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# The State of Commitment:
# An Embedded Ethnography of Court Mandated Psychiatric Treatment
# at a
# Forensic Hospital

By

Renee Mack

A dissertation submitted in partial satisfaction of the
requirements for the degree of

Doctor of Philosophy

in

Social Welfare

in the
Graduate Division
of the

University of California, Berkeley

Committee in charge:

Professor Tina Sacks, Chair
Professor Jonathan Simon
Professor Laura Abrams
Professor Erin Kerrison

Fall 2020

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Abstract

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Renee Mack

Doctor of Philosophy in Social Welfare

University of California, Berkeley

Professor Tina Sacks, chair

Background: This study explores the relationship between hospital organization, therapeutic treatment, and court commitment for persons with mental illness at a California state forensic hospital. I structure the narrative of this dissertation in the context of psychiatric institutionalization (and deinstitutionalization), mass incarceration, and welfare retrenchment for clarification, grounding, and to explain the known interactions between the criminal justice and mental health systems for persons living with mental illness. The criminal justice system is the primary point of contact for many individuals with severe mental illness; therefore, it is necessary to understand how individuals gain access to long-term psychiatric treatment within the criminal justice system via the state hospital system, the terms to which they are committed, and the types of psychiatric treatment they are entitled to based on those terms. As pressing an issue as this is, little is known about the psychiatric treatment provided to persons that are civilly and criminally committed outside of the state hospital system and little critical inquiry is extended to the interdependent nature of the criminal justice and state hospital systems in California.

Method: This dissertation is an institutional ethnography that uses a mixed method design. It follows in the long tradition of institutional ethnographies by examining a hard to reach population in a locked forensic facility. The administration of this study included intensive, close-up observations and interviews in addition to accessing agency documents, reports, and implementing a survey of patient satisfaction. As an embedded ethnographer and employed social worker, I had access to multiple sources of organizational documentation, including administrative directives, internal notices, and training materials. As a result of my direct employment and position as a doctoral researcher, I attended daily treatment team meetings, therapeutic treatment groups, monthly program meetings, and department meetings, in addition to bioethics, program review committee meetings, pain management, and mortality review committee meetings. The qualitative data were analyzed in an ongoing and iterative fashion throughout the data collection period for thematic connections. Additionally, the mixed methodology and multiple data sources allowed for triangulation and clarification as unexpected hypothesis emerged over the course of this study.

Findings: The findings from this study are based on four years of direct observation; semi-structured interviews (N= 62) with psychiatric patients, front-line

clinicians, and hospital administrators, and an analysis of patient satisfaction survey data (N=611). After examining the psychiatric treatment and care provided to patients mandated to treatment at the state psychiatric hospital, I determined that patients at the hospital that are committed as not guilty by reason of insanity receive more opportunities for therapeutic treatment, recreation, leisure, vocational training, and educational opportunities. Patients committed as not guilty by reason of insanity are more satisfied with their overall treatment and care in comparison to patients who are incompetent to stand trial, or patients who are civilly committed due to a grave disability. In contrast, patients deemed incompetent to stand trial receive psychiatric treatment that is solely based on trial restoration competency and ignores other psychiatric and medical needs. Further, administrators, clinicians, and patients all expressed frustration with the treatment provided to patients found incompetent to stand trial, asserting that trial competency restoration treatment did not amount to the comprehensive standard of care they want to provide or receive, nor did trial competency restoration treatment adequately meet the needs of the population committed as incompetent to stand trial; lastly, clinicians and administrators disliked or feared the societal use of the incompetent to stand trial commitment as a mechanism for providing mental health treatment, often describing the phenomenon as a failure of community mental health systems and asserting a need for more comprehensive welfare services in the community. Remarkably, during the data collection period, the hospital received a mandate from the courts to accelerate the treatment of patients found incompetent to stand trial threatening the precarious balance of treatment at the hospital and strengthening the implications of the study's findings.

Discussion: The findings in this study have implications for scholarship across the domains of law and society, community mental health practice, organizational studies, and policy research, suggesting the need for further investigation and promotion of mental health policies that are independent of the criminal justice system. This study provides new information about the nature of mental health treatment within the criminal justice system and important insights into the accessibility of effective or comprehensive mental health treatment in the community. This dissertation is based on a single case study. More studies are needed that use the critical lens of commitment and court regulation to understand the accessibility and production of therapeutic treatment for persons with mental illness and how judicial thinking shapes the nature and distribution of psychiatric care.

I would like to acknowledge and dedicate this dissertation to all persons with mental illness who cannot find the treatment and care they need in the community, and to all persons who attempt to shift an unacceptable status quo.

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# Chapter I. Introduction

> *So, my theory is…* [that] *post recession, the great recession, whatever threads were holding people in their communities, whatever case manager, or housing stipend, or whatever* [it was]*, got cut in the wake of the recession. And what we're seeing now … is an individual who's unsheltered, who's untreated, it's kind of the after effect of all of that. And we get them after…nature takes it course, and they get that felony charge… They've been in this sort of downward drift, post recession. And that's why we see this huge spike, it's because there's just a large group of people who lost whatever was tethering them in their community. That's my hypothesis. We talked to people all over the country all the time, and there's no one out there proving* [it]*, but we have enough data points, so we can kind of put it together, to put enough puzzle pieces together where that hypothesis is supported.*
>
> –Female administrator, 14 years experience

Behind locked doors and barbed wire fences, there are lived experiences that are going overlooked and under analyzed from a critical perspective of social welfare. All too often, under resourced persons with mental illness attempt to navigate the dark roads of welfare and mental health only to find treatment and often shelter within the criminal justice system. Reconsidering the current relationship between the criminal justice system and the state hospital through the long lens of welfare disenfranchisement, a clearer picture of metaphorical 'revolving doors' and 'dead ends' begin to emerge. Understanding the extent to which society has currently abandoned persons with mental illness not only reinvigorates the hoarse cry for community mental health treatment, but demands additional welfare resources that attend to substance use issues, housing, medical care, and occupational needs as policy implications for criminal justice reform.

As mentioned above by a knowledgeable administrator, the constant onslaught of disinvestment in welfare and mental health services are stressing and overwhelming the state hospital system, which is a specific, yet telling, outpost of the larger carceral system. Nevertheless, since deinstitutionalization and the rise of mass incarceration little attention has been paid to how this important system is continuing to operate and provide treatment to patients. In contrast, significant attention has been given to the economic, social, and racial inequities produced by mass incarceration and the disproportionate number of persons with mental illness in the criminal justice system. More specifically, few studies have had the opportunity to compare the forms of psychiatric treatment provided to individuals within the criminal justice system based on court mandated commitment nor has there been a large scale data survey that determines patients' levels of satisfaction with the types of treatment they are receiving once they are in this system.

## Purpose and Study Aims

The purpose of this study is to unearth the experiences of persons committed to court mandated psychiatric treatment at the state hospital. Privileging the experience of the patients, this study also considers the perspectives of frontline clinical staff and administrators. Insights from the study deliver not only a comprehensive understanding of the different psychiatric treatment options available to patients based on commitment type,

but also the impact of providing court mandated treatment on the patient, the clinical staff and the ethos of the hospital including what it is like to receive and provide psychiatric treatment that is under the direction of a legal mandate. This study carefully considers and contextualizes the institutional relationships between the hospital and the criminal justice system as well as the organizational and programmatic needs of the hospital.

Originally, the goals of the study were to explore the differences in treatment provided to persons involuntarily committed to psychiatric care at the state hospital based on commitment type. The study uses qualitative in-depth interviews and participant observation in conjunction with quantitative patient satisfaction survey data and institutional data of therapeutic treatment groups. The study sought to determine and understand how patient satisfaction with treatment at the hospital varies based on commitment type and the ways in which the individual, mezzo, and macro levels factors shape and constrain the available treatments vis-à-vis commitment. During the data collection process a new court mandate was implemented at the hospital[1]. This event changed the original aims of the study to focus and better understand the multi-level implications of a court ordered emphasis of treating patients found incompetent to stand trial within the hospital. The current study is an exploration of psychiatric treatment as an apparatus of the court within the state hospital system.

The research questions that guide the analysis of this dissertation include:

1. What is the organizing principle of California's state hospital system and Napa State Hospital specifically?

2. How does the organizing principle impact the type of therapeutic treatment provided to patients?

3. How satisfied are patients with the treatment and care they receive at Napa State Hospital? Are there differences in patient satisfaction based on commitment?

4. How do patients, clinicians, and administrators perceive the experience of receiving and providing psychiatric treatment based on court ordered commitments?

The study aims to expand the general understanding of how mental health treatment is provided within the state hospital system in relationship to the criminal justice system. Due to difficulties in access, this lens of analysis has been overlooked in both critical legal and social welfare literatures (Rhodes, 2001; Wacquant, 2002). The literature on mental health treatment in the criminal justice system mainly focuses on the psychiatric treatment provided within the jails and prisons and characterizes it monolithically, however there is an entire network of unique mental health treatment options provided to persons with mental illness based on court commitment. More specifically, mental health treatment

[1] Stiavetti v. Ahlin (State Hospital Suit) The ACLU Foundation of Northern California filed a lawsuit against California's

for persons who are not guilty by reason of insanity may consist of substance abuse treatment, dialectical behavior therapy, sex offender treatment, and individual therapy. By contrast, people who are incompetent to stand trial, receive comparably less intensive services and receive treatment solely focused on trial competency restoration. As such, persons receiving and providing this treatment are obliged to implement and navigate treatment in accordance with court requirements and this lens of analysis is being overlooked. To that end, this study examines the experience and relationships of clinicians, administrators, and court mandated psychiatric patients to: the state hospital, the criminal justice system, the community mental health system, and to each other.

## TERMINOLOGY

Merriam Webster defines forensic as "belonging to, used in, or suitable to courts of judicature or to public discussion and debate" (2016). The nomenclature at Napa State Hospital uses the term forensic to refer to patients who are criminally committed; however this is technically incorrect as it improperly distinguishes between civilly committed and criminally committed psychiatric patients. For the purposes of this dissertation, I use the term forensic to refer to any psychiatric treatment mandated through the court system, which includes all criminal and civil commitment types. I use the term civil commitment to refer to patients mandated to psychiatric treatment through civil commitment procedures (e.g. Lanterman Petris Short (LPS), etc.) and the term criminal commitment to refer to patients mandated to psychiatric treatment through criminal commitment procedures (e.g. Penal Code 1370 Incompetent to Stand Trial, Penal Code 1026 Not Guilty by Reason of Insanity, etc.). This study also uses trial competency and competency restoration interchangeably to describe the treatment provided to patients committed as incompetent to stand trial.

Throughout the dissertation both Napa State Hospital and DSH-Napa are used interchangeably to refer to the specific state hospital providing psychiatric treatment and medical care in Napa, California. Additionally, the state hospital system and California's Department of State Hospitals (DSH) are used interchangeable to refer to five interrelated state hospitals still operating in California which include state hospitals in: Napa, Atascadero, Coalinga, San Bernardino County (Patton), Los Angeles County (Metropolitan); and the administrative headquarters in Sacramento.

Lastly, according to the National Institute for Mental Health the terms severe mental illness and severe and persistent mental illness are both commonly used to refer to "mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability" due to a mental illness (2019). Typical mental illnesses treated at Napa State Hospital include schizophrenia, schizoaffective disorder, bipolar disorder, unspecified psychotic disorder, major depressive disorder, borderline personality disorder, and co-occurring substance use disorders; less common mental illnesses treated at the hospital are antisocial personality disorder, neurocognitive disorder, and paraphilic disorders. Mental illness, severe mental illness, and severe and persistent mental illness are used throughout the dissertation. Any specific reference to a psychiatric disorder will use the taxonomic definition included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (APA, 2013).

## CHAPTER II. HISTORICAL CONTEXT

The Twentieth century saw dramatic shifts in societal attitudes towards welfare, punishment, and institutional care, which resulted in three interrelated phenomena known as *welfare retrenchment*, *mass incarceration,* and *deinstitutionalization.* Although seemingly separate or antagonistic in their origins and definitions, all three policy shifts have influenced and shaped one another and continue to have an enduring impact on social order and the ways in which psychiatric and penal institutions operate. Today, the current relationship between the hobbled state hospital system after deinstitutionalization, and the overused criminal justice system due to mass incarceration, recasts the two institutions as interdependent instruments of the *carceral state,* which are then fortified by a societal reluctance to provide welfare services to vulnerable, marginalized, and under resourced persons.

To be clear, deinstitutionalization refers to the specific process of closing public or state hospitals which housed the country's psychiatric and developmentally infirmed population in order to treat them in less restrictive community settings. More broadly, deinstitutionalization, as a term, captures the evolution of mental health care in the United States since the 1950's with regard to purpose, practice, course, and structure; detailing a system that primarily provided psychiatric treatment in large centralized hospitals to a system that provides treatment in a wide variety of health care settings, geographic locations, and ultimately correctional facilities.

Retrenchment or welfare retrenchment is described as a reduction of welfare state generosity. Retrenchment can take the form of lowering the level and or the conditionality of welfare benefits for the elderly or persons experiencing unemployment, underemployment, illness, and disability and gained political popularity in the 1970's. Policy scholars in social welfare argue that welfare retrenchment was actively promoted by an alliance of low-wage employers, politicians, the Christian right, and anti-immigrant organizations that were linked by conservative ideology; these groups gained public support for welfare reform (retrenchment) policies by exploiting an emotionally powerful discourse, which appealed to racist stereotypes of the poor; public anxieties about crime, unwed mothers, and drug addiction; and broadly held values of individualism and meritocracy (Reese, 2007; Schumacher & Vis, 2011).

The carceral state as a scholarly term is often connected to French theorist Michel Foucault, who considered "the carceral" as a mode of power that is a fundamental component of Western authority, using austerity and captivity as a form of control in prisons, asylums, schools, and archives (Foucault, 1967, 1977). In today's context, the carceral state is often narrowly connected to one form commonly discussed as mass incarceration, which refers to the extreme rates of imprisonment seen among Black American men from disenfranchised communities. This shocking spike in the prison population roughly began in the 1970's and has since cauterized the prison-industrial-complex that continues to reinforce the economic dependence on prisons and community surveillance (Berk, 1998). However, some scholars continue to consider the wider use of the term to explore a longer historical time period and a variety of institutions of control including probation, welfare, and psychiatric institutions (Gottschalk, 2008; Parsons, 2018; Simon, 2007a). It is this broad understanding of the carceral state, which incorporates both

psychiatric, welfare, and penal institutions, which I use throughout the dissertation as well as the terms deinstitutionalization, welfare retrenchment, and mass incarceration.

In this chapter, I trace the origins of institutional care and institutional punishment to help delineate the fuzzy boundaries between rehabilitation, punishment, welfare, and tolerance to explain how persons with mental illness are funneled into networks of legal and forensic channels within our current system and the tension this creates in providing psychiatric treatment and care in three parts: Part 1, Institutionalization and Deinstitutionalization, briefly details the known history of psychiatric institutionalization; Part 2, The Rise of Penal Institutions, briefly details the known history of prisons and mass incarceration; and Part 3, California's Mental Health and Criminal Justice Systems explains the current relationship of both institutional systems in California. This endeavor is based on the genealogical approach advanced by Foucault that considers interconnected and counter-histories as well as the position of the subject by following the development of people, attitudes, and societies through history; according to Foucault, genealogy is not the search for a single origin, nor is it the construction of temporaneous developments, rather it is the pursuit of a plural and occasionally contradictory past that reveals a multidimensional account of reality and the truth (1975, 1980, 2003).

## PART 1. INSTITUTIONALIZATION AND DEINSTITUTIONALIZATION

### *Early Institutions*

Although people have suffered from mental illness or been deemed 'mad' throughout civilizations, how and where people with mental illness are treated and cared for is often a reflection of society's tolerance and understanding of aberrant behavior. For example, the first formal institutions or asylums for persons with mental illness are considered to originate during the Fifth Century in the Middle East (Scull, 2015); however, most persons suffering from mental illness in Colonial America were cared for within the home or community mirroring the attitudes and technologies of the times (Grob, 1983, 1994; Rothman, 2002; Scull, 2015). Within the United States, the beginning of institutionalization can be traced back to industrialization, activism, and the American Civil War.

As the United States began to industrialize, which fundamentally changed the structure of work, family, and community, mental health treatment moved from the home to the asylum. Urbanization in the Eighteenth Century broke down traditional pathways of community welfare in the United States, ultimately illuminating a visible proportion of persons with mental illness in noticeable need of care. In 1752, Quakers in Philadelphia made an organized effort to care for persons suffering from mental illness, dedicating rooms within the Pennsylvania Hospital in Philadelphia specifically for patients diagnosed with psychiatric illnesses and eventually opening the Pennsylvania Hospital for the Insane. Similar facilities in Virginia, New York, and Massachusetts emerged shortly thereafter.

