continuing education activities provided a signed attendance log is maintained.