THE FORENSIC FORUM

FORENSIC MENTAL HEALTH ASSOCIATION OF CALIFORNIA

VOLUME 11 NUMBER 2 MAY 1990

PRESIDENT'S MESSAGE

David T. Christensen, Ph.D.

This is my final Presidents Message. I leave the Board on July 1, 1990 and it does not seem possible that six years have passed already. Over these years, and more, I've seen the Association grow, change, branch out and struggle. Our growth has been nurtured by some outstanding people whose talent and energy are characteristic of the Association membership. Pam Craig helped found the FMHAC, and as its first President established the annual Conference as well as the Association's pre-eminent role in statewide training in the forensic arena. Bill Rossiter followed Pam as President, consolidating the Association's goals and objectives and developing training tools for the Conditional Release programs. Under Don Terleski's leadership the Association strengthened its training tradition through its use of training grants. Don implemented the process for updating policies and procedures and oversaw the creation of a written history of the Association.

It has been a privilege to follow in the footsteps of this group of admirable people. During my tenure I have presided over the growth of our networking project with forensic entities in other states and countries. "My" Board has created a Legislative Committee, a Task Force on Juvenile Offenders, and an AIDS Task Force. We have explored the role and the impact the Association can have on legislation related to forensics as well as policy and procedure for dealing with our clientele. We have recruited a number of distinguished columnists whose contribution to the FORUM assist in making it a noteworthy, professional newsletter. Time and perspective will be better able than I to summarize the work of my Presidency, and I do not need to be elaborate and specific here.

I do want to comment about a most significant dimension of my Presidency. I have had the honor and the privilege to meet wonderful people over the past six years. I have had the opportunity to work with and become close to extraordinary new friends, and to deepen my relationship with cherished old friends. I am grateful to the membership for making these opportunities possible and I am very appreciative of the work, the friendship, and the support of the people who served on the Board with me. These friendships endure, even as my service to the Board comes to an end, and I feel fortunate in all respects as I say good by.

Whatever talents and knowledge I have are at the disposal of the incoming Board. Nick Burgeson will become Presi-

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LEGISLATION CORNER

Steve Powell, M.S.W.

For this session of Congress, March 2, 1990 was the deadline for introduction of new bills. Lawmakers have proposed a total of 7,776 new measures during this two year session. Reportedly, each of these pieces of legislation costs taxpayers more than $6,000 just to process. Of those 7,776 bills introduced, we have chosen to follow several which are related to forensic mental health.

The Riese v. St. Mary's California Supreme Court ruling regarding the rights of mentally ill patients to refuse medication continues to generate considerable interest from legislators and affected parties. AB 190 (Bronson) would require an administrative review rather than the judicial review required by Riese. AB 2784 (Pressley), sponsored by CAMI, would require a Jameson-like procedure with a second opinion. AB 4060 (Margolin), sponsored by patients' rights organizations, would essentially codify Riese, requiring a judicial review.

These three Reise-related bills also have some other differences regarding such things as timing of the review, definitions and various procedural details. As information is gathered about the effects of implementing Riese, momentum is building for some legislative relief. AB 190 appears at this time to be the most likely to be approved by the legislature.

The safety and security of staff and patients in forensic mental health settings must remain uppermost in our awareness at all times. Some recent legislation relates to this important issue.

AB 1693 (Hayden) would require that the annual Short-Doyle plan for local mental health services in each county include a plan for worker and client safety. The original version of this bill specified certain areas to be addressed but amendments have left the language much more vague and general. The bill would at least mandate that some thought be given to providing a "safe and secure workplace for the county's mental health workers and clients."

The law has always allowed relatively easy access to home addresses for just about anybody through the Department of Motor Vehicles (DMV) by just providing a vehicle license number. This has been of special concern to those who work in outpatient settings where patients could easily determine car license numbers of staff. Law enforcement

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dent on July 1, 1990. He will be assisted by Nancy Fiske (Vice President), Chris West (Treasurer), Dan Chinn (Secretary), Alisa Dunn (Director for Conference Planning) and Tim Stalder (Director for Education/Training.) What a team! The affairs of the Association are in very good hands indeed.

I urge you to put your talent and knowledge at the disposal of the Board also. The Board deserves your support and involvement. Take care! ❧

THE BOOK REVIEW COLUMN

Stephen H. Wells, J.D., Ph.D.
Book Review Editor

The Atascadero Story, Part I

Relapse Prevention with Sex Offenders, D. Richard Laws, Editor. (1989: Guilford Press, 72 Spring Street, New York, NY 10012).

With the publication of this superb volume, Atascadero State Hospital's place as one of the preeminent sources of creativity and inspiration in the treatment of sexual offenders in the late 1970s and early 1980's is secure. And to the extent that an edifice of expertise and accomplishment so painstakingly erected at Atascadero State Hospital and elsewhere in the system, and so clearly revealed in this book has been dismantled in the aftermath of public and political assault upon the MDSO commitment, we can only experience deep sadness.

Professor Richard Laws, presently of the Department of Law and Mental Health at the Florida Mental Health Institute, traces the development of the cognitive-behavioral treatment approach for sexual offenders that has come to be known as Relapse Prevention (RP) to his years with the Sexual Behavior Laboratory at Atascadero State Hospital. He highlights and presents here the work of such professionals who have been or remain associated with ASH as: Janice Marques, Alan Marlatt, Bill George, Bill Pithers, Craig Nelson, Michael Miner, David Day, Pamela Jackson, Joe Murphy, Kabe Russell, Helen Steenman, Henlie Sturgeon and Carl Viesti.

RP, deriving from models originally employed in the treatment of addictive behaviors and grounded in Bandura's social cognitive theory, seeks to teach and enable patients to anticipate and cope with perils of potential relapse into sexual offending. In an extremely lucid overview (as is, I find, so much writing in the social-cognitive-behavioral area compared, say, to the dismal murkiness of so much one reads in the psychoanalytical realm), Bill George and Alan Marlatt explain the origins, basic assumptions and conceptual framework of RP, its benefits and limitations with sexual offenders and the procedures and techniques it employs.