These first institutions were relatively small and offered individualized care to patients and followed a therapeutic program referred to as "moral treatment," which attempted to improve patients' lives through exercise, religious training, hygiene lessons, and recreational activities like journaling and music (Grob, 1983, 1994; Rothman, 2002; Scull, 2015). In addition, psychiatric hospitals also relied on medical treatments like bloodletting and cold baths. Remarkably, some

elements of this moral treatment, namely the recreational activities, endure to this day and are considered appropriate therapeutic treatment for persons with mental illness.

*The Rise of the Psychiatric Institution*

As the urban population continued to grow so did the need for facilities to house and treat persons with mental illness. This rapid increase in need restricted the ability of psychiatric hospitals to effectively administer moral treatment and these institutions were no longer able to provide effective therapies. At this point, the first wave of criticism surrounding psychiatric treatment within psychiatric facilities began with many condemning the deplorable conditions patients were forced to live in and decrying the abuse and neglect patients were often subjected to (Grob, 1994; Rothman, 2002; Scull, 2015).

Early in the history of institutions, persons with mental illness came into contact with the jails and prisons. In the 1840's, Dorothea Dix was instrumental in founding and expanding psychiatric hospitals for persons with mental illness after witnessing many persons with mental illness being ill-treated at the East Cambridge Jail in Massachusetts (Grob, 1994; Parry, 2006). Appalled by the living conditions in the jails, almshouses, and over crowded asylums, she began lobbying state legislatures to build more psychiatric institutions to remedy the crisis (Appelbaum, 1994; Grob, 1991; Parry, 2006). This new wave of institutionalization was a great relief to many families and communities that felt overwhelmed and burdened by the task of caring for relatives or community members with mental illness. Although popular with constituents and congress, President Franklin Pearce denied federal funding in 1854 for land to build a federal asylum. Importantly, this veto set a precedent that the states, and not the federal government, are responsible for providing psychiatric care. Despite this setback, Dix continued to travel throughout the United States in the 1850's and 1860's bringing attention to the plight of persons with mental illness and by the 1870's almost all states in the Union had at least one asylum funded by state tax dollars, cementing the fiduciary relationship between state hospitals and psychiatric treatment.

The American Civil War (1861-1865) also contributed to the rise of psychiatric institutions in the United States. Many soldiers suffering from postwar trauma were sent to state asylums for care. Seen as extremely deserving, the American public displayed genuine interest in their treatment and care and a state or tax-funded institution seemed the most appropriate environment for their rehabilitation. With its increasing credibility and acceptance, the institutionalized patient population rapidly increased. Over time, this surge in the population overwhelmed the treatment capacity of the asylum and reignited the use of restraints and spurred modern psychiatric therapies like electroconvulsive shock treatment and frontal lobe lobotomy as a means for treating and controlling the patient population (Grob, 1983; Scull, 2015). As time went on during the nineteenth and early twentieth century, state psychiatric hospitals became chronically underfunded, understaffed, and the treatment of patients deteriorated once again drawing criticism from journalists, researchers, and activists effectively prompting the phenomenon of deinstitutionalization (Grob, 1983; Mechanic, 1969; Torrey, 1997)

*Deinstitutionalization*

Deinstitutionalization is the general policy name given to the process of removing long-stay psychiatric patients and persons with developmental disabilities from isolated government-run psychiatric hospitals to community mental health services (Lamb & Bachrach, 2001; Turner, 2004). Sociologists like Goffman argued that psychiatric institutions maintained or created dependency, passivity, exclusion, and disability, which caused people to perpetually remain in a state of institutionalization (1961).

These critical observations of the treatment of patients followed the introduction of chlorpromazine also known as Thorazine in 1955. Considered the first effective antipsychotic medication, Thorazine was thought to be able to significantly curb the maladaptive behaviors associated with some of the most debilitating and stigmatized psychiatric disorders (Torrey, 1997). The advent of an effective psychiatric drug in addition to the findings of researchers and journalists fueled the main argument for deinstitutionalization: simply put, it is more humane to serve people with mental illness in the community than in a larger isolated inpatient hospital setting. In addition, proponents argue that community-based services can be provided more effectively, at a lesser cost, and be less of a constraint on personal liberty.

In place of institutionalized care, community-based mental health care was conceived. The term community-based mental health now refers to a range of treatment options including community mental health centers, smaller supervised residential homes, and community-based psychiatric teams (Appelbaum, 1994; Fakhoury & Priebe, 2007; Grob, 1991). In 1965, funding from the federal expansion of Medicaid[2] and Medicare[3] accelerated and codified the implementation of deinstitutionalization and the number of persons with mental illness in state psychiatric institutions dropped from its peak of 560,000 to 72,000 patients in 1994 (Grob & Goldman, 2006; Langan et al., 1988; Mechanic, 1969; Torrey, 1997). By 2000, the number of state psychiatric hospital beds per 100,000 people was 22, down from 339 in 1955 (Morrow et al., 2008; Novella, 2010). Ultimately, deinstitutionalization is criticized not for its intent, which was to provide higher quality treatment and a better more independent standard of living for persons with mental illness; rather, it is criticized for the reality of its implementation and underfunding.

*Community Mental Health*

Over one hundred years after Dorothea Dix lobbied Congress and helped to introduce the Bill for the Benefit of the Indigent Insane of 1854, President John F. Kennedy signed the first major federal policy encouraging deinstitutionalization, the Mental

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[2] **Medicaid** is a federal-state assistance program and provides health coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities. The Social Security Amendments of 1965 created Medicaid by adding Title XIX to the Social Security Act, 42 U.S.C. §§ 1396 et seq. In some states the program covers all low-income adults below a certain income level. Patients usually pay no part of costs for covered medical expenses or a small co-payment. It varies from state to state and is run by state and local governments within federal guidelines.

[3] **Medicare** was established in 1965 under Title XVIII of the Social Security Act as a federal health insurance program. Medicare is available for people age 65 or older, younger people with disabilities who were entitled to Social Security Disability benefits for at least 24 months, people with end-stage renal disease (ESRD), and people with myotrophic lateral sclerosis (ALS).

Retardation and Community Mental Health Centers Construction Act, on October 31, 1963, prior to the enactment of Medicaid and Medicare. Eloquently asserting the intention of the policy, President Kennedy stated in a special message to Congress:

> *"I am proposing a new approach to mental illness and to mental retardation. This approach is designed, in large measure, to use Federal resources to stimulate State, local and private action. When carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability. Emphasis on prevention, treatment and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away"* (Prioleau, 2013).

The Act provided grants to states for the construction of 1,500 new community mental health centers across the country. The intent of these community treatment centers was to provide comprehensive community psychiatric treatment in five distinct areas including: consultation and education, inpatient services, outpatient services, emergency response, and partial hospitalization. Tragically, these intentions were never fully realized (Dowell & Ciarlo, 1983).

Kennedy's legislation appropriated $329 million for the construction of community mental health centers and the National Institute of Mental Health advocated for system linkages to community services like transportation, public health, medical care, social services, income maintenance, employment, housing, and vocational rehabilitation at the local, state, and federal level to fully support deinstitutionalization. A perfect implementation of the Act would have provided mental health centers with the appropriate supports to most communities. However, that vision of deinstitutionalization was never fully executed (Appelbaum, 1994). Community mental health centers were only built in "catchment areas" or geographic regions with populations between 75,000 and 200,000 residents (Butler & Windle, 1977). Additionally, there was no long-term allocation of funds to support the services once they were implemented and the states and localities were left to operate the centers without federal support. (Appelbaum, 1994; Butler & Windle, 1977)

By 1977, the full extent of deinstitutionalization's failings was becoming clear. The Comptroller of the General Accounting Office released a study to Congress entitled *Returning the Mentally Ill to the Community: Government Needs to Do More.* The study highlighted the poor implementation of the community mental health centers. In addition the Comptroller found that persons with mental illness were increasingly experiencing exclusion and neglect in the community (Rose, 1979). Later, critics denounced the lack of cultural and community awareness in the development of the so-called community mental health centers, pointing out the haphazard placement of the centers in high conflict neighborhoods or neighborhoods with low or non-interaction among the residents (Hunter & Riger, 1986). By the 1980's, most mental health centers failed to grow deep roots in the community (Lamb & Bachrach, 2001). Without a sense of ownership, cuts to federal funding for mental health met little opposition in an era of welfare retrenchment for all social service programs and safety nets. To survive, many community mental health centers switched their primary focus of care to substance abuse, in line with the increasing attention

and funds given to the 'war on drugs'[4] (Heller et al., 2000). Underfunded and disconnected from their original goal, community mental health centers became unable to provide treatment for people requiring long-term care for their persistent and severe mental illness helping to create the current landscape of mental health treatment seen today( Lamb & Bachrach, 2001; Novella, 2010).

*Dangerousness & Civil Commitments*

Other considerations that contribute to the failings of community mental health treatment and the increase of persons with mental illness in the criminal justice system are the significant changes in civil commitment laws since deinstitutionalization. Momentum from the deinstitutionalization movement and civil rights movement changed the rationale behind civil commitment from a "need-for-treatment" to "dangerousness." By the mid 1960s, California's carceral trends were influenced by a host of civil rights changes emerging across the country. Of particular influence was the District of Columbia's adoption of a new legal standard for civil commitments, which detailed that it must be determined that an individual has a mental illness before he or she can be hospitalized, and that this individual must pose an imminent threat to him- or herself or others; or be shown to be 'gravely disabled' meaning that the individual is incapable of providing the basic necessities for survival (Anfang & Appelbaum, 2006). Wisconsin's influential ruling, Lessard v. Schmidt (1976), continued to refine civil commitment laws to a narrow definition of dangerousness in an attempt to expand protections and civil liberties for persons with mental illness. The Lessard decision required that commitment proceedings provide the mentally ill with the same protections that a criminal defendant is awarded, namely, a right to counsel, a right to remain silent, exclusion of hearsay evidence, and a standard of proof that is beyond a reasonable doubt.

The saliency of threat or dangerousness as criterion for involuntary hospitalization of psychiatric patients was fortified by Lake v. Cameron in 1966, which established the right of non-dangerous patients to be treated in the least confining available alternative. Presented before the Washington, D.C. Court of Appeals, this ruling requires that the least restrictive level of treatment be recommended at the time of emergency evaluations for non-dangerous psychiatric patients stating that patients who were not dangerous "should not be confined if a less restrictive alternative is available" (Testa & West, 2010). In 1972, California legislators passed the Lantermen-Petris-Short Act, which effectively changed the criteria for civil commitments in a state hospital setting to the "grave disability" standard.

This combination of case laws essentially shifted the rationale for civil commitment from a 'need-to-treat' criteria to a strict 'proof-of-dangerousness' criteria. In many ways, these rulings honor and protect the civil liberties of persons with mental illness and ensure that they are treated in the least restrictive environment. However, an unintended consequence of these shifts has been the restriction of access to state-funded mental health treatment for many who are suffering from mental illness and lack the means to acquire treatment through other mechanisms.

[4] The war on drugs is a largely unsuccessful campaign led by the U.S. federal government, of drug prohibition, military aid, and military intervention, with the aim being the reduction of the illegal drug trade in the United States.

Today, many individuals who are suffering from serious psychotic symptoms would be eligible for inpatient care, but under commitment criteria based on dangerousness, a patient's eligibility for hospitalization is only granted once he or she exhibits suicidal tendencies, physical violence, or symptoms of a gravely disabling condition. Under this narrowed framework, many individuals that are deemed non-dangerous (or insufficiently dangerous to be treated by the state) are dismissed without any provision of care (Braslow & Messac, 2018). Consequently, a nontrivial proportion of individuals suffering from serious mental health issues must reach a point of significant psychological decompensation before they can receive stabilizing treatment (Copeland & Heilemann, 2008). Thus, the restrictions on civil commitments have been linked to the high incidence of the mentally ill in the streets and criminal justice system, the one place where access to mental health treatment cannot be refused; and also explain the severity of illness seen among civilly committed patients at Napa State Hospital.

Thus, the rise and fall of the psychiatric institution followed the lead of activists, public sentiment, and technologies regarding the best places to care for persons suffering from symptoms of mental illness. However, this siloed examination of the psychiatric institution does not account for the intersection of mental health treatment within the criminal justice system.

## PART 2. THE RISE OF PENAL INSTITUTIONS

### *Early Penal Institutions*

To truly understand the context of providing psychiatric treatment to persons in forensic environments, one must consider not only the history of psychiatric hospitals, but also the history of penal institutions, and the significant overlap between the two. Similar to society's acceptance of persons with mental illness and psychiatric institutions, attitudes towards criminal behavior and penal institutions are also a reaction to the prevailing norms, mores, and structure of a society. Colonial America was settled by tightly knit, patriarchal, and religious communities who modeled their society after the feudal systems that governed European nations. At this time, 'criminals' were considered members of the community who had gone astray and most judicial procedures acted as public arenas of repentance. It was believed that this public display of punishment was necessary to help reintegrate the transgressor back into the community. Incarceration was rarely used as a form of punishment, rather the accused were merely housed in anticipation of their trials. Punishment was less about public shame and redemption and more about quick corporal discipline (e.g. whipping, branding, mutilation, etc.) to quickly integrate the criminal back into the community. In rare cases, banishment and death by hanging was also used for repeat criminals or severe crimes like adultery and murder (Foucault, 1977; Garland, 1993; McKelvey, 1936; Rhodes, 2004; Rothman, 2002).

The Quakers, with a parallel rational that led to the advent of psychiatric hospitals, also declared incarceration to be more humane than death for criminal transgressors and saw the penal institution as a place of rehabilitation rather than a place of brutality and

retribution. The radical concept of humane punishment among the Quakers was fueled by the political philosophy of The Enlightenment, namely the idea that social institutions have the ability to positively form individual character. Additionally, it was believed that the penitentiary could be a place of introspection and penitence prompting the establishment of an organization devoted to improving the conditions of prisons and jails known as the Philadelphia Society Alleviating the Miseries of Public Prisons at the end of the eighteenth century (Considine, 2009; Rothman, 2002). Confidence in the institution's capacity to shape individual behavior is best stated by founding member of the Philadelphia Society and author of *An Enquiry into the Effects of Public Punishment upon Criminals, and Upon Society* Benjamin Rush (1787):

> *"The design of punishment is said to be—first, to reform the person who suffers it, secondly, to prevent the perpetration of crimes, by exciting terror in the minds of spectators; and thirdly, to remove those persons from society, who have manifested, by their tempers and crimes, that they are unfit to live in it."*

This revelatory conceptualization of punishment and individual reform introduced the modern penal institution and three major waves of prison building efforts in the United States.

In line with the considerations defined by the Philadelphia Society, and with an emphasis of physical labor and prison industry, the Walnut Street jail was built in Philadelphia in 1790. The Walnut Street Jail used smaller cells, separated women and debtors from the general population, and placed individuals deemed dangerous in solitary confinement (DePuy, 1951; Skidmore, 1948). Differing from earlier places of confinement, the Walnut Street jail was characterized by work, education, smaller-shared cells, and religious observance.

The operating principles of the Walnut Street Jail served as a blueprint for early prison development known as the Pennsylvania system; however, a riot and escape attempt in 1802 prompted the advent of a new style of detention that was more restrictive and isolative. In reaction to early prison reform pressures and fear of prisoner collusion, the Auburn Penitentiary was designed and built in upstate New York in 1817 and required that prisoners work throughout the day in silence and sleep in solitary cells at night, allowing prisoners to congregate briefly for meals in large mess halls. This style of prison referred to as the Auburn System, became known for having seemingly well-behaved prisoners, a strict code of silence, and being profitable because of its use of forced prison labor. Ultimately, the Auburn system's forced labor requirements proved to be lucratively superior to the Pennsylvania system and the Auburn system became the standard design of penal institutions during the first swell of prison expansion in the United States, which took place between 1828 and 1854 (Moynahan & Stewart, 1978).

*Racist Roots of Imprisonment*

Coinciding with the rise in psychiatric institutions, the second wave of prison expansion began after the Civil War and the end of slavery and gained momentum during

the Progressive Era[5]. Although slavery was formally abolished in 1865, the void of cheap labor and embedded racism in America nurtured a system of prison expansion that soon turned highly racialized (Blackmon, 2009; Oshinsky, 1997). Minor vagrancy laws were enforced disproportionately against Black people after Reconstruction[6] and overly aggressive enforcement of these laws beget the lucrative practice of convict leasing, which supplied the labor needed to rebuild the South by supporting industries like farming, mining, logging, and railroads. Infamously, this kind of incarceration sometimes took on the form of a chain gang, or a group of prisoners literally chained together and forced to perform difficult and exhausting physical labor. During this period of contract leasing, many Black prisoners, were charged with minor crimes, court costs, or fines and were sold to private bidders under the legal status of laborers (Blackmon, 2009). This so-called innovation in detention prompted the incarcerated population to grow ten times faster than the general population and prisoners became increasingly younger and Blacker (Oshinsky, 1997). Objecting to the advancement of prison labor and chain gangs as a means to extract cheap labor from a vulnerable and disenfranchised people, the reformers of the Progressive Era reinvigorated rehabilitation as a rational for imprisonment, which prompted innovations in penal surveillance with the introduction of probation[7], parole[8], and indeterminate sentencing[9]. These developments in carcerality continue to impact the ways in which persons engage with the criminal justice system today. By allowing the police or other state agents to continue to surveil and monitor individual behavior outside of the institution, persons in contact with the criminal justice system often become incapable of escaping it[10] (Garrett et al., 2019; Harris, 2016).

*Mass Incarceration*

The third major development in prison expansion began in the early 1970's, after the initiation of deinstitutionalization. The prison population rose dramatically from 196,441 in 1970 to 1,127,132 in 1995 and is commonly referred to as the era of mass incarceration (Clear & Frost, 2014; Feeley & Simon, 1992; Greenfeld, Beck, & Gilliard, 1996; Langan et al., 1988 Simon, 2014).

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[5] **The Progressive Era** (1890-1920) refers to the political and social-reform movement that brought major changes to American politics and government. Reformers attempted to address the social problems that arose with the emergence of a modern urban and industrial society. The U.S. population nearly doubled between 1870 and 1900.

[6] **Reconstruction** (1865–77) refers to the period of time immediately following the Civil War (1861-1865) in the U.S. when the government attempted to redress the lingering inequities of slavery and solve the political, social, and economic problems that arose in the aftermath of war and from the readmission of the eleven confederate states back into the Union.

[7] **Probation** as a penal concept refers to the attempt to rehabilitate a convicted offender without formal incarceration in a jail. It gained popularity during the first decade of the twentieth century when Progressive era reformers asserted that the act of imprisonment substantially interfered with a person's ability to rehabilitate.

[8] **Parole** refers to the release of a prisoner whose sentence has not expired, on the condition of continued good behavior. The sentence is not commuted, rather it is suspended and the individual remains under the supervision of the parole board.

[9] **Indeterminate sentence** is a non-defined sentence imposed for a crime. Indeterminate sentencing allows for a judge to impose a punishment within a range of time rather than imposing a fixed or predetermined length of time, allowing for extenuating circumstances to mitigate the length of the sentence.

[10] There is a vast body of ligature regarding **fees** and **fines** that is beyond the scope of this dissertation. As a deterrent and punishment, fines are imposed upon conviction. In contrast, fees are intended to raise revenue and shift the costs of the criminal justice system from the taxpayer to the defendant. Fees are often automatically imposed and bear no relation to the offense committed. Both fees and fines create significant debt for the defendant and the defendant's family, are applied in a racially discriminatory manner, and create a significant barrier to successful community reentry following a conviction.

This rise in incarceration was in part a reaction to the prison rebellions[11] seen throughout the United States in the mid century[12] and the Civil Rights movement[13]. Investigative reporting, media coverage, and first hand accounts of the riots and inhumane treatment of prisoners changed some reformers and much of the public's opinion about penal institutions. Namely, people were concerned about the ability of institutions to correct or rehabilitate inmates and declared that therapeutic attempts to reform inmates had failed and would continue to fail (Martinson, 1974). The 1970's saw the abandonment of the moral obligation to help rehabilitate prisoners seen during the Progressive Era and a return to a view of incarceration as a retributive and incapacitating institution.

Racism also continued to impact the rise of people in the prison system. In 1971, Nixon officially declared a "war on drugs," decrying drug abuse as "public enemy number one." Although the stated intent of these new drug policies was to deter problematic behavior related to drug activity, later interviews with Nixon's domestic policy chief, John Ehrlichman, reveal that the Nixon campaign was more antagonistic towards "the antiwar left and [B]lack people" than it was towards drug use, stating:

> *"We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and [B]lacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course, we did"* (Baum, 2016, p. 1).

Thus, the changing political climate of the 1960s and 1970s, imbued with the racial tension of the Civil Rights movement, reshaped the theoretical orientation of the public and ignited a series of reactionary policy choices that impacted criminal processing and sentencing across all levels and branches of government.

By the early 1980's, social deterrence theories of crime like "Broken Windows," which encouraged the policing of minor crimes like vandalism and public intoxication to prevent major crimes became increasingly popular; however, this theory was later discredited (Harcourt, 2005; Wilson & Kelling, 1982). And, in 1984 state legislatures began enacting "Truth in Sentencing" laws mandating lengthy prison sentences for drug offenses, violent offenses, and repeat offenders and requiring that convicted offenders serve at least eighty-five percent of their sentences (Shepherd, 2002). Continuing the punitive incarceration trend, President Reagan signed the Anti-Drug Abuse Act in 1986, which required harsh mandatory minimum sentences or determinate sentences for drug offenses (Bourne, 2008). Later in the 1990's, the U.S. Congress, President Clinton, and many state legislatures stoked the fires of incarceration by enacting "three strikes and you're out" laws that mandated minimum sentences of 25 years or longer for many felonious crimes including drug use. Thus, by design and public approval, a combination of intentional and racist policies created a

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[11]**Prison rebellion** is used to imply a reaction by incarcerated persons to imposed injustices experienced while incarcerated that use concentrated tactics and efforts in order to alleviate human rights violations, maltreatment, and discriminatory practices

[12]In 1952 there were eighteen major prison rebellions in the U.S. including prisons in Jackson, Michigan, Trenton, New Jersey, and Columbus, Ohio. Overcrowding and poor treatment prompted the rioters to demand better facilities and access to counseling and medical care. Racial tensions ignited riots in San Quentin State Prison in California in 1967 and 1968. Later at New York's Attica Correctional Institution, riots resulted in the death of a prison guard, hostages, and dozens of prisoners in 1971 see (Adams, 1994; Goldstone & Useem, 1999; Useem & Reisig, 1999).

[13]**The Civil Rights movement** (1954-1968) refers to the social activism supporting Blacks to gain equal rights under the law in the United States. Despite emancipation from slavery, Black Americans continued to endure individual and systemic racism, including violence, legalized disenfranchisement, and segregation based on race throughout the U.S. and especially in the American South. The movement sought to secure protections and human rights in federal law, through resistance and community organization and the courts (Hall, 2007).

bloated criminal justice system within the United States that disproportionately impacts persons of color and continues the subjugation of marginalized people (Alexander, 2012; Carson, 2015; Feeley & Simon, 1992; Henrichson & Delaney, 2012; Wacquant, 2001).

## PART 3. CALIFORNIA'S MENTAL HEALTH AND CRIMINAL JUSTICE SYSTEMS

Focusing attention to the continued operations of California's Department of State Hospitals and its relationship to the criminal justice system, helps to merge the long history of deinstitutionalization and mass incarceration in light of welfare retrenchment in California and set the stage for this ethnographic inquiry. Established in 1875, Napa State Hospital was California's first state-funded institution devoted exclusively to mental health care. In California state psychiatric hospitals followed the general trend of institutionalization across the United States and reached a peak of more than 35,000 patients being treated in fourteen hospitals.

Deinstitutionalization in California began in 1957, with the implementation of the Short-Doyle Act, which sought to encourage the treatment of patients suffering from a psychiatric disorder in the community, with the assistance of local medical resources. The significant reduction of funding and patients sent to the hospital for treatment subsequently caused nine of the fourteen state facilities to close.

Napa State Hospital's patient population peaked at a little more than 5,000 patients in 1960, before beginning its decline. By 1984, California's psychiatrically committed population dropped by 84%. Facing its own closure in 1998, Napa State Hospital contracted with the California Department of Corrections, which was buckling under the pressure of its increased prisoner population, to treat patients referred through the court system. This transformative decision overhauled operations and treatment goals for the patients at the hospital and begets the modern relationship now seen between the two institutional systems.

The story of California's deinstitutionalization mirrors the inadequate community mental health implementation efforts and welfare aversion seen throughout the county. The Short-Doyle Act first proposed to match 50% of state funds to California cities and counties. Later, the state increased its subsidizing rate to 75% and expanded the types of programs eligible for reimbursement in 1963. This, in conjunction with the narrowing of commitment standards under the Lanterman-Petris-Short Act (1968), began to greatly reduce the number of patients being treated in state facilities consequently initiating deinstitutionalization. Ronald Reagan, then governor of California and one of the largest welfare antagonists, vetoed two bills in 1972 and 1973 that were designed to protect the funds designated for community mental health treatment first proposed in the Short-Doyle and Lanterman-Petris-Short Acts. The restrictions placed on civil commitments and the piecemeal application of the California Medical Assistance Program (Medi-Cal) limited services to those that were easily reimbursable, ultimately leading to a haphazard implementation of community mental health treatment in California. Further, in 1978 Proposition 13 passed. This ballot initiative capped property taxes at both the state and county level effectively desiccating funds for mental health and education at the local and state level. As funding for mental health began to disappear in California, the Bronzan-

McCorquodale Act or Realignment Act of 1990, AB 1288 gave counties primary control over mental health treatment and provided them with a stable revenue stream from vehicle registration fees and taxes; however, this act provided limited improvements in care according to a 1991 report from the California Legislative Analyst's Office and ultimately left community mental health systems underfunded (Taylor, 2018).

Turning to California's criminal justice system, mass incarceration proved to be an economic and social disaster for California. The unprecedented rise in the prison population prompted several mandates and initiatives that attempt to reduce the number of incarcerated persons (Alexander, 2012; Simon, 2014; Wacquant, 2001). Specifically, California has implemented several policies designed to reduce or speed the processing of the prison and jail populations. For example, *"realignment* "refers to a series of policies implemented in California by Governor Jerry Brown that shifts program and fiscal responsibilities associated with the supervision and sentencing of a select portion of inmates in the criminal justice system from the state and parole boards to the counties and probation offices. The most notable of these policies are Assembly Bill (AB) 109 and AB 117, which state that as of October 1, 2011, California's counties and probation officials are required to supervise newly released prisoners who would have previously been placed on parole if the offender's committing offense was considered nonviolent, non-serious, and non-sex related. Although Realignment is seemingly a criminal justice policy, it was originally spurred by mental health and health concerns within the prison system and has many implications for mental health in the community. The federal class action lawsuits Coleman v. Wilson (1995) and Brown v. Plata (2011) alleged that the California prison system violated prisoner's 8th Amendment rights, which states that it is unconstitutional to inflict cruel and unusual punishment. These violations were in reference to California's inability to provide adequate mental health and medical care to inmates within the department of corrections, which the courts attributed to overcrowding. In 2011, the United States Supreme Court upheld a mandate to limit the population of California's prisons to 137.5% of design capacity within two years, down from 158%. AB 109 and AB 117 are California's attempt to rapidly decrease the size of the prison population, placing the burden of housing lower-level offenders in the county correctional system rather than the state correctional system, which also stresses the need for mental health treatment and services at the county level. Prior to Realignment, mental health treatment in the jail setting centered around screening and short-term care: under Realignment, jails face increasing pressures to treat persons with mental illness on a long-term basis and with more extreme symptom presentation.

Since Realignment and deinstitutionalization the pressure placed on the prisons and county jails to provide mental health treatment persists in California. While there is no clear commitment from local or state officials to fund the construction and operation of either new community-based psychiatric and mental health clinics, or new larger hospital based psychiatric care facilities, there is explicit interest in providing psychiatric treatment within the jails and prisons in impacted locales. For example, Los Angeles County Supervisors approved and canceled a $2.2 billion plan to build a 3,885-bed treatment facility in place of the Men's Central Jail in an attempt to replace the county's aging jail network that currently houses 17,000 inmates, a third of whom are reported to be receiving mental health treatment (Lau, 2019; Stiles, 2019). Activists and organizers from JusticeLA feared the facility would merely be another replacement jail. Initiating a campaign to cancel the

contract, JusticeLA gathered community members and persons directly impacted by mental illness and incarceration to meet with health officials, supervisors, and the sheriff's department. After the coalitions met, the county board voted 4 to 1 to cancel the contract (Pino, 2019).

The acknowledgement of the unmet mental health needs among incarcerated persons, along with the pressures to reduce the number and presence of the mentally ill among the homeless populations, appear to be driving support for construction and operation of mental health facilities that will function as part of the criminal justice system. The consideration of these hybrid facilities codifies the latest shift in institutions that prioritizes the needs of criminal justice incarceration and forensic treatment over comprehensive mental health treatment that is not connected to the criminal justice system. In the midst of calls for alternatives to incarceration, new penal/mental health facilities are justified as necessary to meet the mental health needs of increasing numbers of inmates in county and state correctional facilities in a way that ignores the macrostructural forces that perpetuate the current circumstance.

This genealogical examination of institutionalization in both the psychiatric hospital and the prison recounts the historic interplay of the two institutions based on the social rationale of worthiness, culpability, social tolerance, and race. The proceeding three chapters are dedicated to a review of the literature in several distinct areas. The next chapter explains the current landscape of mental health treatment in the community and the criminal justice system.

## Chapter III. Literature Review: Community and Forensic Mental Health

The wake of welfare retrenchment, deinstitutionalization, and mass incarceration left several unforeseen consequences, which continue to garner harsh criticisms from researchers, policy analysts, and mental health providers. What remains is a convoluted and porous system that ushers certain persons onto the streets and others into penal institutions while shutting the door to voluntary treatment and hospitalization for others. To understand the sticky web currently connecting the mental health system to the criminal justice system and social welfare policy it is necessary to understand where persons with mental illness *are* and some of the obstacles continuing to prevent their access to mental health treatment.

To untangle these complicated relationships I am choosing to present three separate chapters dedicated to reviewing the literature. This literature review chapter is divided into two parts. Part 1 clarifies the difficulty persons with mental illness have in accessing mental health care in connection to the failed policies that followed deinstitutionalization, the connection persons with mental illness have to homelessness due to these failed policies, and societal misconceptions about mental illness that perpetuate fear and indifference. Part 2 clearly demonstrates the social problem of allowing the criminal justice system to respond and treat persons with mental illness in the community, jails, and prisons. Both bodies of literature presented in Part 1 and Part 2 shape the current social problem of mental health treatment and ground the policy implications stated in the greater discussion presented in Chapter XI.

### Part 1. Mental Health Treatment in the Community

#### *Mental Illness and Homelessness*

Many of the patients treated at Napa State Hospital were in an unsheltered living situation prior to committing their instant offense[14]. Persons with mental illness, especially those experiencing psychotic symptoms are more susceptible to homelessness[15] for seemingly obvious individual reasons including: poverty, lack of affiliation, and personal vulnerability (Baker & Evans, 2016; Burt & Cohen, 1989). The nature of mental illness can easily impact an individual's ability to sustain employment or social support, and delusional

[14] The legal expression, "**instant offense**" is defined as the offense with which you are currently charged. An individual may have a lengthy history of serious convictions, but may currently be incarcerated for a minor offense or parole/probation violation.

[15] **Homeless** describes a person who lacks a fixed, regular, and adequate nighttime residence. Unsheltered Homelessness refers to people whose primary nighttime location is a public or private place not designated for, or ordinarily used as, a regular sleeping accommodation for people (for example, the streets, vehicles, or parks). Chronic homeless is defined as "an individual with a disability who has been continuously homeless for one year or more or has experienced at least four episodes of homelessness in the last three years where the combined length of time homeless in those occasions is at least 12 months" (U.S. Department of Housing and Urban Development, 2018)

or irrational thinking can impair judgment and reduce resiliency. However recognizable these personal difficulties are, it is impossible to overlook the systemic contributions that sustain the current crisis of persons with mental illness also experiencing homelessness.

The failures of community mental health centers, economic downturns, anti-welfare policies, the lack of affordable housing, and the HIV/AIDS epidemic all contribute to the modern crisis of homelessness (National Academies of Sciences et al., 2018). By the late 1980's, homelessness was estimated to affect 500,000-600,000 on a daily basis and chronic homelessness began to be recognized as one of America's great societal problems (Burt & Cohen, 1989). Legislation targeting homelessness began with the McKinney–Vento Homeless Assistance Act of 1987, which federally funded homeless assistance programs including the Continuum of Care (CoC) program, the Emergency Solutions Grant (ESG) and helped establish the United States Interagency Council on Homelessness (USICH). Current estimates conducted by the government place the point-in-time count at 552,830; of these individuals approximately 20% (111,122) were considered 'severely mentally ill;' 35% (194,467) were in an unsheltered living situation; and 17% (96,913) were considered chronically homeless (HUD, 2018).

In addition to mental health issues, researchers conducting work in this area highlight that individuals experiencing chronic homelessness overwhelmingly suffer from physical disabilities as well as substance use issues, compounding the expense and difficulty of disrupting the cycle of homelessness[16]. Further, the implicit stress of homelessness like food uncertainty, victimization, assault, and rape can trigger or exacerbate symptoms of mental illness, facilitate substance dependencies, and induce trauma or avoidant behaviors, increasing the likelihood of experiencing longer and more frequent stretches of homelessness (Burt et al., 2001; Burt & Cohen, 1989; Johnson et al., 1997; Lippert & Lee, 2015; Rowe, 1999).