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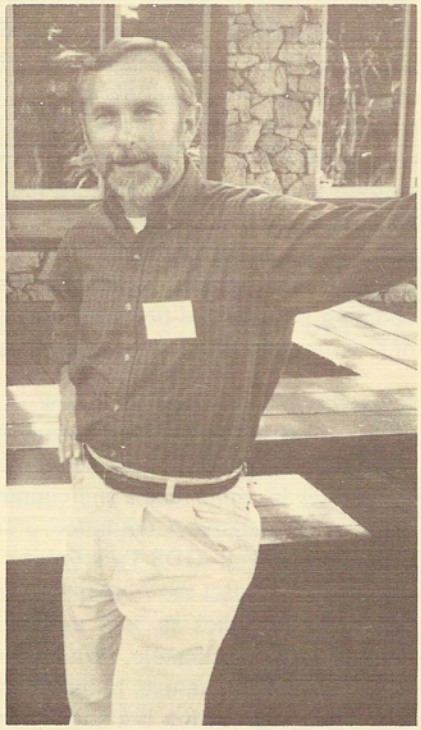
TIM STALDER

Director for Education/Training

Tim Stalder began his career in mental health as a Los Angeles County Deputy Public Guardian where he conducted conservatorship/guardianship investigations and provided case management services including managing a caseload at Atascadero State Hospital. In 1974 he accepted a research assistant position at ASH where he participated in a statewide study of released patients. Following that assignment he was appointed as ASH's Affirmative Action/EEO Coordinator. In 1977 he was appointed Training Officer. In addition Tim has served in a variety of other assignments including a one year residency in Hospital Administration in 1988-89.

He holds degrees in Sociology (BA), Cultural Anthropology (MA). His PhD is in Human Resources Department with a concentration on Team Building.



Tim Stalder, Director for Education/Training

Tim teaches in the Cal Poly San Luis Obispo Management Certificate Program and provides Team Building Consultation for not only Department of Mental Health groups but private agency and volunteer groups.

He is an active member of the San Luis Obispo County Coalition for the homeless. ❧

WILLIAM E REID RECEIVES ROSSITER AWARD

The William T Rossiter Award represents the highest honor the FMHAC can bestow. It is given each year to a person who has consistently demonstrated leadership, creativity, administrative skills and personal dedication to forensic services.

The 1990 recipient of this award represents the epitome of these qualities. Perhaps more than any other single person, Bill Reid is responsible for the forensic system that exists in California today. In the early 1970s, when there were a limited number of champions of the needs of forensic pa-

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officers and certain other limited categories of persons were able to be on a "restricted access" list, but mental health workers were not eligible.

In response to the much-publicized murder of an actress in Los Angeles last year by a man who stalked her and obtained her address through DMV, AB 1779 (Roos) was passed. This bill, which was signed by the governor and took effect January 1, 1990, put severe limitations on access to home addresses except by public agencies and private corporations with a business reason to obtain the information. It is now very difficult for a private person to get someone's home address, and ten days prior notice is provided to allow each person to stop the release.

The DMV interpretation of AB 1779 was so restrictive that business interests have now sponsored AB 2754 (Johnson) which would loosen access somewhat. Assemblyman Johnson's office states that the original legislative intent of AB 1779 was to require affirmative action by each person who wished confidentiality to request it and provide an alternative mailing address. If AB 2754 passes, all citizens would be able to request restricted access but it would not be automatic as it has been since January 1, 1990, pursuant to AB 1779.

The Not Guilty by reason of Insanity (NGI) plea and commitment would be changed by AB 3951 (McClintock). Supported by some District Attorney's offices, the bill has

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State Senator Diane Watson, 1990 Conference keynote speaker, with Nick Burgeson and Dave Christensen, in-coming and out-going Presidents respectively.

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already generated the opposition of the California Psychiatric Association. For reasons that will be obvious from the description below, the provisions of the bill would make NGI a less attractive plea for the defense bar, thereby potentially reducing further its already infrequent use.

AB 3951 would make three fundamental changes: 1) it would prohibit entry of the plea after the commencement of trial; 2) it would require that when the crime committed by the person was murder or manslaughter, the minimum period of hospitalization would be equal to the minimum period of imprisonment, had the person been convicted of the crime; and 3) it would require that persons who have been hospitalized for the maximum period required by law shall have one year of supervised outpatient treatment upon their release. This bill has not yet been analyzed and discussed through the committee process.

Since 1985 the Office of Criminal Justice Planning (OCJP) has financed three pilot county programs to treat juvenile sex offenders who were not committed to the California Youth Authority. The operation of these pilot programs will terminate on July 1, 1990. SB 1895 (Seymour) would appropriate $500,000 to the OCJP to provide financial and technical assistance to selected, eligible counties to provide such treatment programs on an on-going basis.

The legislature frequently includes requirements that research or outcome studies be performed as part of changes.

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Contributing to relapse are high risk situations (HRS) such as negative emotional states (e.g., anger or boredom), interpersonal conflicts or confrontations and social pressures, both direct and indirect, to violate rules that have been set and accepted. Five chapters in the book plumb the long and the short of HRS (including via penile plethygsmography). Along the path to relapse are to be found hazards and seductions including AIDs (not the disease, although these days possibly that too, but "apparently irrelevant decisions" that rationalize return to relapse behaviors), PIGs ("problems of immediate gratification," but I'm sure something else came to mind) and AVEs (not a form of bestiality involving birds, but "abstinence violation effects," which facilitate lapses becoming relapse). Lapse is to relapse as Figaro is to Don Giovanni and as Henry James is to Henry Miller.

Once the patient is aware of his HRS, understands the covert antecedents of relapse situations (the early warning signals) and has developed adequate motivation to cease the offending behavior, then specific intervention techniques can be taught including: self-monitoring; self-efficacy enhancement (promoting feelings of competence and confidence); remedial skill training (rectifying deficiencies in

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coping skills, including assertiveness, stress management, anger management, communication skills and social skills); decision matrix (a technique for focussing consideration of both positive and negative potential outcomes of yielding to self-gratification); urge coping (preventing and managing urges through stimulus-control, avoidance strategies and breaking the continuity of the urges); coping with lapses; achieving a balanced life that will inoculate against the antecents of relapse. Fully ten chapters of a most practical sort intended explicitly for practitioners are devoted to these various techniques.

The final chapters provide detailed descriptions of California's own relapse prevention program (clearly the national leader, but for the crippling effects of public blindness and political impotence) and those of Vermont (Bill Pithers is there now, in a state whose only previous claim to fame in the mental health field was for having applied Tarasoff to barnyard animals) and Florida (Laws' own program in the most bizarre place in the world, a Disney World of human deviance).