In 2018 HUD also reported that roughly 16% (86,647) of the homeless population also suffered from a chronic substance use disorder. The high rates of reported drug and alcohol abuse within the homeless population are confirmed by other studies and contribute to the cycle of homelessness (Burt et al., 2001; Johnson et al., 1997; USICH, 2017; Wright et al., 1998). In 2010, USICH introduced a federal plan to effectively end homelessness, which was amended in 2012, and 2015 (2017). Although there was a 26% decrease in the overall number of individuals with chronic patterns of homelessness between 2007 and 2018, there was also a two percent increase between 2017 and 2018 (HUD, 2018). Budgetary concerns are cited as the underlying inability for USICH to meet their goal of eradicating homelessness (USICH, 2019).

*Insurance, Access, & Health Disparities*

Although it is beyond the scope of this dissertation, it is necessary to mention that America's strained history and current relationship with health coverage continues to impact the ways in which economically disadvantaged people and persons with mental

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[16] The USICH characterizes the cycle of homelessness as a series of hospitalizations in emergency rooms and inpatient beds, followed by detox programs, jails or psychiatric institutions and cost the taxpayer between, $30,000 to $50,000 per person annually (2017).

illness are able to access medical and mental health treatment. As stated earlier, the Mental Retardation and Community Mental Health Centers Construction Act (CMHA) of 1963 was the first federal legislation enacted to help provide mental health care for persons in the community.[17] Since the CMHA and the enactment of Medicaid and Medicare in 1965, there have been several federal acts targeting the expansion of health care that have implications for the treatment of mental illness.[18]

Despite the piecemeal attempts to provide health coverage to Americans, the U.S. health system does not provide sufficient health treatment for economically disadvantaged persons and persons of color (Garfield et al., 2011; Gilmer et al., 2010; Mangan, 2017; McAlpine & Mechanic, 2000; McConnell et al., 2012; Mechanic & Olfson, 2016; Quadagno, 2004; Quealy & Sanger-Katz, 2014; Saloner et al., 2017; Sommers et al., 2017). For example, the U.S. health care system has: low levels of acquisition and under-utilization of services amongst racial minorities and low-income populations; inequitable distribution of quality services; and it lacks culturally sensitive treatment options for minority groups (Adepoju et al., 2015; Mechanic & Olfson, 2016; Snowden, 2012; Thomas & Snowden, 2001).

Major changes to the U.S. health care system are met with political and public resistance. Seeped in welfare reform ideology, the negative perception of health care expansion is attributed to: 'American exceptionalism[19]'; anti-statist values; fear of the government; diffusion of political authority; lack of organization among labor unions; and, the highly organized opposition of physician lobby groups and the American Medical Association (Jacobs, 1993; Navarro, 1989; Poen, 1996; Quadagno, 2004; Steinmo & Watts, 1995). Thus, America's contentious cultural values, relationship to labor, and active interest groups coalesced and continue to resist major advancements in healthcare reform, leaving a commercialized health care industry that excludes a significant portion of the population from proper care (Quadagno, 2004).

With a weak and ineffectual health care system, obtaining health care and mental health treatment remains one of the greatest obstacles for many vulnerable groups and reinforces many health disparities. In the United States, adults without health insurance

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[17] Prior to CMHA of 1963, the National Mental Health Act of 1946 provided funds solely to support research relating to psychiatric disorders in the areas of prevention, diagnosis, and treatment provided by establishing the National Institute for Mental Health (NIMH).

[18] **The Emergency Medical Treatment and Active Labor Act of 1986** passed as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and requires that hospital emergency accept payment form Medicare to provide treatment to all patients regardless of citizenship, legal status, or ability to pay which ensured that patients without insurance would still be treated. Prior to **The Mental Health Parity Act (MHPA) of 1996,** insurers were not required to provide mental health treatment. The MHPA banned caps on mental health care services that exceeded general medical care costs. The **Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008** expanded the MHPA and mandated that private insurers provide equal benefits coverage for mental health and substance use disorders (as for medical or surgical benefits) for group health plans with more than 50 employees. The **Affordable Care Act (ACA) of 2010** expanded MHPAEA by mandating that Medicare and Medicaid also provide equal mental and physical health benefits coverage and extended Medicaid coverage to apply to individuals whose annual income fell below 133% of the poverty line.

[19] **American exceptionalism** is the theory that the history of the United States is inherently different from that of other nations, stemming from its emergence from the American Revolution and developing a uniquely American ideology, based on liberty, equality before the law, individual responsibility, republicanism, representative democracy, and laissez-faire economics (Lipset, 1996)

receive poorer quality of medical care, have less access to recommended care, and experience worse health outcomes than adults with insurance (McWilliams, 2009). Additionally, individuals with mental illnesses are less likely to be insured than the general public, to be able to afford treatment for mental and physical disorders, and to receive preventative care for both mental and physical disorders; further, when persons with mental illness are able to receive treatment they also receive lower quality treatment (Corrigan et al., 2014; Garfield et al., 2011; McAlpine & Mechanic, 2000; Mechanic, 2002, 2014). Morbidity and mortality rates for individuals with serious mental illness such as schizophrenia, schizoaffective disorder, bipolar disorder and major depressive disorder are considerably higher than individuals without mental illness for the same medical issues in the United States and in countries with universal healthcare systems (Hert et al., 2011). In some studies, researchers determined that medical professionals will sometimes misattribute physical health symptoms to mental illness, rather than considering it a legitimate complaint, and fail to provide appropriate medical care ( Jones et al., 2008). Other researchers attribute the health disparities seen among individuals with mental illness to the negative side-effects of psychotropic medications, risky lifestyle factors, difficulties associated with accessing and properly utilizing health care, as well as the lack of quality or comprehensive care (Hert et al., 2011).

Besides the use of the criminal justice system, the breakdown of the community mental health centers and the complicated relationship between health insurance coverage and mental illness leaves persons suffering from mental illness to use emergency rooms as the only other option for treatment. The literature looking at emergency room usage shows that there was a 26% increase in emergency room visits by the uninsured between 1993 to 2003 (Garcia et al., 2010). Additionally, of those frequenting emergency rooms for treatment, there is an increase of the number of patients with mental illnesses and substance use disorders. Weiss and colleagues (2006) found that from 2006 to 2013, there was a 55.5% increase in emergency room and trauma center visits for depression, anxiety or stress reactions, 52% increase for persons with psychotic or bipolar disorders, and 37% increase for complications due to substance use disorders. Other studies confirm the high prevalence of homeless individuals, persons from low economic status, persons with mental illness, and individuals with substance use disorders as among the most frequent emergency room visitors (Cheung et al., 2015; Kushel et al., 2002, 2001; Weiss et al., 2006). When considering alternatives to jails or emergency rooms to and implications for policy reform, researchers have been able to show that proper outpatient care or preventative treatment may reduce the use of emergency room visits (Boudreaux et al., 2016).

Lastly, an important and overlooked component of accessing healthcare is a sense of dignity when receiving treatment. Health disparities among persons with mental illness are also associated with the stigma felt from healthcare providers (Lawrence & Kisely, 2010). The internalized stigma associated with mental illness can discourage help-seeking behaviors by those with mental illnesses, particularly among racial and ethnic minorities and immigrant groups (Clement et al., 2015; Conner et al., 2010; Corrigan & Phelan, 2004; Schomerus & Angermeyer, 2008; Snowden & Cheung, 1990). Further, the experience of racial and mental health stigmatization and discrimination can decrease additional treatment efforts for mental health and substance abuse, which eventually leads to a negative impact on all health outcomes (Mays et al., 2017).

*Media Portrayal, Public Perceptions, & Violence*

Beyond the treatment room, stigmatization of persons with mental illness bleed into the public psyche, perpetuating negative assumptions and impeding progressive reforms for treatment. As discussed in the section on mass incarceration, the fear mongering cultivated by politicians and the media in the 1970's successfully garnered support for major legislative changes in the criminal justice system that contributed to the rise in the prison population (Scheingold, 2011; Simon, 2007b). In a similar vein, negative and sensationalized portrayals of mental illness in the media coupled with the increased visibility of persons with mental illness in the streets and community adulterate the public's understanding of mental illness, manipulate funding for treatment for persons with mentally illness, and support the use of aggressive criminal justice interventions (Stuart, 2006; Teplin, 1984, 1991; Wahl, 1987, 1997).

In essence, the American public fears mental illness. In a pioneering paper presented to the National Association for Mental Health Studies by Shirley Star (1952), the Senior Study Director at the National Opinion Research Center at the University of Chicago, opined after analyzing 3,500 interviews that:

> *"people's ideas about mental illness are ill-defined, confused, shifting, and contradictory…they appear to be equating mental illness with psychosis, although, of course, most people would never use this term, But, generally, they speak of the mentally-ill as being "insane," "crazy, "nuts", "out of their minds", and attribute to them such characteristics as unpredictability, impulsiveness, loss of control, extreme irrationality, and legal incompetence; or such symptoms as hallucinations, delusions or violent behavior" (p. 3).*

Despite increased scientific understanding and effective psychotropic medication to combat the extreme symptoms of mental illness, the public continues to associate persons with mental illness as perpetrators of violence and crime, especially in discussions of psychosis (Corrigan & Watson, 2002; Link et al., 1999; Martin et al., 2000; Phelan & Link, 1998;. Phelan et al., 2000; Steadman, 1981; Wahl, 1987, 1997).

Contrary to this perception, and the depictions of persons with mental illness in the media, studies show that as a whole, individuals with mental illness are less likely to commit violent crimes and more likely to be victimized (Diefenbach, 1997; Parcesepe & Cabassa, 2013; Taylor & Gunn, 1999; Teplin et al., 2005). For persons experiencing severe mental illness, a greater overall percentage do commit a higher rate of violent acts compared to the overall non-mentally ill population (Silver & Teasdale, 2005; Swanson, 1993; Swanson et al., 1990). However, the portion of violent crime attributed to persons with severe mental illness is a small portion of the overall violent crime and is consistently below 10% (Fazel & Grann, 2006; E. Walsh et al., 2002). Substance abuse, age, and gender are all more predictive of violent acts than mental illness (Fulwiler et al., 1997; Swanson et al., 1990). In one study, using survey data from the National Institute of Mental Health's epidemiological catchment area ($N$ = 3,438), researchers found that individuals with a substance use disorder had rates of violence at 19.2% of the surveyed participants, compared to 8.3% for those with a major mental illness, 2.2% for persons with a minor mental illness, and 2.1% for persons with no reported mental illness. (Silver & Teasdale, 2005) Yet, many news outlets, fictionalized television programs, and films conflate mental illness with violence

(Diefenbach, 1997; Wahl, 1997).

Also troubling, depictions of recovery are rarely shown in the media. Often characters seeking treatment for mental illness never get better or live full lives, rather they are depicted as temporarily stabilized and incapable of integrating into the larger world (Wahl, 1997). This assertion contradicts the longitudinal clinical research in this area which shows that after the initial onset of a mental illness, improvement is just as common, if not more so, than progressive deterioration; and that with community support and proper treatment persons with mental illness are capable of self-determination and inclusion in community life despite continuing to suffer from mental illness (Corrigan & Phelan, 2004; Davidson & Roe, 2007).

Confounding the situation is the stigmatization associated with homelessness and the misperception that the majority of homeless people have mental illness. Policy makers often attribute the causes of homelessness to individual factors like personal disability, substance abuse, and poor decision making rather than structural factors such as insufficient affordable housing and employment opportunities (Cronley, 2010; Wright et al., 1998). This tension in the public can unfairly blame persons experiencing homelessness for their own plight and write them off as public nuisances (Bhui et al., 2006). Additionally, the public assumes that the majority of homeless people are mentally ill and that mentally ill persons are dangerous (Arumi et al., 2007; Lee et al., 1990; Link et al., 1999; Link & Cullen, 1986; Snow, 2013). The experience of multiple stigmas, or intersectionality, can manifest in unique ways of oppression and marginalization that leave people unable to access treatment (Crenshaw, 1990). For example, Bhui and colleagues (2006) reported in their qualitative study that homeless individuals seeking mental health treatment were denied services due to assumptions made by the service providers that they were malingering or faking psychiatric symptoms to gain shelter on a cold night. In this study, the service providers' judgments of worthiness for treatment illuminate the tension welfare reform and limited resources has on the delivery of mental health services.

Thus, misinformation about mental illness, homelessness, dangerousness, and the nature of criminal behavior stoke public fears of mental illness. These streams of confusion work in concert to prime a public seeped in individualism and uncertainty about treatment and punishment to underfund mental health services and relinquish the care of persons with mental illness to the criminal justice system (Beckett, 1999; Corrigan et al., 2014; La Fond & Durham, 1992; Lamb & Weinberger, 1998; Petersilia, 1987). As the analysis of this dissertation supports, without proper psychiatric treatment in the community that support early intervention and diversion to comprehensive services, by default the criminal justice and state hospital system will be used to provide treatment.

## PART 2. MENTAL HEALTH TREATMENT IN THE PRISONS AND JAILS

### *Transinstitutionalization*

As previously stated, critics of deinstitutionalization stress that its major fault was that it was in effect a poorly orchestrated rehousing of persons with mental illness into other ill-equipped facilities like nursing homes, prisons, acute care settings (i.e. emergency rooms), and public shelters (Lamb & Bachrach, 2001; Novella, 2010; Torrey, 1997). This phenomenon is known as transinstitutionalization. As noted, the rate of deinstitutionalization accelerated significantly after the enactment of Medicaid and Medicare in 1965, which effectively gave federal health insurance to the very poor, elderly, and other identified groups. Prior to this legislation, while a patient was being treated in a state hospital they were the fiscal responsibility of the state and there were few alternative treatment facilities. After this legislation, older patients could be discharged from the state hospital and sent to nursing homes where they would be the fiscal responsibility of the federal government. Additionally, the federal government specifically excluded Medicaid payments for patients in state psychiatric hospitals and other "institutions for the treatment of mental diseases." By the mid-1980's, 23% of nursing home residents were diagnosed with a mental health disorder. Further, studies suggest that since 1980, roughly 6-8% of the prison population can be attributed to the defunding of state psychiatric hospitals (Primeau et al., 2013; Steadman et al., 1984; Torrey, 1997; Torrey et al., 2010; Turner, 2004).

Critics of the transinstitutionalization thesis insist that the argument is often used too broadly by researchers who attempt to use it as an explanation for the rapid increase in the prison population. They argue instead that only a small minority of mentally ill prisoners would have been housed in a state psychiatric institution had deinstitutionalization not occurred (Primeau et al., 2013; Prins, 2011; Raphael & Stoll, 2013). Although a direct causal link between deinstitutionalization and mass incarceration can only account for a small portion of the dramatic increase in the prison and jail population, it is clear that persons with mental health issues are not being adequately treated in the community and are increasingly being treated within the criminal justice system. The Bureau of Justice Statistics reports that over fifty percent of the total prison population in the U.S. had experienced "a recent history of symptoms of a mental health problem" and roughly twenty-five percent of state prisoners had a prior history of mental illness (James & Glaze, 2006). Therefore, regardless of any causal association between deinstitutionalization and mass incarceration, it is evident that the two policy interventions occurred in chorus and have left a subset of the population without proper mental health treatment in the community experiencing a cycle of homelessness, brief hospitalization, and incarceration.

### *The Criminalization of Mental Illness*

The "criminalization of mental illness" is often used as shorthand to refer to the theory of transinstitutionalization, which asserts that individuals who would have historically been treated in psychiatric hospitals are now being treated in the criminal justice system. I choose to assert the original reading of the theory. First described in 1972, Abramson feared that there would be a limit to society's tolerance for mentally disordered behavior and without adequate access to mental health care, and other supportive services, the behaviors exhibited by persons with mental illness would eventually be criminalized:

> *"I believe that …mentally disordered persons are being increasingly subjected to arrest and criminal prosecution. They are often charged with crimes such as drunkenness, disorderly behavior, malicious mischief, or, interestingly, possession of marijuana or of dangerous drugs. Frequently, mentally deranged youth come to police attention because of their disorderly public behavior, and are found to have some marijuana in their possession…On, occasion, concerned friends or relatives inform police that a mentally disordered person has a stash of marijuana in his room in order to secure his involuntary detention and treatment"* (Abramson, 1972, p.103)

Therefore, criminalization of mental illness is attributing or renaming mentally disordered behavior as criminal behavior and the process of enacting criminal justice interventions to provide psychiatric treatment or involuntary detention.

Since deinstitutionalization, many researchers demonstrated that persons with mental illness, especially those visible to the public because of compromised living situations, are both susceptible to surveillance and vulnerable to crime perpetration, regardless of the severity of offending, which encourages interaction with the criminal justice system (Amster, 2003; Ditton, 1999; Kupers & Toch, 1999; Lamb, 1989; Lamb & Weinberger, 1998; Perez et al., 2016; Sigurdson, 2005). Additionally, the comorbid experience of substance use and mental illness compounds the likelihood of criminal justice involvement (Abram & Teplin, 1991; Draine et al., 2002; Kessler et al., 1996). In fact, drug possession and trafficking are cited as the most common serious offenses among detained inmates with mental illnesses (James & Glaze, 2006). Consequently, persons that demonstrate disordered behavior, use substances, and are visible within the community have a greater likelihood of being charged and detained for low-level, non-violent charges like drug possession, loitering, vagrancy, petty theft, and other public nuisance violations. Many patients treated at Napa State Hospital fit this categorization.