I felt proud reading the book. Proud of the intellectual achievements of our colleagues in breaking new ground, proud of their creativity in bringing illumination and possibilities to such a difficult treatment enterprise, proud of their courage to persevere in the face of such public and political antagonism and proud of the willingness of so many of them to continue to serve in our public facilities and systems.

Three cheers for Atascadero and all the rest and make this the one indispensable volume in your libraries on sexual offenders.

The Atascadero Story, Part II

It struck me at the Asilomar Conference that the FMHAC is in many ways becoming the Atascadero Forensic Mental Health Association. I feel certain possibilities must be faced. One is that almost our entire leadership could be wiped out in a moment by a malfunctioning Sally-Port. Another is that the Colossus of the Central Coast might decide to replace this reviewer, an effete big-city slicker if there ever was one, with someone temperamentally more suited to the Central Coast.

Should that happen, the following are some of the reviews you could anticipate in this column:

- "A Month in Different Rooms at the Madonna Inn, the Induction of Multiple Personality Disorder and the Insanity Defense."
- "Fifty Ways to Kick Shit Off Your Boots."
- "The Morro Bay Approach to the Treatment of the

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tients in California, Reid pioneered a number of projects that continue to guide our work to the present day. During these formative years he worked closely with Assemblyman Lanterman and his staff on AB 1228 and AB 1229; worked with county staff throughout the state on development of their programs; coordinated the state's efforts to develop forensic services. He served the Department of Mental Health with distinction in a number of capacities. He was the Department's Personnel Officer, the Chief of the Hospital Services Section, and finally, until his retirement about 9 years ago, the Chief of the Forensic Services Branch. He was a key figure in the organization of the first Asilomar Conference, which grew into the FMHAC.

Bill has been living in Mexico since his retirement, and the award was accepted on his behalf by Diane Serber, during a presentation ceremony at the annual Conference. ❧

DAN CHINN
Secretary

Dan Chinn, the new Service Secretary, is a social worker who has worked at Atascadero State Hospital since 1978. Dan has twice been elected the chairperson of the Social Work Service and is well-known for his even-handed approach and his sense of humor in carrying out this responsibility. He has been instrumental in designing the quality assurance plan used by the Service as well as contributing to the refinement of the peer review and recruitment process. He is an EEO counselor and a member of the EEO Committee, and has served as a union steward. Some of you met him in March, 1989 at Napa State Hospital where he was part of the Treatment Activities Evaluation Team. He has a private practice in Atascadero and in his other spare time he plays saxophone with a band.

Dan Chinn, Secretary

Dan is a positive person and will be an excellent addition to the Board. ❧

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Borderline Personality: Between a Rock and a Power Plant."

• "The Sally-Port as a Sexual Intromission Symbol in the Mutative Dreams of Judicially-Committed Sexual Offenders."

• "The Complete Guide to Touring All of the Places of Interest in San Luis Obispo County in Two and a Half Minutes."

• "Use of Radioactive Effluent in Potentiating Neuroleptic Medications."

• "The Pick-Up Truck as a Sexual Intromission Symbol in the Mutative Dreams of a Forensic Hospital Staff."

• "Fifty More Ways to Kick Shit Off Your Boots."

More on TPD

Treatments of Psychiatric Disorders, Four Volumes, American Psychiatric Association. (1989: American Psychiatric Association, 1400 K. Street, N.W., Washington, D.C. 20005)

The more I use and the deeper I penetrate (notice a theme in this month's column?) into this monumental set of volumes, the more I am impressed with it. It is really as much an encyclopedia of mental health treatment as it is a manual and there is copious information here from both the treatment and research literatures that will not be found in any other single place. While there are other comprehensive psychiatric texts at more moderate cost (my personal favorite is The American Psychiatric Textbook of Psychiatry, edited by John Talbott, Robert Hales and Stuart C. Yudofsky, 1988, American Psychiatric Press, at the same address as the APA), nothing else comes even remotely close in quality and thoroughness.

I recently used it in a criminal justice mental health case involving organic impairment and I found it exhaustive in its coverage and responsive to every question I needed to pose and issue I needed to resolve. I needed to go nowhere else for all of the state-of-the-art information on etiology, signs and symptoms, differential diagnosis, treatment and maintenance strategies and research developments. Being able to quote a source of this special standing was an added benefit of its use.

Let me put to rest the idea, so rife in many circles, that TPD is part of an ongoing psychiatric conspiracy to take over and completely dominate the mental health field. While that conspiracy does in fact exist, TPD, whatever the original intention was, does not serve it. The basic thrust with regard to treatment of all disorders here is multi-modal, making the emphasis, therefor, inherently multi-disciplinary. Take the ten chapters devoted to schizophrenia, edited by the distinguished Robert Cancro. The treatment approaches elaborated and recommended include, of course, psychotropic medication (especially good material here on negative effects of neuroleptics, as well), but also: individual psychotherapy (practical, goal-oriented approaches are wisely recommended over intensive insight-oriented and psychoanalytical ones); group therapy (superbly organized material here on primary uses, clinical expectations, patient assignment strategies, goals of the again wisely recommended supportive-social learning and interaction-oriented approaches); family therapy, including material on psychoeducational strategies, family crisis intervention, multiple relatives groups, phase-oriented treatment procedures, home-based family management of the patient and family skills training); behavior modification and behavioral rehabilitation; problem-solving skills training; attention-focusing training; guided self-help approaches; and vocational rehabilitation. And so on for every disorder in DSMIII-R.

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As for the crucial issues of the possible use of TPD by lawyers and the courts for the long-sought standard-of-care manual for psychiatric malpractice, I think this is quite likely. But, given what TPD actually is, the focus may well shift somewhat in the future from psychotropic medication effects (these will always be the largest part of malpractice suits throughout the mental health field) and need for or release from hospitalization to whether a broad and comprehensive group of treatment modalities addressing the multi-dimensional needs in the treatment of any mental disorder was employed, requiring the referral to and utilization of diverse other professional disciplines for the provision of those adjunctive treatments. What a stunning irony this would be as the primary contribution of TPD to the evolution of psychiatric practice: a landmark movement away, in effect, from the medical model to one that institutionalizes multi-modal, multi-disciplinary practice as a standard of care.