Importantly, Fisher and colleagues (2006) contend that the criminalization theory of mental illness that was first defined after deinstitutionalization should be expanded beyond the simplistic equation that less mental health treatment equals more persons with mental illness in jails and prison to encompass contemporary crimongenic theories like life-course, local-life circumstances, and lifestyle/routine activities to better address the current tensions between mental health treatment, services, and incarceration. They argue that the myopic concentration on therapeutic intervention and service system inadequacy deflects the attention of researchers and policy makers away from other potentially useful perspectives and exacerbate the problem of mental health within the criminal justice system. In other words, solely attending to the lack of mental health treatment in the community may ignore other systemic and individual factors that contribute to criminal behavior. This expansion of the criminalization theory may help to address complicating factors such as substance abuse and the lack of safe affordable housing that contribute to the high rates of incarceration among persons with mental illness. All of these factors come up in the analysis of this dissertation as pressing issues that impact the patients at Napa State Hospital prior to being mandated to treatment at the hospital, and this assertion is the evaluative lens of welfare used throughout this dissertation.

Another analytic tool used in the analysis of this dissertation is the incorporation of a stratified taxonomy that accounts for the heterogeneity of persons with mental illness coming into contact with the criminal justice system. Among persons with mental illness

that engage in criminal behavior there are five distinct subgroups including: (1) persons that commit misdemeanor nuisance offenses; (2) persons that commit survival behaviors offenses; (3) persons that commit substance abuse related offenses (including the use of illegal substances, illegal actions used to support the use of drugs and/or alcohol, and from violence arising as a direct consequence of drug and/or alcohol use); (4) persons that commit violent offenses directly related to psychosis; and (5) persons that commit felonious criminal offenses due to character or personality disorders, especially for violence against others (Hiday & Burns, 2010; Hiday & Wales, 2013). According to Hiday and Burns (2010) there is a tendency for all five groups to live in underserviced and impoverished areas where it is difficult to thrive with a major mental illness. Therefore, without mental health treatment and a wide-range of services available in the community, the criminal justice system will continue to serve as a de facto shelter, substance rehabilitation, and mental health treatment center.

*Police*

Taking into account the visibility and negative public perceptions of persons with mental illness, disordered behavior regardless of whether it is violent or criminal, is frequently construed as disruptive, dangerous, and illegal creating a sense of fear and apprehension among the general public. With few alternatives, encounters between the public and persons with disordered behavior result in increased calls to the police for intervention (Bonovitz & Bonovitz, 1981; Menzies, 1987; Teplin & Pruett, 1992). These encounters can then result in arrest, detention, and incarceration.

Charging persons with mental illness with crimes becomes increasingly more appropriate when viewed through a lens of tough-on-crime policies, such as the War-on-Drugs, determinate sentencing, and shifts to proactive policing styles (Simon, 2007b; Walker, 1993; Wilson, 1978). Further, researchers attest that the policing style changed during the tough-on-crime era and became increasingly legalistic, which resulted in the police having less discretion in their decisions or use of informal interventions to resolve disputes (Goldstein, 1979; Scheingold, 2011; Simon, 2007b; Skolnick & Bayley, 1986; Wilson, 1978; Wilson & Kelling, 1982).

During this period, law enforcement also began to see arrest and detention as a faster and more efficient placement for individuals with mental illness, rather than attempting to access or place people in mental health treatment centers in the community (Jemelka et al., 1989; Laberge & Morin, 1995; Lamb et al., 2004; Ogloff et al., 1990; Teplin, 2000). Templin (2000) found that police discretion in hospitalization of persons with mental illness is limited by the number of psychiatric beds in the community and the criteria for admission to these beds. Also, there is evidence that police are more likely to arrest persons displaying signs of mental illness than non psychiatrically disordered persons (Teplin, 1984) However, other reports show no difference in the prevalence of arrest among mentally-disordered persons and non-mentally disordered persons (Engel & Silver, 2001). Adding to the high rate of police contact among persons with mental illness, researchers indicate that persons with mental illness are more likely to be arrested multiple times (Ditton, 1999; Steadman et al., 1978). And, results from a systematic review that analyzed 85 studies and 329,461 cases determined that one in ten individuals have police

encounters on their way to mental health treatment, one in four persons with mental illness have histories of police arrest; and one in 100 police dispatches are for incidents involving someone with mental illness (Livingston, 2016). Although, police contact does not have to end in incarceration, without diversion programs and a robust welfare system to support persons with mental illness, the likelihood of long-term incarceration increases with every police encounter.

*Mental Illness in Jails and Prison*

To understand the extent to which the criminal justice system is now used to provide mental health treatment in the United States, it is necessary to look at the prevalence rate of mental illness in the jails and prisons. By the end of the twentieth century there were more persons with mental illness in jails and prisons than in state hospitals (Sigurdson, 2005). And in a report published in 2006, the Bureau of Justice Statistics (BJS) found that 56% (n= 14,499) of state prisoners, 45% (n=3,686) of federal prisoners, and 64% (n=6,982) of jail inmates reported having serious psychological distress based on two measures: either a recent history (clinical diagnosis or treatment) of mental health problems or current symptoms of mental health problems (James & Glaze, 2006). More recent BJS estimates from a 2011-2012 report a total of 26% (n=61,351) of jail inmates and 15% (n=43,721) of state and federal prisoners met the threshold for serious psychological distress in the past 30 days based on the Kessler-6 scale of serious psychological distress; and 37% of state and federal prisoners had a history of mental health problems compared to 44% of jail inmates (Bronson & Berzofsky, 2017). The most common diagnosis among state and federal prisoners (24%) and jail inmates (31%) with mental illness is major depressive disorder compared to 7.1% in the general population (Bronson & Berzofsky, 2017; National Institute for Mental Health (NIMH), 2019). The NIMH reports that only 3% of the general population meet diagnostic criteria for schizophrenia or severe bipolar disorder (2019); whereas, the combined estimates are as high as 37% of jail and 26% of prison inmates (Bronson & Berzofsky, 2017). Additionally, persons with mental illness have a more difficult time managing the expectations of prisons and spend more time in jail (Ditton, 1999). They are less likely to earn probation (Steinberg et al., 2015); and when granted release, persons with mental illness recidivate sooner and more often than formerly incarcerated persons without mental illness (Bales et al., 2017; Feder, 1991). In addition, parolees with mental illness have a higher rate of returns to custody for parole violations or other low-level offenses compared to their counterparts without mental illness (Lovell et al., 2002).

The overzealous use of incarceration ultimately creates a burden of use. Despite the high rate of prison expansion, U.S. prisons and jails are overcrowded and housing conditions are frequently poor. According to the Bureau of Justice Statistics, overcrowding reached its peak in jails in 2007 at 95% average operating capacity and by 2016, jails were operating at 80% capacity (Zeng, 2018). In 2017, federal prisons operated at 114.1% of custodial design with 135,792 persons incarcerated; further, a total of 13 states met or exceeded the maximum capacity of their prison facilities, and 24 states and the Federal Bureau of Prisons had a total number of prisoners in their custody that met or exceeded their minimum number of beds (Bronson & Carson, 2019). Overcrowded living conditions are unsanitary, violent, stressful, and can perpetuate traumatic psychiatric symptoms like

hyper-vigilance and anxiety, and exacerbate other preexisting psychological disorders (Haney, 2006). Experiences like rape, assault, self-injurious and suicidal behavior, and exposure to communicable diseases are prevalent amid these circumstances and can often lead to trauma reactions (Haney, 2006; Kupers & Toch, 1999; Travis et al., 2014).

Conjecture about the disproportionately high rate of mental illness in the jails and prisons lead some researchers to question not only the extent to which criminalization contributes to these extraordinary numbers, but to what extent these rates can be attributed to the increased ability to diagnose a large range of mental health conditions in one environment, and to what extent the conditions in prison and jails contribute to or aggravate existing mental health conditions (Lamb et al., 2004; Lamb & Weinberger, 1998). Roughly one in five incarcerated people have some kind of mental health problem; however, according to the BJS, since admission into a correctional institution, approximately 44% of jail detainees who had ever been told they had a mental disorder received treatment compared to 63% of prison detainees who had been told they had a mental disorder. Further of those that met the criteria for serious psychological distress in the last thirty days only a third were receiving treatment for mental health at the time of the interview (Bronson & Berzofsky, 2017). In addition, co-occurring substance use disorders are common among persons with mental illness and studies place the median prevalence of alcohol and substance dependence for jail and prison inmates at 73% and 59% respectively (Bose et al., 2018; Sacks, 2003). Other studies indicate that less than half of incarcerated persons diagnosed with mental illness and substance use disorders received any treatment for their substance use while they were incarcerated (Perez et al., 2016; Teplin, 2000; Veysey et al., 1997; Walsh & Holt, 1999).

The main body of literature that relates to mental illness in the criminal justice system looks at the lack of adequate psychiatric treatment for persons with mental illness within correctional facilities (Gibbs, 1987). Frequently, disordered behavior due to psychiatric illness is met with disciplinary action from staff and possible assault from other incarcerated persons (Ditton, 1999; Gibbs, 1987). "Cell extractions" may be used for psychotic or uncooperative persons within the jails and prisons who refuse to leave their cell, this forcible process of physical removal from a jail or prison cell may be experienced as violent or traumatizing (Kupers & Toch, 1999). Another particularly deleterious form of discipline that is often used as a precautionary or punitive intervention for persons with mental illness is solitary confinement. Although solitary confinement varies across states, it usually involves 22-24 hours of detention to a cell in addition to severely limited contact with other human beings, including family. Researchers determined that even brief stays in this kind of environment are associated with negative or decreased psychological well being regardless of a preexisting psychiatric condition (Arrigo et al., 2011; Hafemeister & George, 2012; Haney, 2003; Rhodes, 2004; Smith, 2006). Currently, there are approximately 61,000-68,000 individuals in the U.S. are experiencing solitary confinement at any given point (Resnik et al., 2015; Resnik & Bell, 2018). Determining the exact extent of persons experiencing solitary confinement and the full cost of service utilization in jails and prisons is difficult to determine amid the current carceral landscape with its network of federal, state, and local jurisdictions (Fuller et al., 2016). However, the experience of incarceration may worsen any medical, mental, and drug issues that exist prior to incarceration and ultimately contribute to recidivism or the constant rehousing and treating of persons with

mental illness in the criminal justice system (Fuller et al., 2016; Hafemeister & George, 2012; Travis et al., 2014) (Travis, Western, Redburn 2014).

This wide scope of the criminalization of persons with mental illness and their experience in jail and prison demonstrates that not only is there an alarming disproportionate rate of persons with mental illness in the criminal justice system, but they also receive inadequate treatment while they are incarcerated and are susceptible to increased punishment due to difficulty adapting or navigating the jail or prison environment. What is important to note about this literature is that mental illness is regarded as a separate domain from the criminal justice system. In other words, persons with mental illness come into contact with the criminal justice system and then they experience the criminal justice system, when in reality once a person with mental illness enters the criminal justice system there is a network of commitments that relate to mental illness that are employed in reaction to psychiatric presentation or as a means of judicial procedure. The next chapter begins to explain this network and the impact it has on the experience of receiving mental health treatment in a forensic hospital once involved in this system.

## CHAPTER IV. CONTEXT: PSYCHIATRIC COMMITMENTS AND COMPETENCY RESTORATION

This chapter is meant to provide context to the overall dissertation and is sandwiched between two literature review chapters for clarification purposes. Part 1 of this chapter addresses the three main forensic commitments treated at Napa State Hospital: the civil commitment code for grave disability passed under the Lanterman-Petris-Short (LPS) Act, California Welfare and Institutions Code § 5008(h)(1)(A)), the criminal commitment California Penal Code §1026 Not Guilty by Reason of Insanity, and the criminal commitment California Penal Code §1370 Incompetent to Stand Trial. In Part 2, I will explain in greater detail trial competency restoration treatment and the court mandate that went into effect during my data collection period.

### PART 1. MANDATED PSYCHIATRIC COMMITMENTS

#### *Gravely Disabled Civil Commitment*

Civil commitment laws experienced drastic reshaping in the circuit courts and state legislature over the last half century. In an effort to protect the civil liberties of the mentally ill, the rationale behind civil commitments changed from a *need-to-treat* to a *threat-of-danger* (Testa & West, 2010). In most states it is not enough to mandate someone to mental health treatment because they are experiencing symptoms of severe mental illness; rather an individual must pose some kind of danger to themselves or others, or demonstrate extreme disability due to their mental illness. The threat of violence/dangerousness criterion for involuntary hospitalization and the ruling that requires psychiatric patients be treated in the least restrictive level of care was fortified in California in 1972. Legislators passed the Lanterman-Petris-Short (LPS) Act, which effectively changed the criteria for civil commitments in a state hospital setting to "grave disability." Grave disability is defined as being “unable to provide for his/her food, shelter and clothing because of a psychiatric disability” (CA W&I § 5008(h)(1)(A)). In many ways, these rulings honor and protect the individual freedoms of the mentally ill and ensure that they are treated in the least restrictive environment.

The civil commitment process is much different than the criminal commitment procedures and generally begins within a community mental health center. The professional treatment staff at the community mental health facility begins the conservatorship process at the point when the needs of the patient exceed the ability of the facility to provide sufficient or adequate mental health treatment. Generally, the first step is to request an investigation from the Office of the Public Conservator in the patient’s residing county. If the investigation by the Public Conservator agrees with the treating mental health professionals, the Public Conservator will then send a formal request also known as a Petition to the Probate court to establish a temporary mental health conservatorship (T-Con). The proposed conservatee is then notified of the temporary conservatorship status at least five days before it begins and is appointed a public defender to represent him or her. The T-Con only lasts up to thirty days and at the end of thirty days a general conservatorship petition is submitted to the court. At this point, the Probate Judge

considers the general conservatorship petition at a hearing, where a District Attorney (D. A.) presents evidence supporting the petition. If the proposed conservatee objects to the petition, a psychiatrist or psychologist must then testify. Based on the testimony and the evidence submitted by the D.A., the Judge will grant or deny the petition, or continue the proceeding to a later date. If the petition is granted, then the Judge appoints a conservator and the Judge will determine which, if any legal rights will be removed from the conservatee. A general conservatorship expires at the end of one year's time, but may be renewed yearly, if the treating medical team formally requests a continuation hearing from the Probate Court to continue treatment. Similarly, the conservatee is entitled to a full evidentiary hearing and legal representation on the renewal petition as well. In general, most patients conserved under LPS are treated in community facilities. If treatment cannot be provided in the community then the county may request that the patient be treated at the state hospital. Treatment at Napa State Hospital for LPS civil commitment is considered the most restrictive level of care available.

*Not Guilty by Reason of Insanity*

Not Guilty by Reason of Insanity or the insanity defense is the primary criminal commitment type at Napa State Hospital comprising roughly fifty percent of the total patient population. The insanity defense is based on the principle that a person charged with a crime is too impaired due to mental illness to be held criminally responsible for his or her actions. Under California law a person is considered "legally insane" if, because of a mental illness, he or she cannot understand the nature of his or her criminal act, or cannot distinguish between right and wrong. This legal definition of insanity links back to the M'Naghten Rules of 1843, when Daniel M'Naghten, experiencing paranoid delusions attempted to assassinate the Prime Minister of Britain and mistakenly killed Edward Drummond instead (Borum, 2003).

The insanity defense is available for any criminal charge and generally proceeds in this manner: a defendant submits an insanity defense to the court and is required to prove that he or she was insane when the crime was committed by a "preponderance of the evidence" meaning that he or she must show that it is more likely than not that he or she was insane. During the sanity hearing, the defendant presents expert witnesses—usually psychiatrists—who testify that at the time of the offense, the defendant either did not understand the nature of his or her act, or did not understand that the act was wrong. Successful insanity defense pleas result in being committed to treatment at a state psychiatric hospital in lieu of jail or prison time. The reasoning behind commitment at a psychiatric hospital is two-fold: to rehabilitate and treat the defendant, and to protect the defendant and society from further harm.

The number of mentally ill criminal defendants who actually plead not guilty by reason of insanity is quite low. Nationwide, only about one percent of all criminal defendants assert the insanity defense, while in California the rate was as low was .58 percent, further the acquittal rate of those nationally was 26 percent and 46 in California (Callahan et al., 1991). Although substance use is a major contributing factor to criminal behavior, substance use may not be asserted as a legal defense of insanity. In cases where

the defendant has a history of mental illness and homelessness questions arise regarding the appropriateness of an insanity plea and the right of a defendant to refuse or pursue the plea; in this circumstance, "ethical considerations are seriously complicated when theory and reality come into conflict" (Bruning, 1975, p. 243).