I hope that the APA will realize that the asking price of $250 is prohibitive and that a much-lower priced softcover edition is needed. Until then, every institution, facility, agency and clinic should possess at least one set.

Dangerousness Concisely

The Concise Guide to Assessment & Management of Violent Patients, Kenneth Tardiff. (1989: American Psychiatric Press, as above).

This latest addition to the Concise Guides Series (others include: Somatic Therapies, Group Psychotherapy and Treatment of Alcoholism and Addictions) joins a series of volumes intended, we are told, to provide "practical information" on a level suited "for psychiatry residents and medical students" (and, therefore, probably low enough for

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most of us) and in a size "designed to fit into a lab coat pocket." For those who have never had the privilege of providing treatment in a white lab coat, the reference may not be fully appreciated. The important things to know are that in psychiatry, no one who is ever permitted to wear a lab coat is ever in danger of being sullied except by an errant Mont Blanc pen; those staff who are in fact likely to get mussed, such as nurses, are never permitted to wear them; the whiter the lab coat, the more anal retentive will be the personality and the lower the intellectual quotient of the wearer; and, finally, that the coats are never to be worn outside of the hospital, especially in large cities, lest the homeless mentally ill immediately flee in all directions at one's approach.

Carrying this book around in his or her lab coat pocket (always comfortably large) will permit the clinician to respond effectively to any violent situation. Thus, if a choke hold is attempted by the patient, quickly turn to page 21 before oxygen is cut off completely and find the instructions to "tuck chin rapidly" and "use force against patient's thumb." If one finds oneself in the midst of a terrified group of staff cowering in the face of an assault from the patient known on the ward for the ferocity of his violence, quickly turn to page 35 and find that "staff should gather around the leader with an image of confidence and control."

For those who like well-devised lists (remember the success of the various Books of Lists?), this book will be a treat. It is well-stocked with lists of important factors relating to violent patients (for example: Verbal Interventions in Emergencies, Doses of Medications Recommended in Emergencies of Violent Patients and Indications and Contraindications for Seclusion and Restraint) that can be easily grasped and remembered. The book is actually rich in helpful material for one so concise (only 118 pages) and the information is quite up-to-date. All in all, a book worth having. And if you keep it in your lab coat, kicks to certain parts of the anatomy will be defended against as well.

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I received a very nice letter from Reid Meloy, for which many thanks, but from the rest of you only silence, let alone any submitted reviews. How often do you need to wash your pick-ups or kick you know what off you know what? Well, the offer still stands and the address remains: 26701 Quail Creek, Suite 256, Laguna Beach, CA 92656. Foucault on the prison; Robert Simon's Review of Clinical Psychiatry and the Law with an article by the Psychiatrist-to-the-Stars and Born-Again Gun Advocate Park Elliot Dietz; and more. ❧

T-SHIRT OPPORTUNITY!

Get them T-Shirts while they're hot! We still have a good selection of T-Shirts from the Conference.

Pale blue short sleeve medium
short and long sleeve large
long sleeve extra large

Mint, peach, blue women's French cut (scooped neck)
small, medium, large, extra large

Short sleeved are $10, long sleeved $15, including postage. Please send your check to FMHAC in Anaheim. Attention: Anne-Margret Bellavoine ❧

IT'S A GIRL

Anne-Margret Bellavoine

Conference 1990: Anne-Margaret working at staying pregnant until after the Conference. Chris West in a supporting role.

Seems like deja vu - same headline two years ago, only it was a boy. Many of you who attend the Conference regularly have this vision of me being constantly pregnant. But it's not true. I was not pregnant last year, despite so many of you being sure about it. Alex was 2 years old on April 2. His sister Brigitte Monika Bellavoine (she has my last name, he has his Dad's), was born March 25, just 9 days after the end of the Conference. She weighed 8 lbs 12 oz and measured 20". Big baby! ❧

THE MENTALLY DISORDERED JAIL INMATE

Myra Sherman, MSW
Mental Health Program Supervisor
Contra Costa County Detention Facilities

There are many misconceptions about the mentally disordered jail population. The public is generally unaware of the increasing numbers of severely mentally disordered inmates in the county jails.

The mental health system views these inmates as personality disorders with long criminal and substance abuse histories. Many are regarded as untreatable and some mental health professionals would prefer to see these difficult patients locked-up forever.

To the custody staff responsible for detention, the mentally disordered inmate is viewed as a management problem who is frightening to both staff and other inmates. Viewing these inmates as sick and crazy, custody staff does not un-

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derstand why they are not in long-term locked psychiatric facilities.

The problem is a complex one with no easy solutions. The mentally disordered are often incarcerated for minor criminal offenses directly related to their psychiatric condition. The lack of community treatment, non-existent social supports and financial resources and an increase in substance abuse have all contributed to the increase in numbers.

In Contra Costa County all mentally disordered inmates are housed at the Martinez Detention Facility. This is the maximum security jail, serving the entire county. During the past year a 58 bed housing module has been designated just for the seriously and/or acutely mentally ill and this often is not sufficient.

A Case Example

GB is a 28 year old male who has spent most of the past three years at the Martinez Detention Facility. His charges are usually minor: trespassing, disturbing the peace and failure to appear are recurrent offenses. His pattern has been to spend 1 week - 3 months in custody, be released and within a week be back in jail.

With a diagnosis of paranoid schizophrenia GB responds to medication but refuses voluntary treatment, including prescribed medications. He is seen sporadically at the local mental health crisis unit.

Until two years ago GB lived with his family. However, during psychotic episodes, he has become assaultive and the family now refuses to have any contact with him. GB lives in the streets. He has become a heavy crack-cocaine user. He also abuses alcohol, amphetamines and marijuana.

In the past GB would be taken to the local psychiatric hospital by police when they found him in a floridly psychotic state. At present GB, if found by the police during a psychotic episode, is brought directly to the detention facility, charged with a minor criminal offense. GB will not accept voluntary community treatment. There seems to be no way to help him break this cycle.

Some Statistics

Almost half of all jail inmates receiving on-going mental health treatment in Contra Costa County are diagnosed as schizophrenic. The following statistics for January, 1990 are typical.

Number of jail inmates	1344
Number of jail inmates at the MDF (Maximum security: all mentally disordered inmates housed here)	809
Mental health caseload (on-going service)	115

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Fifty-four per cent of the above group have dual diagnoses of mental disorder and substance abuse. Personality disorders comprise 5% of the group, with schizophrenia, bi-polar, other affective disorders and adjustment disorders making up the rest.

Solutions

There is no real solution at present. There are few mental health community resources due to continued decreases in funding. In addition traditional treatment approaches are often not effective with this population.

Perhaps the first step is recognition of the problem by the local community. The mentally disordered should not be incarcerated because there is no other solution. Local jails should not become state hospitals. The mentally disordered jail population needs treatment and help. ❧

FORENSIC TRAINING PROJECT SAYS GOOD-BYE

Malina Kaulukukui, M.S.W

The Forensic Training Project, under its current organizational structure as a contracted service, ends June 30th. Beginning July 1st, the State Department of Mental Health will assume direct responsibilities for all state-wide training and consultation. Current thinking is to have training coordinated by State employees who will be based in the Forensic Services Branch in Sacramento. Rationale for this organizational change is tied to budgetary constraints faced by the Branch during the next fiscal year.

The Training Project staff, Charlotte Saito as program coordinator, Diane Serber, Malina Kaulukukui, and Marjorie Ricci, would like to take this opportunity to thank the Conditional Release Programs, State Hospitals, and other participating agencies for the interest in and attendance at the various training workshops over the past eighteen months. Evaluations from these workshops indicate that, overall, they have been very well-received, and also that participants expect a high degree of sophistication and expertise from trainers. This reflects the general stability of CONREP professional staff, who are becoming forensic mental health experts themselves.

We are confident that future training endeavors will meet the challenge of continuing to provide relevant forensic training to those of you who work with the mentally disordered offender. Thank you for your support and feedback in helping to make the Forensic Training Project a successful training experience. ❧

THE CURIOUS CLINICIAN

Donald T. Lee, MSW

In the last issue of THE FORENSIC FORUM I discussed some background of self-help and focused on Recovery, Inc, a major self-help organization for nervous and mental patients. Well ahead of most mental health professionals, in 1937 Abraham A Low, MD, was developing an extensive cognitive therapy system for his patients. Many clinicians outside the psychology field are less familiar with cognitive therapy but may recall that Eric Berne's work on Transactional Analysis and William Glasser's Reality Therapy are two approaches which have a high cognitive component. Albert Ellis with Rational-emotive Therapy and B F Skinner, J Wolpe, D Meichenbaum and others have written on cognitive-behavioral approaches. A most useful book on cognitive-behavioral interventions is Interviewing Strategies for Helpers by William H and L Sherilyn Cormier.

Cognitive therapy has some well-defined steps which I will "over simplify" for this column.

1. Therapist educates patient about stressful reactions. The patient is given a conceptualization about the symptoms and reactions experienced to the stress encountered. In this process the therapist 2. Breaks problems into small pieces. The patient is helped to sort problems and to identify components more manageable. The therapist 3. Re-labels the problems and re-frames them to present a different view for the patient. This process gives the patient a better grasp of his problems and tends to lessen the stigma associated with them. 4. Therapist teaches the patient how to use self-monitoring methods. This is a key to cognitive therapy as the patient must learn how to both identify the problem with new understanding and use self methods to overcome the problem. The patient must always be alert to these two components of self-monitoring. Therefore 5. The therapist coaches the patient in how to do this. The patient presents situations difficult to handle and the therapist coaches in the use of these methods to give proper labels and to apply the requisite solutions. In this process, the patient's ability to "self-monitor" is enhanced. 6. Therapist instructs the patient in applying these concepts in daily life situations. This is another major step where the patient must begin to apply what has been learned from past events to problems faced in the real world. The therapist then 7. Instructs the patient in process of giving self a reward for the use of the concepts and training. Unless the patient has some reward system, the learning process is negated or made exceedingly difficult. Reward which is given immediately after the task is worth far more than rewards given later. Self reward is doubly valuable as this builds self esteem in people who suffer from a deficiency of this asset. It serves to build a pattern where rewards from the outside world are less important that self-reward. 8. Therapist encourages and supports patient in telling how he/she was before treatment and how he/she is now in reacting to real life situations. The patient must be made to review in each situ-

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ation how the cognitive therapy approach has made a real difference. This is further support for the self-reward process and when done within a group builds group identification and helps new patients see changes in more experienced group members. In the group situation, the next stage is when 9. The patient takes on the role of teacher to others. This permits the patient to impart the cognitive therapy concepts to less experienced group members. To teach is to learn. Those who teach the method are the ones who gain the most for themselves.

What is the role of the therapist? The therapist has the responsibility to help patients initially identify problems and to effectively re-label them so the patient can begin to use the concepts being taught. (I have not included these concepts in the interest of space and time. The next issue will include several concepts.)

There is much individual work involved to get the patient properly coached during the early phase in the use of self-monitoring and self-reward processes for them to be effective. From this point on, the best learning is through group process. Group members can learn to help each other and this reduces "resistance" to the therapist. It also permits different types of patient to participate in group sessions. As we all know so well, it is awkward to work with schizophrenic, depressive reaction and character disordered patients in the same group. Cognitive therapy makes this possible and enables the therapist to have a group of three or four people instead of the traditional seven or eight. It will also work with more patients in the group than you could have with traditional group therapy. Probably 12 to 15 members is maximum.

Now, how does this fit in with Recovery, Inc? The work of Low was unique on both treatment concepts developed and in conducting group sessions. When he was starting he was the individual therapist for each of his patients and performed the points 1, 2, 3 and 4 above. As he formed groups of his patients he carried out points 5, 6 and 7 in the group meetings and individually. This combined individual and group method was particularly effective as, when he died (1954), this was not possible except where patients had other therapists willing to combine their individual work supported by the patient's attendance at Recovery meetings. Since his death, the Recovery group has been the authority, with his writings and recordings, as the framework in carrying out points 1 to 7.

He introduced several special concepts, to the best of my knowledge, not found in the writing of others. He had his patients only focus on "trivialities of everyday life." In part, this was to limit patient leaders of community groups from delving into complex issues and unconscious material which new patients might bring up. Equally important, was the insight which the "here and now" has for people. He wanted his patients to be concerned with the everyday real-

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ity which presented problems for them. He also know that no matter what complex issue or problem existed for any individual this was manifested in the microcosm of the triviality of daily life. The so called "trivialities of everyday life" are just the tips of the "unconscious iceberg." By focusing attention on these "tips" the work on the basic problems was also being addressed and done in a way which was not threatening. One of Low's concepts was to have patients "work on the weakest link, not the strongest." You do not try to break a chain at its strongest link, instead you try to break it at the smallest or weakest link. Trivialities of everyday life are also the weak links.