In California, a person is committed with a determinate sentencing length (DSL) date that is equivalent to the maximum amount of time associated with the criminal charge; however, a defendant found not guilty by reason of insanity is ostensibly committed to the hospital until the clinical treatment team believes that the person can safely be treated at a lower level of care. Ideally, the insanity defense would be used efficiently, without extra punitive infringement or stigma. It is intended to provide psychiatric treatment in the least restrictive environment appropriate for care for a minimal duration of need. However, in practice treatment duration is indefinite and the insanity defense is cumbersome often resulting in lengthy treatment periods that are oversized to the instant offense. In many jurisdictions, persons who are found not guilty of crimes by reason of insanity are in a worse position than if they were convicted, sentenced, and imprisoned in regards to length of incarceration (German & Singer, 1977). Therefore, some defense attorneys and public defenders will only encourage the use of the insanity defense for defendants facing serious charges with significant time.

In light of the reality of the insanity plea and within the wake of a tragically flawed mental health system many believe that a not guilty by reason insanity defense is reserved for persons that have allegedly committed serious felonious crimes with lengthy sentencing ranges. However, this is a misconception and not reflective of the true application of the insanity defense. In reality the insanity defense is seldom used and when it is employed only one third of insanity defenses are for cases involving a victim's death (Perlin, 2016). When looking at the demographic, historical, and psychological data of individuals acquitted by reason of insanity Cooke and Skorski determined that "race, sex, education, occupation, marital status, place of birth, area of referral, type of crime, past hospitalization, previous convictions, performance of a competency evaluation, and placement" are all factors associated with increased length of stay at a psychiatric hospital; whereas age was not related to release (p. 251, 1974). Thus, the matrix for which a person receives a not guilty by reason of insanity acquittal is fraught, confounding, and appears almost capricious in relationship to the societal problem of an underserved and criminalized community of persons with mental illness.

Treatment for insanity at the state hospital is considered the end of the line, the last exit before death or life imprisonment and a rare opportunity for comprehensive care. Haplessly, this comprehensive care comes with the complicating disadvantage of a burdensome criminal justice system and is available only after the perfect storm of mental illness, crime, an appropriate defense, and a sympathetic jurisdiction.

*Incompetent to Stand Trial*

When a person with mental illness or cognitive impairment is first arrested and detained in jail, they may not be able to proceed to trial due to symptoms of their mental disorder, which may impede an understanding or present an inability to rationally

participate in the criminal adjudication process. During this pretrial stage, if there is any concern regarding a defendant's ability to understand the nature of their charges, the procedures and personnel of the court, or work rationally with his or her attorney a competency evaluation may be raised by either the defense or the judge in any case. This evaluation, often referred to as an alienist report, is intended to provide sufficient information to allow a judge to rule on the competency of the defendant should any concern regarding competency rise from the prosecution, defense or judge.

Competency was originally established by the Supreme Court decision Dusky v. United States 1960. With this case, the Court affirmed a defendant's right to have a competency evaluation before proceeding to trial and defined competency as the defendant's ability to consult rationally with an attorney to aid in his own defense and to have a rational and factual understanding of the charges. The case set the current standard for adjudicative competency in the United States. Although the statutes addressing competency vary from state to state in the United States, the two elements outlined in the Dusky v. United States decision are held in common. Namely, the defendant must understand the charges and have the ability to aid his attorney in his own defense.

In California, the judge determines competency on a case-by-case basis, usually with the assistance of a court appointed psychiatric evaluator known as an alienist. In addition, the judge also has the authority to order a defendant to take medication to address a condition known as an involuntary medication order (IMO). Once a person is found to be incompetent to stand trial they are mandated to trial competency restoration. In California, if a defendant is charged with a misdemeanor, they will receive treatment in a county jail in a specialized competency restoration unit. In misdemeanor cases, they can be held in a county jail for up to one year for competency restoration. Defendants charged with a felony, are sent to a state hospital for competency restoration. Effective January 2019, in felony cases, the defendant has up to two years to become competent to stand trial instead of three years.

The time limit restriction for trial competency restoration treatment is based on Jackson v. Indiana, 406 U.S. 715 (1972). This landmark decision of the United States Supreme Court determined a U.S. state violated due process by involuntarily committing a criminal defendant for an indefinite period of time solely on the basis of his permanent incompetency to stand trial on the charges filed against him. The Supreme Court held that the state of Indiana could not constitutionally commit the petitioner for an indefinite period of time on the sole grounds that he was incompetent to stand trial on the charges filed against him, thus violating both the equal protection and due process clauses of the Fourteenth Amendment. Therefore, the Court ruled that Indiana's indefinite commitment of a criminal defendant solely because he lacks the capacity to stand trial violates due process. Such a defendant cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he or she will attain competency in the foreseeable future. Once patients are restored to trial competency, they are returned to the county jail and the adjudication process will continue. If the patient is returned to court as unlikely to be restored to competency they can either have their charges dropped; be committed to treatment if they meet the standard of grave disability

defined under the Lanterman-Petris-Short (LPS) Conservatorship; or be committed in a Murphy Conservatorship[20].

PART 2. INCREASE IN INCOMPETENT TO STAND TRIAL POPULATION

Competency evaluation is quickly becoming the leading concern in the field of criminal mental health. As an example, a law suit filed in Alameda county known as the Stiavetti Case claimed that the Department of State Hospitals violated the constitutional rights of defendants found Incompetent to Stand Trial by allowing them to languish in the jails awaiting trial competency restoration. This claim is based on a rapidly increasing incompetent to stand trial population being housed in the county jails awaiting treatment. The remaining portion of this chapter will detail the problem as seen in the jails and state hospitals regarding the incompetent to stand trial population that lead to the law suit and mandate that creates accelerated pressure within the jails and hospital to provide immediate trial competency treatment.

Based on Dusky v. US, defendants cannot be convicted of a crime, if they are not mentally competent to stand trial, as it violates constitutional protections by denying the right to a fair trial. As previously stated, trial competency is comprised of being able to understand the procedures and personnel of the court; knowing one's charges, and being able to rationally assist in one's own defense. A defendants' lack of competency forms a figurative roadblock within the adjudication process. Constitutionally, being found incompetent to stand trial does not prevent law enforcement officers from making an arrest, or prevent the prosecuting district attorney from filing charges, but the proceedings cannot move forward or progress in a speedy manner until and unless the defendant is restored to trial competency. When the jails and the court are the first line of treatment for persons with mental illness a bottleneck occurs within the jails creating pressure to house and treat persons with serious mental illness.

Since 1973, the rate of competency evaluations increased, from 25,000 to 36,000 evaluations each year to roughly 50,000 to 60,000 between the years 1994 and 2004 across the country (Mossman et al., 2007). As the impact of the rise of incompetent to stand trial patients is felt acutely by state hospital systems, the National Association of State Mental Health Program Directors Research Institute queried states regarding how they currently structure their systems to accommodate their legal obligations to serve the courts and found that for years 1999, 2005, and 2014 there was a 72 percent increase in referrals for

[20] Murphy conservatorship is reserved for defendants who have not regained competency to stand trial within the period allowed by law and who are considered dangerous. Additionally, (i) The complaint, indictment, or information pending against the person at the time of commitment charges a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person. (ii) There has been a finding of probable cause on a complaint or a grand jury indictment, and the complaint, indictment, or information has not been dismissed (iii) As a result of a mental health disorder, the person is unable to understand the nature and purpose of the proceedings taken against him or her and to assist counsel in the conduct of his or her defense in a rational manner. (iv) The person represents a substantial danger of physical harm to others by reason of a mental disease, defect, or disorder. [(Conservatorship of Hofferber, supra, 28 Cal.3d at p. 178.)]

incompetent to stand trial patients between 1999 and 2014 for the twenty-six states that had complete data, and in California specifically, the one-day-census for patients found incompetent to stand trial rose from 763 patients in 1999 to 1256 patients in 2014 an increase of 65 percent (Wik et al., 2019). Similarly California's Department of State Hospitals research division found a 60 percent increase in monthly referrals, from 232 in the 2013/2014 fiscal year to 372 in the 2017/2018 fiscal year and a 139% increase in average monthly pending placements from 342 to 819 respectively (The California Department of State Hospitals, 2018).

Prior to that investigation, an internal study conducted by the California Department of State Hospitals (2016) found the Judicial Council of California Court Statistics Report showed that between a five-year period between 2009-10 and 2013-14 there was an increase of 72 percent in annual mental health filings (from 12,254 to 21,081). Additionally, during the 2009 to 2012-13 time period, felony cases declined from 261,768 in 2009-10 to 241,117 or eight percent. Felony cases then began to climb and returned to 260,461 by 2013-14. During the same five years, California's population growth was only three percent. Therefore, the increased mental health filings cannot be explained by California's population growth.

The two counties with the greatest growth in Superior Court mental health filings are Los Angeles County and San Diego County per the Department of Finance. Examining data from these two counties gives a better indication of the accelerated nature of this phenomenon. Between 2009-10 and 2013-14, Los Angeles County comprised twenty-six percent of California's population, during that period, its population grew two percent; however, its mental health case filings increased by 401% (from 1,226 to 6,144). Accordingly, during this same time frame, incompetent to stand trial patients from Los Angeles County who were treated within the state hospitals grew by 36% (from 816 to 1,112). Similarly San Diego County saw a 106% increase in mental health filings and the California Department of State Hospitals saw a 46% (153 to 224) increase in treating incompetent to stand trial patients referred from Sand Diego County. The average of the remaining 56 counties in California shows a 31% growth in incompetent to stand trial patient referrals across the five years examined. Regarding mental health expenditure at the county level, the data reveals that there was an increase in thirty-eight percent in mental health funding for all California counties between 2009-10 and 2014-15 (California Department of State Hospitals, 2016).

Although there is no research specifically examining the causal increase of the incompetent to stand trial referral rate, it is important to note the decrease in community psychiatric beds and treatment facilities. Since 1995, there has been a twenty-three percent decrease (181 to 139) in psychiatric facilities in California, which corresponds to a twenty-seven percent decrease in psychiatric beds (9353 to 6777); while California has experienced twenty five percent increase in population growth from roughly thirty-two million to forty million people (California Hospital Association, 2019).

The spike in the incompetent to stand trial population and seemingly significant decrease in access to psychiatric care in the community is creating a crisis of care within the jails. If a defendant becomes incompetent to stand trial in jail it can take months for the defendant to receive competency restoration treatment; and the wait list has ranged from

500-900 persons consistently over the years. These conditions have sparked several lawsuits including one filed by the ACLU in Alameda Superior Court on July 29, 2015, known as the Stiavetti v. Ahlin ACLU on behalf of plaintiffs Stephanie Stiavetti, Kellie Bock, Kimberly Bock, Rosalind Randle, and Nancy Leiva. The lawsuit alleged that the criminal defendants who have been found to be incompetent to stand trial have a constitutional right to adequate and timely evaluation and treatment[21]. On March 15, 2019, the Superior Court of the State of California sided with the defendant and decided that the hospital must reduce the wait times by admitting patients into some form of trial competency restoration treatment within sixty days within one year's time, and further reduce this to thirty days within two years' time: this ruling went into effect during my data collection period and became part of my inquiry into its impact on treatment and care within the hospital (*Stiavetti v. Ahlin*, 2019).

The information presented in this chapter is meant to contextualize the three main psychiatric commitment types treated at Napa State Hospital and the pressures seen within the jails and hospitals due to the increasing incompetent to stand trial population, which factor into the understanding of hospital organization and procedures. The information presented in the next chapter lays the foundation for the ethnographic inquiry by relating the known literature on institutional violence at forensic hospitals and Napa State Hospital specifically and the known literature on therapeutic relationships between psychiatric patients and staff in mandated settings both of which inform the qualitative portion of this investigation. I also present the literature regarding patient satisfaction or service user involvement in psychiatric hospitals, which grounds the quantitative portion of this dissertation and the implementation of the patient satisfaction survey.

[21] The ACLU alleged that DSH, along with the Department of Developmental Services (DDS), was not providing treatment in a constitutionally permissible timeframe. The complaint alleged the following causes of action: (1) violation of California Constitution, article I, section 7, violation of due process due to the delay of admission; (2) violation of California Constitution, article I, section 15, defendants' rights to a speedy trial; (3) violation of California Constitution, article I, section 14, prohibiting due process of law, due to the delay of admission; and (4) taxpayer action under Code of Civil Procedure section 526A to prevent the illegal expenditure of funds, based on the delay of admissions.

## CHAPTER V. LITERATURE REVIEW: HOSPITAL AND THERAPEUTIC DYNAMICS

The initial inquiry of this dissertation is to understand the operations and procedures of the state hospital. As previously stated, due to limited access and changes in research perspective there is very little information that details the procedures, the operations, or the clinician-patient dynamics that are happening within the walls of modern forensic hospitals. Although meager, it is imperative to know what literature is available regarding psychiatric hospitals and mandated psychiatric treatment and to consider how this literature may inform the methodology and findings of this dissertation. In this chapter I will review the known literature on violence within psychiatric and forensic hospitals, the known literature on mandated therapeutic relationships in hospital settings, and the known literature on service user perspectives or psychiatric patient perspectives of mandated psychiatric treatment.

*Institutional Violence at Psychiatric Hospitals*

Beyond the prison and the jailhouse, the psychiatric hospital as a criminal detention center receives less attention in the literature than the prison or the community since deinstitutionalization. However, the historic interplay of the criminal justice and psychiatric hospital system has created an extremely violent therapeutic environment, which is integral in understanding the culture of Napa State Hospital. Assaultive behavior and aggression among psychiatric patients at inpatient facilities is extremely prevalent and detrimental to the operations and goals of the facility and can potentially derail attempts to create effective therapeutic relationships (Flannery et al., 1994; Quintal, 2002). Violence in this setting speaks to the real fears and concerns of the staff, the patients, and the general public and shapes how treatment is administered throughout the hospital. Significant attention has been paid to institutional violence with regards to inpatient psychiatric hospitals and understanding what is already known about this phenomenon can help clarify and contextualize some of the procedures at Napa State Hospital as well as the perspectives of the staff and patients (Hamrin et al., 2009).

Sometimes referred to as institutional violence, the term generally includes any actual, attempted, or threatened harm directed at another individual within the institutional setting, which may take the form of physical, verbal and/or sexual aggression. Institutional violence has many negative ramifications (Gadon et al., 2006). Researchers note that some effects of institutional violence include direct economic costs consisting of: disability pay, illness, absenteeism, counseling costs, sick pay, loss of experienced staff, and high staff turnover; as well as more distal economic costs like a tarnished reputation to the institution, reduction in morale and motivation among remaining staff, and diminished loyalty to the organization or cause (Daffern et al., 2004; Gadon et al., 2006). In addition to the economic costs, therapeutic aims and objectives are also impacted by institutional violence, which disrupt programing and the therapeutic milieu.

Ultimately, institutional violence is destructive to the therapeutic, organizational, and societal aims of psychiatric hospitals. To understand and properly address violence in

psychiatric inpatient hospitals most researchers have looked at individual characteristics of the psychiatric patients such as: a history of substance abuse and addiction, a history of abuse, the onset of violent behavior, diagnosis, stage of illness, antisocial personality traits, age, race, and gender (Monahan et al., 2001; Quinsey et al., 1998; Stahl et al., 2016; Webster & Jackson, 1997). A review of the literature on aggression among psychiatric inpatients determined that a history of violence as well as a history of drug abuse and addiction is associated with higher rates of institutional violence. There are mixed results with regards to diagnosis, but researchers have found an association between a diagnosis of schizophrenia, in particular paranoid schizophrenia and antisocial personality disorders as well as patients suffering from acute manic states. Some studies found that race and gender predicted institutional violence, but other studies found that race and gender were not good predictors of violence. Additionally, some studies demonstrated a greater association between institutional violence and younger patients (Davis, 1991).

Categorization of the types of aggressive acts among psychiatric inpatients has also been researched. Nolan and colleagues (2003) classified acts of aggression based on the motivating factor for the assault and were able to identify three primary classifications for assaultive behavior: disordered impulse control; psychopathic or predatory; and psychotic. Impulsive aggression usually stems from hyper-reactivity to stimuli or an exaggerated threat perception and involves no planning by the patient; in contrast, predatory aggression is generally defined as being planned, goal-directed and the aggressor lacks remorse for the aggressive act; psychotic aggression stems from a misinterpretation to stimuli and is attributable to positive symptoms of psychosis such as paranoid delusions of threat or persecution, command hallucinations, and grandiosity (Nolan et al., 2003; Stahl et al., 2016).

Napa State Hospital is a notoriously violent hospital. Researchers at the hospital examined all assaults within a limited one-year period and were able to categorize most types of assaultive behavior using the typology developed by Nolan and colleagues (2003). Because most assaults are committed by a small percentage of patients, Quanback and colleagues ( 2007) examined the assaultive patterns of "recidivistic assaulters" and found that among this population 54% of assaults were impulsive; 29% of assaults were predatory or planned; and 17% of assaults were psychotic. Among the assaults 60% were perpetrated against patients, whereas 40% were perpetrated against staff. Furthermore, among predatory assaults, 79% were perpetrated against patients, whereas 21% were committed against staff; among psychotic assaults, 71% were committed against patients, whereas 29% were committed against staff; and impulsive assaults were relatively equal with 53% perpetrated against staff and 47% perpetrated against patients. This information has helped inform practices at the hospital and is incorporated into the safety training for all staff.