He formulated a wonderful self reward system which he called "self endorsement." The process is to give yourself a verbal pat on the back when - and here is the crucial point - you make an effort to use the method. This avoid the problem of rewarding success and creating a growing sense of failure in those who can't master the system initially. Even the most modest effort is worth "endorsing." Such self rewards can be given instantly when they do the most good. Self esteem is created each time the effort is made despite whether success or failure followed.

A third major part of Low's system was the method wherein "examples" are presented. Examples are those "trivialities of everyday life" reported on in group meetings or individually as illustrations of how the patient is trying to apply Recovery concepts to real daily life situations. Here we find a blending of the phenomonological approach of Samenow and Yochelson in their work, Criminal Personality. However, Low worked out the details and the process more carefully and effectively. It is a model of how to get patients to present problems in no more than five minutes with all the essential points of cognitive therapy covered.

Two years before Low died, he trained his patients how to establish meetings and start them throughout the country. In this way the full effect of 9. was utilized and patients became teachers of other patients.

In the next column some specific concepts of cognitive therapy as developed by Low will be discussed, including some suggestions for referring patients to meetings. ❧

1990 Conference Planning committee: Alisa Dunn and Elizabeth Weatherford seated, Tim Meehan and Raul Espinoza standing, Tony Streveler hiding.

JOB OPPORTUNITIES

STAFF PSYCHIATRISTS

The University of California, Davis, Medical Center, needs psychiatrists to staff a 14 bed acute inpatient unit inside Sacramento's new generation jail. University clinical faculty appointment. University paid professional liability. Competitive salary and liberal benefits. Part-time psychiatrist positions are also being recruited. Equal opportunity employer. Call Will H Green, MD, Clinical Director. 916-440-5222

CLINICAL PSYCHOLOGISTS

The Department of Mental Health has 2 full time and one half time openings for clinical psychologists to work in an exciting new psychiatric program at the Correctional Medical Facility at Vacaville. In addition to assessment and therapeutic intervention, there will be opportunities for the psychologist in program development and evaluation, staff training, coordination of clinical services, and research. Supervision toward licensure and a neuropsychology seminar are available.

Interested applicants should send a vitae and letter of interest to: Linda Young, PhD, at DMH Psychiatric Program - Vacaville, PO Box 2297, Vacaville, CA 95696, or telephone 707-449-6504. ❧

WRAP-UP
15TH ANNUAL TRAINING CONFERENCE

Timothy Meehan, MSW
Director for Conference

The Conference is over and it was GREAT! I felt it, several people commented on it, and the evaluations confirmed it.

I want to thank the Planning Committee for all of their work. The Committee was composed of Elizabeth Weatherford, MD, Raul Espinoza, MHA, Anthony Streveler, MSW, and Alisa Dunn, MSW. Alisa will be the Director for Conference Planning for next year. With Alisa, I am positive that next year's Conference will be an excellent one. I am already planning to go.

I especially want to thank Anne-Margret Bellavoine, FMHAC administrative assistant, and her daughter Brigitte. Brigitte decided to make her appearance 9 days after the Conference. (And you thought Conference planning only involved workshops and food!)

I also want to thank all the others who helped shape the Conference. There were a lot of you and if I listed you this would become an Oscar speech. It is important to recognize that the Conference is created over again each year, and there are a lot of people who participate in making it the wonderful experience it is. The Director for Conference Planning receives the applause for the many who contribute.

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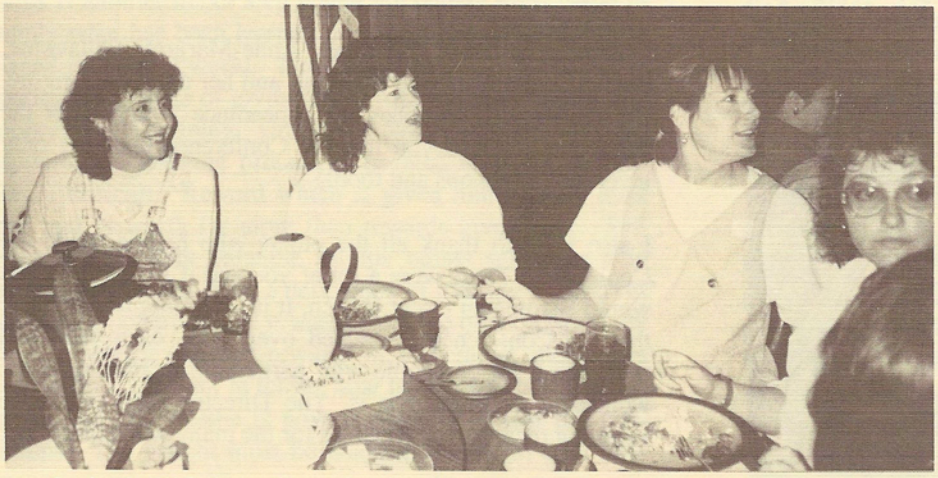
I have received the applause for two years in a row and I have enjoyed it - both the experience and the applause. I encourage others to work on the Planning Committee and to take on the task of Director for Conference Planning. It is a great way to meet people in the field and to have an effect on the kind of Conference we have. For those of you who want more from the Conference, consider becoming involved in the planning. It is a rewarding experience.

Now, on to the heart of the Conference wrap-up. We had about 611 attendees this year (about the same as last year.) The breakdown looks like this. (Remember that some people fit into more than one discipline.)

Social Workers	147
Nurses	84
Psychologists	71
Psychiatric Technicians	52
Medical Doctors	43
Marriage, Family, Child Counselors	26
Rehabilitation/Recreational Therapists	23
Parole Agents	12
Attorneys	8
Guests	45
Faculty	15

We received 117 completed evaluation forms. The overall response was that the Conference was very good: informative, diverse, and fun. It appears that most of you like the workshops and feel that they are steadily improving. Some problems continue to plague us. The size of the workshop rooms is too small; it is difficult to hear in the larger rooms. In order to continue to have the Conference at Asilomar, some new and creative ideas are needed to address these problems.

The possibility of a four day Conference is well received (2 to 1) for those who completed the questionnaire, but that response represents only about 20% of the attendees. The FMHAC Board would appreciate knowing your opinion about the length of future Conferences.

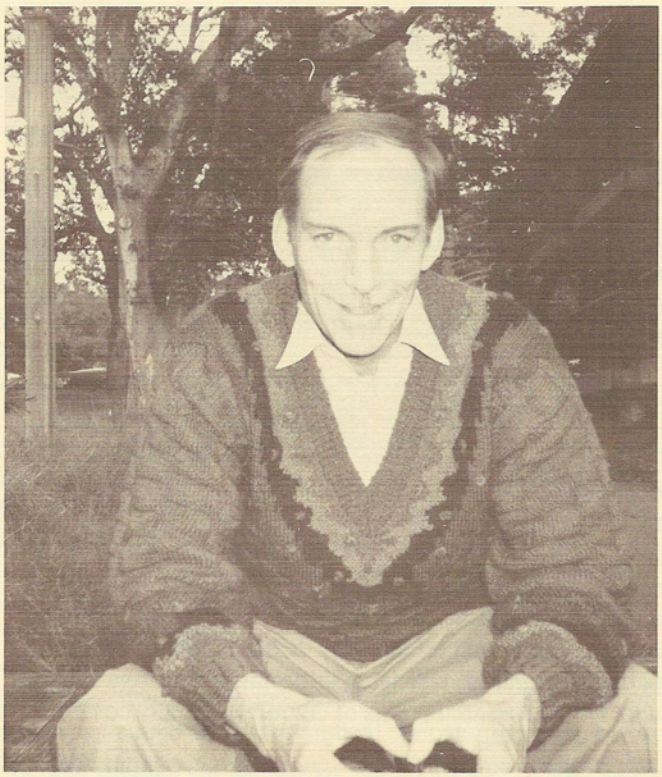


Lunch at the 1990 Conference: these people are happy because they didn't wait their turn to go through the serving line.

GRANT UTE RETURNS!

Since the establishment of the Northern California Regional Office in 1985, there have been six Northern California Regional Managers for the Forensics Services Branch. Three of them have been Grant Ute. For those of you who are keeping track: Grant Ute, Jack Herrera, Grant Ute, Louie Beerman, Grant Ute and Jane Woehl. Grant again accepted the (hopefully permanent) position in August, 1989.

Grant began his career with the State in 1972 as a Psychiatric Social Worker at Napa State Hospital. He became a



Grant Ute, in a characteristically thoughtful pose

supervising psychiatric social worker in 1978 with the Community Services Section (OMHS). In 1980 he took a position as program analyst for the Bay Area Service Team. It was in this capacity that he started working on the 1229 PC program review in the latter part of 1983. Grant, Elsie Lu, Rick Mandella and Bill Rossiter formed the team that would conceptualize, design and implement the statewide Conditional Release Program (CONREP).

The team spent approximately one and a half years researching 1229 PC programs. Grant defined the goal of the research as a "search for the best" of the 1229 PC programs. "We took the best of all the operating programs and designed a model and a standard of

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care and practice based on excellence...We saw what worked and what didn't, and we were able to take the best and make that the expectation."

The idea of building a system from the ground up was one of Grant's reasons for entering the forensic field. After working in the Short-Doyle/LPS (Community Mental Health Services) system, he stated that he saw forensics as a challenge. "If we can design programs to work with the most difficult to treat patient population, then we can really accomplish something." Grant stated he realized that if a program with a coherent philosophy of treatment and supervision was developed then resources would be made available to fund and implement the program.

Grant identified fiscal constraints and a non-expanding client population as this year's most pressing issues for the Conditional Release Programs. He noted that these issues will demand some re-focusing and setting of priorities. CONREP was conceptualized as a caseload driven model, wherein the funding follows the patients and their level of acuity and need. The unanticipated drop in 1026 PC commitments, the predicted trickle of Mentally Disordered Sex Offender patients, and the problems with the implementation of Mentally Disordered Offender program have prompted a new goal: to find other forensic patients that will fit into CONREP's treatment and supervision model.

Last year Grant served as Acting Branch Chief for Forensic Services for a ten-week period. He describes his limited tenure as a great opportunity (he actually described it as "really neat" - but editorial license was employed), "I was able to get an idea of what it would be like to manage an entire program from start to finish...It was a critical ten weeks for me, I was very fortunate...I enjoyed working with the program and the staff was great...They really wanted the position of Forensic Services Branch Chief to work and they were very supportive and helpful.

After his tour as Forensic Chief, a few other side trips through Forensics, Tahiti, and a brief stint as a retiree, Grant says that he is glad to have been thoroughly rehabilitated and glad to be back at the Northern Regional Office. He cites his staff, John Kincaid and Joan Roth (consulting psychologists), Jane Woehl (fiscal officer), Heather Chiappuzzo (office manager), and Tim Meehan ("Main Man"), and the continued challenge of Forensics, as the reasons for his readiness to resume his role as the Northern Regional Manager.

Grant sees the upcoming year as a time to "begin again - to go out and continue the process of learning from the programs, to take and use what is the best and make it the standard." ❧

ALISA DUNN

Director for Conference Planning

Alisa Dunn received her MSW from Fresno State University in 1980. Her career with the state began at Metropolitan State Hospital, from which she transferred to the MDO unit of the Los Angeles Office of Mental Health Service in 1981. She has been with this unit since, in various capacities, and as the unit has undergone transformation from a state unit to an LA County unit. Her assignments have included placement work with men and women from state hospitals and jails, and with the aftercare providers for these people. In 1986 she became the supervisor of the unit. She has also been the Coordinator of the Homeless and Court Diversion Program, and the Coordinator of the Arraignment Court Diversion Program. Currently she is Acting Clinical Program Director for the Forensic Aftercare Unit, Los Angeles County. For the last 7 years she has conducted LCSW and MFCC training workshops for the Association for Advanced Training in the Behavioral Sciences.