Guidelines for dealing with assaultive behavior in California State Psychiatric Hospitals have been established, which include ecological and situational risk factors as well as individual characteristics (Stahl et al., 2016). Situational risk factors examine the environmental influences that contribute to violent behavior within institutional settings and include the history and culture of violence within the institution, the current levels of violence, the physical layout of the institution, the population density of the institution, and the quantity of staff as well as the training quality of the institutional staff (Gadon et al., 2006; Megargee, 1977). Cooke (1989, 1991) was able to determine that a manipulation of situational risk factors could reduce the level of institutional violence among prison

populations. A review of the literature on aggression in psychiatric hospitals has determined that certain interactions such as medication administration, assistance with activities of daily living, and limit setting as instances of high risk for institutional violence (Hamrin et al., 2009).

The huge attention paid to aggression and violence within psychiatric hospitals has also led to the investigation of how violence impacts the therapeutic relationship. Within the context of situational variables, therapeutic relationships and aggression have been examined; but mostly focus on perpetrators of domestic violence and partner abuse (Taft & Murphy, 2007). However, there are two studies that specifically examined the role of the therapeutic relationship during inpatient treatment. Beauford and colleagues (1997) found that a poor therapeutic alliance is associated with more aggression. More recently Cookson and colleagues (2012) found no association between therapeutic alliance and aggression in short-term psychiatric hospitalization. At this point there is very limited research regarding the relationship of therapeutic alliances and aggression among psychiatric hospitalization.

*Therapeutic Alliances & Mandated Treatment*

Administering therapy at a state psychiatric hospital is markedly different from other therapeutic settings. Typically, outcomes for patients receiving therapy can be categorized four ways: extra-therapeutic factors, expectancy effects, specific therapy techniques, and common factors (Lambert & Barley, 2001). According to Lambert and Barley (2001), common factors that impact therapy are: empathy, warmth, and the therapeutic relationship, all of which correlate more highly with client outcome than specialized treatment interventions, meaning that regardless of the type of therapy administered the therapeutic relationship is the most salient curative component of the therapeutic process and the common factors most frequently studied in the therapeutic relationship literature are, person-centered facilitative conditions (empathy, warmth, congruence) and the therapeutic alliance (Lambert & Barley, 2001). Understanding the importance that therapeutic alliance between the client and clinical provider is valuable for comprehending the relationships between the clinician staff and the patients at the hospital.

The therapeutic alliance as a concept was first defined as an aspect of psychoanalysis and referred to the maintenance of therapeutic work within in the context of resistance and negative transference from the client (Bibring, 1937; Greenson, 2008; Horvath & Bedi, 2002; Horvath & Luborsky, 1993; Sterba, 1934; Zetzel, 1956). Greenson (2008) helped clarify concepts of "transference," the "real relationship," and the "working alliance" in the psychoanalytic literature. Boudin (1979) further developed the therapeutic alliance definition within the psychoanalytic literature by outlining three dimensions of the client-therapist relationship. Boudin (1979) wrote that the therapeutic relationship ought to consist of collaborative goal setting; collaborate task setting to achieve the agreed upon goals; and finally the development of an interpersonal bond between the client and the therapist. Since these early psychoanalytic formulations, therapeutic alliance has expanded to be defined broadly as the internal processes that occur between the therapist and the client while working toward common treatment goals that happen in parallel of any specific treatment techniques (Beauford et al., 1997; Bordin, 1979; Elvins & Green, 2008; Marziali & Alexander, 1991).

A key aspect to early iterations of research on therapeutic alliances in the psychodynamic literature is that the therapeutic relationship is often voluntary and did not incorporate clients that were suffering from serious mental illness (SMI) like schizophrenia or bipolar disorder (Buck & Alexander, 2006; McCabe & Priebe, 2004). Non-mandated therapy is a significantly different therapeutic environment than court ordered treatment; and the type of therapy needed by psychotic patients is significantly different than non-psychotic patients. This poses a substantial problem to understanding how the therapeutic alliance operates with forensically committed populations, most of which suffer from a severe mental illness and all of which are ordered by the courts to inpatient treatment.

In present day, the bulk of mental health providers working with individuals involved with both the criminal justice and mental health systems are ostensibly employed either directly or tangentially by the state (Steinberg et al., 2015). Therapeutic alliances within this context are particularly unique due to the boundary blurring and "dual role" or "dual relationship" nature of the therapy between provider and client. Forensic mental health providers are charged with both the public protection and ethical patient care making their role an example of an institutional dual role (Carroll et al., 2004).

The changing nature of mental health provision and the ensuing disruption of traditional therapeutic roles in mental health provision led researchers to focus on the efficacy of therapeutic alliances in mandated treatment (Howgego et al., 2003). The bulk of this research has concentrated on community treatment, due to the larger proportion of persons receiving treatment in the community, the overarching push for prevention, and for the desire to have people treated in the least restrictive setting.

Early investigation into mandated treatment in the community relied heavily on measures developed within the field of psychotherapy (Howgego et al., 2003; Neale & Rosenheck, 2000). For example, Calsyn and colleagues (2006) concentrated on identifying predictors of the working alliance among homeless individuals with co-morbid SMI and substance use disorder receiving Assertive Community Treatment (ACT) and found less agreement between clients and case managers with regards to the impact of the working alliance than is generally reported in the psychotherapy literature. With a large portion of patients at Napa State Hospital being homeless prior to being mandated for treatment, this literature has some relevance to the overall dissertation.

Noticing the discrepancy between therapeutic alliances in the psychodynamic literature and the mandated treatment literature, Angell & Mahoney ( 2006) qualitatively examined staff perceptions of the working relationship among ACT teams in rural and urban settings. Considering the context of mandated treatment more fully, they theorized that earlier studies might be overlooking differences in tasks, clinical role, and settings while assessing the role of the therapeutic alliance. In their investigation, the researchers found a difference in the perspectives of treatment between the clinical teams and the clients in each setting. They also recommended an adapted measure of therapeutic alliance to better capture the distinctions between therapeutic alliances in voluntary psychotherapy and mandated treatment. Accepting the charge to better capture the dual-relationship inherent in mandated treatment, Skeem and colleagues ( 2007) developed, validated, and revised the Dual Role Inventory (DRI-R) and found that in mandated treatment the quality of the relationship is highly important and involves caring and fairness, trust, and an authoritative

(not authoritarian) style. Furthermore, they were able to determine that higher quality therapeutic alliance in mandated treatment is able to predict future compliance with the rules when using probation violations and revocations as an outcome measure.

In secure settings, when therapeutic alliances were examined with strict adherence to traditional psychotherapeutic measures no clear association was found between the quality of therapeutic alliance and the duration of treatment; while modest associations were found among perceived amount of time of therapy and years of professional experience (Krupinski et al., 1997). However, other researchers have found that the dual role relationship has been shown to impact the therapeutic alliance and the amount of perceived coercion at the time of admittance; and level of coercive intrusion can ultimately affect patient attitudes towards future treatment (Lidz et al., 1995; Lucksted & Coursey, 1995; Szmukler & Appelbaum, 2008). Therapeutic alliances were also shown to influence likelihood of violent behavior based off of therapist perceptions of the therapeutic alliance (Beauford et al., 1997). When the perceptions of the clients were examined, perceived social climate and perceived therapeutic relationships were viewed as important indicators of treatment outcome and that experience of the therapeutic alliance is strongly associated with their closest staff and the ward atmosphere (Bressington et al., 2011). Also, in a parallel fashion to the community treatment measures of therapeutic alliances, researchers have adapted the Working Alliance Inventory (WAI) and the Interpersonal Trust in Physician (ITP) measures to better reflect the dual role relationship in secure settings (Donnelly et al., 2011).

Although great progress has been made in determining the extent to which therapeutic alliances are created within the context of a dual role relationship within secure settings there remain questions after examining the literature. Most notably is the lack of theorizing over what macro (e.g. criminal justice system, mental health system), mezzo (e.g., financial resources, regulations, organizational), and micro level factors (e.g., race, age, gender, mental health diagnosis, criminal history) factors facilitate or hinder therapeutic alliances.

*Service User Involvement and Psychiatric Patient Perspectives*

Lastly, the service user involvement and perceptions literature must be addressed to ground the implementation of the DSH-Napa patient satisfaction survey and demonstrate its value. Levels of patient satisfaction are considered to be an indicator of quality of care, compliance with treatment, and improvement in health status (Shiva et al., 2009). The increase in security due to patients' forensic status as well as the Health Insurance Portability and Accountability Act of 1996 have made it increasingly difficult to obtain perceptions of treatment and therapy from the perspective of the patient in state hospital settings. Service User Involvement and Perspectives (SUIP) and Psychiatric Patient Perspectives (PPP) for health care and mental health delivery has received some attention in the United Kingdom and Canada, and in recent years, patient satisfaction surveys are administered more frequently in the field of mental health, but it is still uncommon to find these kinds of surveys employed on involuntary psychiatry units and no one has compared satisfaction with treatment across commitment types (Bhugra et al., 2000; Livingston, 2018).

At its core, SUIP seeks to involve consumers of health care and mental health services in decisions affecting policies, treatment, and recovery processes by eliciting their perspectives on services (Landsberg et al., 2002); National Health Care Act 2012, UK). Research in SUIP has expanded to forensic mental health facilities. However, forensic facilities have the dual challenge of serving those receiving services and appeasing societal responses to criminal offending; therefore, there are significant gaps in the SUIP literature with regards to this population.

Critics of measuring PPP state that patient opinion can be unreliable because of their underlying psychiatric conditions or that there is a tendency for the inflation of satisfaction ratings due to social desirability (Elbeck & Fecteau, 1990; Wykes & Carroll, 1993). Despite these criticisms, these surveys are a useful way to elicit perspectives from this hard to reach population and to ground future investigations.

Researchers in several studies reported that psychiatric patients tend to be satisfied with the services offered, staff, and cleanliness and that the quality of the therapeutic alliance is the most salient factor for psychiatric patients (Hsu et al., 1983; Morrison et al., 1996; Wykes & Carroll, 1993). In contrast, other researchers report voluntary non-psychotic psychiatric patients to be dissatisfied with the number of sessions they had with their doctor and the involvement of their family and relatives, food choice, availability of discharge plans, choice in psychiatrist, and procedures regarding the management of side effects from medication, privacy, and ambient noise (Bhugra et al., 2000; Morrison et al., 1996). However, this body of research is mostly based on small inpatient populations and does not consistently survey involuntary psychiatric patients (Bressington et al., 2011; Coffey, 2006; Livingston, 2016). Thus, further investigation into the satisfaction and PPP is necessary in this field because relatively little is known regarding the experience and perspectives of people who use forensic mental health services and nothing is known about the differences in satisfaction and PPP based on court commitment (Coffey, 2006).

The research that has investigated SUIP in forensic mental health settings found that the quality of the therapeutic alliance is the most salient for service user consumers. However, this body of research does not meet the methodological rigor or consistency required to give real insight into the SUIP in forensic facilities due to methodological inconsistencies and weak theoretical underpinnings (Coffey, 2006). Thus, further expansion of methods and theory is necessary because “we still know relatively little of the experience and perspectives of people who use forensic mental health services” (Coffey, 2006 p.73).

The next chapter explains the theoretical factors that currently impact the criminal justice and mental health system and highlights how these macrostructural forces impact the micro and mezzo level operations of a total institution like Napa State Hospital.

## CHAPTER VI. THEORY

The theoretical foundation of this study is sectioned into three parts. Part 1 expands the mechanisms, namely penal expansion and welfare retrenchment, that contribute to Loïc Wacquant's *centaur state* to incorporate deinstitutionalization and the increase of persons with mental illness in carceral settings as a third specialized mechanism of disenfranchisement within a neoliberal context. Part 2 describes the seminal work of Erving Goffman's *Asylums* as the antecedent to the current conceptualization of institutionalization as not only brick and mortar, but also as: adaptive behavior within the institution; policy and legal frameworks; and, paternalism and clinical responsibility. Finally Part 3 connects both Part 1 and Part 2 to create the theoretical framework that will serve as the guide for this dissertation.

### PART 1. EXPANSION OF PUNITIVE MECHANISMS

Chapter II and III of this dissertation looked to the literature to explain penal expansion and psychiatric deinstitutionalization from a genealogical perspective as well as the harm these two policy initiatives currently impose on individuals and communities, and the economic inequality inherent in the current crisis of psychiatric care in the criminal justice system. Loïc Wacquant's *Punishing the Poor* (2009) works at the theoretical intersection of carcerality and economic inequality by focusing on the nature of the state, and the 'transformations of the field of power in the age of ascending neoliberalism'[22] (2009: xviii). By asking how and why the prison was reprised in post-industrial societies after appearing to decline in the mid twentieth century, Wacquant reveals a punitive management system that uses the dual processes of social welfare reform/retraction and penal expansion/control as the central mechanisms that regulate the poor. Wacquant exposes the connection between advanced marginality and state-craft that are reinforced by these institutional mechanisms (Flint, 2019; Wacquant, 2016). Further, he conceptualizes these two systems of regulation as the core drivers of neoliberal governance and views them as two parts of a whole, namely a centaur state or bifurcated political regime that is libertarian in nature for its minority upper class and intrusive and imposing for its majority lower class (Wacquant, 2009, 2010). This intrusive regulation of the poor and marginalized is then used to discipline and correct behavior and wed the disenfranchised to low-wage labor (Wacquant, 2008; Wacquant et al., 2014). In the following sections I will first reiterate Wacquant's thesis that the expansion of the carceral state is in response to social insecurity rather than criminal insecurity. Second, I will then reestablish his thesis that social and penal policies act as two variants of poverty policy in a neoliberal context. Third, I will introduce the literature linking deinstitutionalization to neoliberalism. Finally, I will incorporate deinstitutionalization as a mechanism, along with hypercarcerality and welfare retraction as an under recognized contributor to the centaur state as theorized by Wacquant.

#### *Penal Expansion*

[22] Neoliberalism "a policy model that encompasses both politics and economics and seeks to transfer the control of economic factors from the public sector to the private sector. Many neoliberal policies enhance the workings of free market capitalism and attempt to place limits on government spending, government regulation, and public ownership"(Kenton, 2020)

As stated in Chapter II, the arc of mass incarceration begins to peak in the three decades after the Civil Rights movement when the United States went from being a leader in progressive justice to an advocate of zero tolerance, determinate sentencing, an incapacitation causing the American prison and jail population to explode. A lay explanation of this phenomenon may be attributed to a rise in crime rates; however, Wacquant and others point out that during this time period crime rates actually stagnated and decreased as the prison population continued to rise and asks the question why (Alexander, 2012; Blumstein & Beck, 1999; Simon, 2007; Wacquant, 2009)? Wacquant sees the answer, not in the common crime-and-punishment rhetoric, but in the extra-penological functions of penal institutions (2009).

Wacquant theorizes that in reaction to the race riots of the 1960s the American ruling class configured the police, courts, and prisons to control the social disruption caused by the implosion of the American ghetto as an ethno-racial container and impose economic control over a racialized underclass (2009). These institutional apparatuses ensure tenuous employment at the bottom of a stratified class structure through community interruption and displacement. Wacquant thus sees the resurging prison as serving three goals that have little to do with the ostensible intent of controlling crime. In summary, Wacquant sees the criminal justice system as a means to tie the post-industrial working class to precarious wage-work; to warehouse the most disruptive or burdensome members of the working class; and to patrol and regulate the boundaries of the deserving upper class, while reasserting the authority of the state in its remaining sphere of influence, the working class.

*Penal and Social Policy and Ascending Neoliberalism*

Critical to the analysis of the state hospitals role within the criminal justice system is Wacquant's second thesis from *Punishing the Poor* wherein he states that welfare and criminal justice are two forms of enmeshed public policy that are deployed as a way to control the poor, thus it is untenable to isolate penal policy from social policy as they are integral (2009). Wacquant reframes the downsizing of public aid along with the shift away from the right to welfare towards an obligation of workfare, and the fattening prison system as synergistic and sees both workfare and *prisonfare* as a double regulation of poverty during a period of increasing economic disparity and social insecurity. In fact, according to Wacquant, supervisory workfare and the prison pull from the same marginalized sectors of the unskilled working class, are guided by the same philosophy of moral behaviorism, and use the same techniques of stigma, surveillance, punitive restrictions, and graduated sanctions to achieve their stated goals (2009). Further, Wacquant recognizes that to understand trends in offending and the incarceration, one must consider the changing constellation of welfare provisions including direct assistance, public housing, foster care, and related state programs (2009).