Alisa has formed her Planning Committee for the 1991 Conference. Returning to the Committee are Elizabeth Weatherford MD and Raul Espinoza MHA. They are being joined by Dave Polak MSW from Santa Cruz County and Grant Ute MSW, who is celebrated elsewhere in the FORUM. Alisa has organized a number of excellent ideas for the Conference, and we will keep you informed as the theme becomes firmly established. Alisa is appreciative of the numerous offers of help and participation, and in order to capture as much help as she can, she is forming an ad hoc committee of representatives from all over the state to assist with Conference activities in many different capacities. If you are interested in being part of this committee call Alisa at 213 974 6658 or at the Association number, 714-283-2104. ❧

Alisa Dunn, Director for Conference Planning

UPDATE ON JUVENILE OFFENDER TASK FORCE

Laura Werner, MSW / Task Force Chair

As some of you are aware, in early 1989 there was a subcommittee formed of the Forensic Coordinators Outpatient Committee, called the "Juvenile" Task Force. The Task Force met February 14 and March 30, 1990 and I would like to take this opportunity to bring you up to date on our activities.

The idea for potentially serving a juvenile population was originally discussed in a concept paper submitted to the Forensic Coordinators in 1989. At that time, the goal was to present the idea of serving the juvenile and his family. As we have progressed it has become evident that the most likely population to initially receive services from CONREP might be the California Youth Authority (CYA) parolee.

There are a number of reasons which make the CYA parolee a good test group for a pilot study. There are a significant number of disturbed clients in the CYA: that is, clients with an Axis I diagnosis. The CYA has identified and provided special inpatient programs for these psychiatrically disturbed young people which include 100 beds. There are 132 identified "ITP" (Intensive Treatment Population) inmates. There is a waiting list of about 30 clients within the CYA for this intensive inpatient program at any one time. Approximately 70 clients annually are released directly from the ITP programs to parole, often with few or no after care services. This is the population that most closely resembles our Axis I clients within the CONREP program. This would be the most likely group to serve in a pilot project. When the idea was originally discussed between the CYA and the Department of Mental Health (DMH) it was discussed in terms of three pilot projects existing within three CONREP programs. Because the CYA is a state agency, facilitation and coordination could be simplified.

In their Treatment Needs Survey of April 1, 1988 the CYA identified nearly 30% of their nearly 9000 wards and residents as needing specialized treatment services. Part of that group is the intensive treatment population as described above. Others included are sex offenders and other wards and parolees with specialized counseling needs. At this time the Task Force is advocating for the establishment of an inter-agency committee, to be comprised of members of both the CYA and the DMH Forensics Branch, to continue discussion of CONREP serving some of the mental health needs of CYA parolees. Task Force members have also volunteered to be part of this inter-agency committee. Clearly, if discussion does go forward, this committee will have to examine funding, the logistics of a bifurcated approach to supervision and treatment, and program development. The Task Force has, by correspondence, continued

(Continued from Column 1)

to advocate for preliminary discussion to take place.

In closing, one word regarding the term "juvenile." When I agreed to chair this Task Force in early 1989, it was. under the guise of developing services to "juveniles." Actually, "juveniles" is defined by law as any person less than 18 years of age. Most of the young people admitted to the CYA are older than we might imagine. The mean age of admission is between 17 and 19 years old and the average age of the CYA parolee is 21.2 years. This was a realization for me as I had been informing everyone of the "juveniles" that we might serve in CONREP. The facts are that these people are mostly over the age of 21 upon release from the CYA. Developing programs for these older youthful offenders would appear to minimize the complexities of serving a young, "juvenile" population.

The Task Force will continue to advocate for services to this population. We feel that these parolees offer a reasonable population base for CONREP to consider. Additionally, we know CONREP's services are high quality and CONREP clients have significantly reduced recidivism rates. This increases public safety, which is the primary goal of these programs. ❧

Do you have an article that would be of interest to the FORUM readership?

Articles may be submitted tot he editor at the association's address. See the article on job openings for publishing deadlines and dates.

EDITOR'S NOTES

On April 16, 1990, George Bergstresser, a long time and well-beloved employee at Atascadero State Hospital, was killed by a patient. Bergie's death has had a profound effect on us and we are struggling with feelings of depression, helplessness, anger and fear. My own sorrow is such that I can hardly find the words to write this. We can be certain that Bergie's death will leave its mark on us in many ways, as well it should. Knowing the kind of loving, accepting, thoughtful man Bergie was, I hope that we honor him with a struggle that unites us, not divides us, and that the mark that is left upon us will enlighten us and make us safer in our work. ❧

DO YOU HAVE A JOB OPENING?

THE FORENSIC FORUM is printed as a service to members as an educational and information resouce. The Board believes one important service the FORUM can provide is to share information about open positions in forensic mental health. We encourage submission of information about job openings to Grenda Ernst, Editor, at the Association address. Each position listed should include contact information so that respondents can contact the advertiser directly rather than going through the Editor or the Association office. Inclusion of information about the job title/duties, geographic location, and salary and benefits is helpful in attracting responses to ads. THE FORENSIC FORUM is published on a quarterly basis. The deadlines for submission of information are January 15th, April 15th, July 15th, and October 15th. Address job announcements to Grenda Ernst, Editor, Forensic Forum, 6312 Santa Ana Canyon Road, Suite 123, Anaheim Hills, California 92807. ❧

Happy Conference-goer about to gratify herself with a tee shirt

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(Detach and Return)

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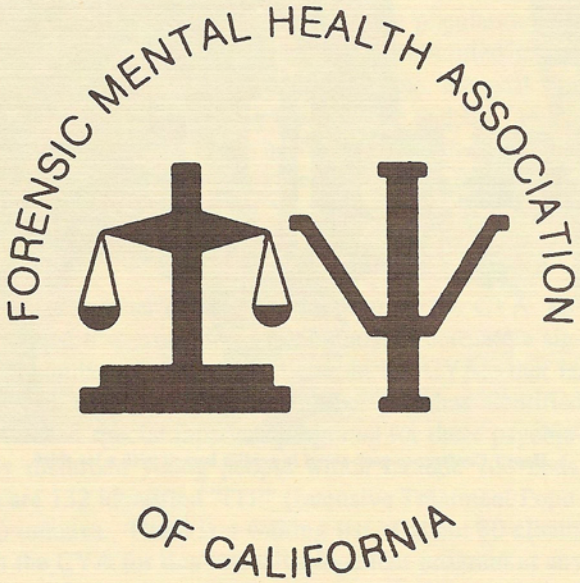

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