The symbiotic relationship of workfare and prisonfare described by Wacquant then helps generate and promote the neoliberal state. Balking at the conception of neoliberalism as merely free market economics and small government, Wacquant explains that the ideology of neoliberalism is not its reality and theorizes a centaur state or a system of government that allows Leviathan or laissez faire practices for corporations and elites and

authoritarian and interventionist practices for people situated at the bottom of the racial-socio-economic hierarchy. This beastly bifurcation is needed because free market behavior is undisciplined and irregular. Market economies left unchecked undermine the authority of the state and meet with resistance and defiance from the people. Thus, institutional mechanisms, namely an oversized penal state, are required to support and maintain neoliberalism. Wacquant also sees the welfare-penal relationship as increasingly corrosive to democratic ideals. The constant and continued interactions with welfare and penal systems create different experiences of citizenship across the racial and class spectrums curtailing freedoms and principles of equality. He also regards the aggressive deployment of involuntary programs that stipulate personal responsibility while simultaneously rescinding institutional supports as undermining the consent of the citizen. However, this democratically and individually injurious system is not preordained, rather it is a result of policy choices. Finally, Wacquant stresses the need to reveal the overall architecture of the institutional maze that continues to sustain the punitive management of poverty. Understanding the use of the state hospital as an apparatus of the criminal justice system helps reveal this architecture.

*The Centaur State Redux—Deinstitutionalization*

With that call to arms in mind, it is imperative to understand deinstitutionalization's tandem role with welfare retention and penal expansion as a contributor and example of the centaur state. In addition to the broad strokes of free market economics and small government, neoliberalism involves the outsourcing of services previously provided by the government. For mental health services, this operational expression of liberalism evolved into a primarily legalistic model of treatment and intervention for persons with severe and persistent mental illness during the process of deinstitutionalization. As stated in Chapter III, the turn in mental health treatment insisted on judicial screenings prior to making involuntary committal orders in addition to higher standards of proof and an emphasis on grave disability and danger as an important factor in civil commitments. This created a veneer of liberal ideals that would ultimately be plastered on a body of authoritative criminal incapacitation.

On its face, these changes in the structure of treatment provision touted a respect for civil liberties, humanity, dignity, and human rights, while also promoting evidence based treatment policies as a kind of neutral arbitrator of intervention and authority (Carney, 2008). This liberal mask of mental health treatment and deinstitutionalization allowed for the tide of welfare retention and penal expansion to engulf the mental health system. As the formal criteria for government provided mental health treatment began to tighten, extra-legal variables like underfunded community services began its corrosion, leaving a porous welfare net that is unable to provide for vulnerable citizens. Manifestations of neglect like homelessness and crime begin to encompass persons with mental illness and we see the widening penal system taking over the care and treatment of its citizenry, while one's perceived proximity to penalty negotiates the care one receives outside of the jail setting (Comfort, 2007, Lara-Millán, 2014).

Lack of housing, insufficient direct assistance, in addition to poor access to health care deepen criminogenic factors that lead persons with mental illness directly into the

hands of the criminal justice system. The culmination of this *widening gyer* is that the mere introduction of more mental health treatment centers is not sufficient to combat the explosion of persons with mental illness (Fisher et al., 2006). Thus mental health policy and access to health care should be considered along with other social and penal policies. In this vein, deinstitutionalization becomes one of many mechanisms of neoliberalism and requires its own specific lens of analysis.

## PART 2. THEORIZING THE PSYCHIATRIC INSTITUTION

Moving away from the theoretical construction of neoliberalism as a primary mover of incarceration among persons with mental illness, Part II will address the theoretical architecture of the institution itself.

### *Goffman's Asylum*

As evident by the history of the psychiatric institution outlined in Chapter II, asylums were the main form of care for persons with severe mental illness until the latter part of the twentieth century, yet few people had access to these cloistered spaces. Curious to the social world of psychiatric inpatients and the effects of the asylum on the individual, Erving Goffman conducted ethnographic fieldwork for over a year at St. Elizabeth hospital starting in 1955. St. Elizabeth was the first federal psychiatric hospital in the United States and at the time of Goffman's observations, the hospital served over 7,000 patients in the Washington D.C. area. Goffman regarded the mental hospital as a prison-like institution, albeit at the time, the patients committed to the hospital had not broken any laws and were not committed through legal channels. Additionally, he saw the psychiatric institution as a closed system separate from society, coining the term "total institution" to refer to this specific form of ostracism. Goffman defined total institutions as a closed social system in which life is organized by rules, schedules, and strict norms that are determined by a single authority whose will is carried out by staff as enforcers of the ethos.

Goffman conceptualized the lives of individuals living and working in asylum settings, and theorized that the "moral career" of a psychiatric patient is derived largely from the definition and characterization of a total institution, which is all encompassing. Additionally, he describes the mortification of self, which he defines as a process that strips the inmate or patient of their real lives and changes them to the structure of the institution. For Goffman, the mortification of the self begins when a barrier is placed between the individual in an institution and the wider world. The barrier requires that the individual breaks with his past roles and takes on an institutional role that supersedes any previous role the patient once had. For example, prior to hospitalization a person may regard himself or herself as a child, a parent, an artist, a student, or a sage, but after hospitalization, the institution requires that a person must understand himself or herself primarily as a patient before all other roles. This process of becoming acculturated into the role of a patient is commonly understood as 'institutionalization.' For Goffman, institutionalization then creates a kind of harmless and inconspicuous patient whose dull presentation then reinforces notions of chronic mental illness and fosters an inability to care for oneself outside the institutional setting. To further explain the processing of institutionalization,

Goffman conceptualizes five types of total institutions with different aims and societal obligation as shown in Table 1 (p.4, 1961).

**Table 1. Goffman's Total Institution Typology**

| Purpose of Institution | Example of Institution |
|---|---|
| *…to care for people felt to be both harmless and incapable* | Orphanages, poor houses, nursing homes |
| *…to care for people felt to be incapable of looking after themselves and a threat to the community, albeit an unintended one* | Leprosariums, mental hospitals, and tuberculosis sanitariums |
| *…to protect the community against what are felt to be intentional dangers to it, with the welfare of the people thus sequestered not the immediate issue* | Concentration camps, P.O.W. camps, penitentiaries, and jails. |
| *…to better pursue some worklike tasks and justifying themselves only on these instrumental grounds* | Colonial compounds, work camps, boarding schools, ships, army barracks, servants' quarters. |
| *…as retreats from the world and training stations for the religious service* | Convents, abbeys, monasteries, and other cloisters |

Since Goffman's seminal work there is little common understanding or agreed usage for the term 'institutionalization.' Focusing within the field of psychiatry and medicine, Chow and Priebe conducted a review to identify instances and commonality among the meanings and connotations of institutionalization starting from Goffman's work on mental hospitals and continuing to the present day to analyze and synthesize how the term is used in the psychiatric literature (2013). They discovered four distinct paradigms for describing institutionalization theoretically, which will subsequently be discussed.

*Bricks and Mortar*

The architecture of a building, or the overall design of a group of buildings that comprise a psychiatric hospital have been an obvious and important focal point in the psychiatric literature on institutions. Goffman made a point to describe the physical structure of the total institution and the psychiatric hospital as having a "barrier to social intercourse with the outside…that is often built right into the physical plant, such as locked doors, high walls, barbed wire, cliffs, water, forests or moors" (p. 4, 1961). Since the advent of the modern institution in the early 19th century, asylum architecture developed from a belief that psychiatric patients needed to be isolated from their families and community in a suitable therapeutic space to be cured often in a remote geographical location (Sine, 2008). Theoretical considerations about the physical nature of the psychiatric hospital evolved into a consideration of patients' rights and autonomy caused by the architectural design of inpatient facilities and the legitimacy and ethical value of a space when it is used to restrain and impose control in an attempt to prevent harm and danger (Sine, 2008). This emphasis on the 'bricks and mortar', the physical environment of the psychiatric hospital, continues to be researched as a contributor to treatment processes and safety (Davis et al., 1979; Dvoskin et al., 2002; Karlin & Zeiss, 2006; Moos, 1972; Moos, 1973; Priebe, 2004; Sine, 2008; Taj & Sheehan, 1994). Chow and Priebe (2013) determined that the discussion of the

physical psychiatric institution remains constant in the literature as a possible contributor to the experience of treatment and care. Conversely, they note that few research studies have focused primarily on the theme of architecture, considering the rise in community mental health treatment, and the negative connotation associated with the psychiatric hospital after deinstitutionalization as possible deterring factors for investigators.

*Adaptive Behavior within the Institution*

Another prominent theoretical understanding of the psychiatric institution is the adaptive behavior exhibited by patients in response to psychiatric treatment within the hospital setting (Chow & Priebe, 2013; Wing, 2000). First recognized in England in the 1950's, institutionalism was coined as a term used to describe the social withdrawal and maladaptive behaviors observed among long-stay psychiatric patients (Wing, 2000). Considered a syndrome induced or worsened by the psychiatric facilities themselves, institutionalism was first associated with the poverty of the physical environment and three variables that increase the negative effect: the social arraignment or lack thereof of the institution; the length of stay; and the severity of primary psychiatric symptoms and secondary disabilities that are not part of the psychiatric illness itself (Wing & Brown, 1970). In a comparison of several psychiatric institutions, Wing and Brown determined that patients with schizophrenia that were treated at hospitals with richer social environments and opportunities had fewer negative symptoms[23] and disturbances in verbal and social behavior; moreover, patients with few activities and opportunities for social interactions are considered the most unwell (1970). By design, most institutional settings are isolated from the outside world which can promote the loss of independence and personal responsibility needed to function in the community making it more difficult to survive outside of the institution (Goffman, 1961; Liberakis, 1981; Ochberg et al., 1972). Even when admission to a psychiatric hospital is perceived as humiliating and stigmatizing, patients will adapt to their environment and become dependent on receiving care from services, lose their confidence to make decisions and consequently become institutionalized (Ford et al., 1998). Social breakdown syndrome is another conceptualization of this phenomenon and is characterized as the loss of normal role functioning after exclusion from typical family or community roles (Gruenberg et al., 1972; Gruenberg, 1967).

Critics of the institutionalism argue that there are little differences in terms of cognitive deficits among persons with schizophrenia in hospital and out-patient settings when age and duration of illness were controlled (Johnstone et al., 1981). Moreover, Pine and Levinson conceptualized the relationship between the patient and the psychiatric hospital as a kind of "patienthood" and described voluntary psychiatric patients as analogous to college students (1961). Further arguing that despite the similarity to prison and the stigma associated with institutional psychiatric care, hospital admission can be seen as an opportunity for advancement and personal growth similar to going away to a university when patients are able to successfully adapt to their physical environment and meet their institutional goals (Pine & Levinson, 1961). Adaptive behavior as a theoretical

[23] Negative symptoms of schizophrenia include the inability to show emotions, apathy, difficulties talking, and withdrawing from social situations and relationships. These symptoms are separate from the positive symptoms of schizophrenia, which include hallucinations, delusions, and repetitive movements; and cognitive symptoms, which include disorganized thoughts, memory problems, and difficulties with focus and attention.

touchstone of institutionalization is consistently part of the literature; however, it has lost popularity during the course of deinstitutionalization (Chow & Priebe, 2013).

*Policy and Legal Frameworks*

As community mental health became the primary provider of psychiatric treatment for persons with mental illness, attention shifted away from the institution as building or a structure and the institution as an adaption of the patient to the environment of the structure, and began to become associated with the policies and legal frameworks associated with the care of the psychiatric patient. This newer conceptualization emerged as a restriction of the rights of a patient (Ochberg et al., 1972). In the literature, when institutionalization is theorized as a restriction of rights, researches focus on mandated treatment in locked facilities, the use of seclusion, restraint, and sedation as treatment interventions (Georgieva et al., 2012; Lang et al., 2010; Lewis, 2002). Further, participation in treatment activities and therapies is often compulsory or narrow in focus (Johnson & Rhodes, 2007). Additionally, restriction of freedom in the form of movement is still associated with psychiatric institutionalization and hospital treatment. In many hospitalizations, patients are not permitted to leave the psychiatric institution without being officially released or discharged. Mandatory treatment then leads to the theorization of institutionalization as commitment. As legislation developed to regulate the behavior of persons with mental illness, involuntary placement and the limitations of psychiatric practice on individual autonomy become another theoretical frame to explore mental health treatment (Chow & Priebe, 2013).

*Paternalism and Clinical Responsibility*

Clinical responsibility and paternalism, as a guiding theoretical principle, emerged in the 1970s within the literature on psychiatric treatment and increased substantially in the 1990's (Chow & Priebe, 2013). Safe keeping such as shelter and protection, especially in relationship to homelessness and victimization, emerges as a theorized component of institutional psychiatric treatment in addition to psychopharmacological intervention. After the inability for community mental health centers to provide comprehensive treatment to persons with mental illness in the 1990's, the potential benefit of inpatient facilities started emerging in the literature (O'Brien & Cole, 2003; Prior, 1995; Talbott & Glick, 1986; Wasow, 1986; Wing, 1990). The institution, especially inpatient hospitalization, becomes a space where treatment for persons with chronic mental illness can be supervised and controlled. This form of paternalistic intervention is criticized for its potential to hinder community reentry and potential (Talbott & Glick, 1986). In contrast, it is argued that inpatient care or the asylum can offer more care and protection for certain persons with chronic mental illness that need permanent, structured supervised housing (Wasow, 1986).

Power dynamics as a form of paternalism are also theorized within the literature on institutions and psychiatric care. Displays of unequal power are constant among the staff, among the patients, and between the staff and patients. Psychiatrists are often situated at the top of the clinical totem and have authority and responsibility for patient safety and care, clinically and legally. Nursing staff and other clinical care providers are charged with

the allocation of unit privileges, preferred accommodation, access to social facilities, activity, or extra food (McCubbin & Cohen, 1999). Staff members in highly formalized institutions behave more paternalistically towards patients than staff members in less formal ward environments; and guardedness between a clinician and his or her patient/client is dependent on the social culture of the institution and the legal status of the patient (i.e. voluntary versus involuntary (Quirk et al., 2006). At times, the paternalistic relationships between staff and patients can take the shape of coercion. Coercion, even in subtle or informal forms, is frequently practiced by staff to ensure safety and medication adherence (Lay et al., 2011). Voluntary patients have been found to feel coerced into admission and can continue to feel coerced throughout their treatment ( Katsakou & Priebe, 2006; Katsakou et al., 2010, 2012; Priebe et al., 2009). In relationship to therapeutic relationships, higher perceptions of coercion are associated with perceived negative relationships between patients and clinicians and feel less coerced when their satisfaction with hospital treatment increases (Sheenan & Burns, 2011). The use of coercion is often justified in mental health settings based on the concepts of capacity and ability to make decisions for oneself. Formal coercion even spills into community treatment orders, especially those that are mandated from the courts (Jarrett et al., 2008; Lützén, 1998; Wing, 1990). As the treatment of persons with mental illness shifted from need-to-treat to dangerousness, how to care, convince, and coerce patients into treatment continues to muddy the ethical intervention of mental health treatment (Gong, 2017).

*The Institution as a Theoretical Project*

Chow and Priebe (2013) were able to outline four distinct conceptualizations of institutionalization within the psychiatric literature which include: bricks and mortar or the physical space; walls and fences of a building, which can contribute to the treatment capabilities and violence on a unit; the adaptive behavior exhibited by patients to institutionalized care which impact treatment efficacy and community reentry; the policy and legal frameworks that regulate care and shape the course of treatment; and the clinical responsibility and paternalism associated with treatment which mitigate the strength of the clinician-patient relationship. However discrete these conceptualizations are, there is significant thematic overlap within singular studies and emphasis on specific themes has evolved over the course of deinstitutionalization (Chow & Priebe, 2013). Thus, the psychiatric institution as a theoretical project draws from all four conceptual themes illustrated in Figure 1.

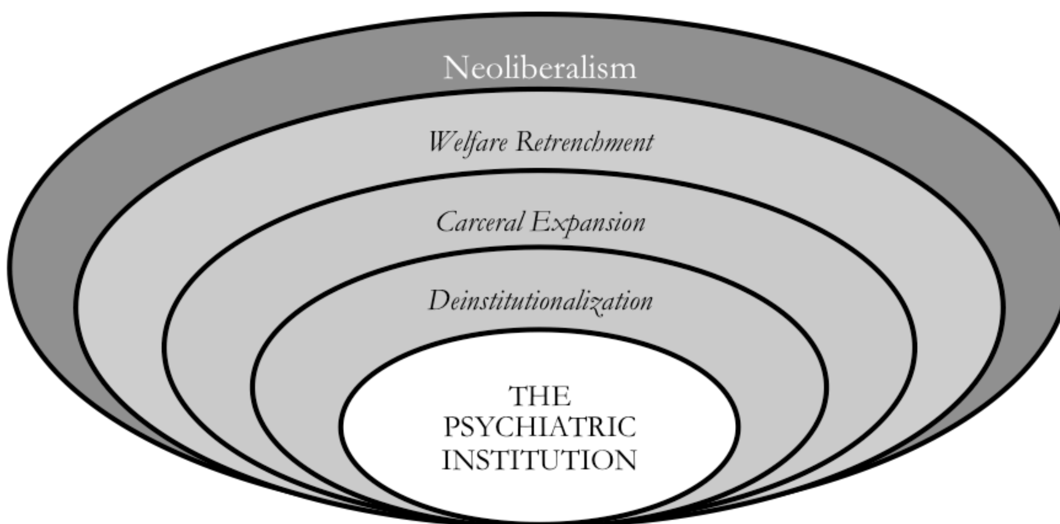
**Figure 1. The Psychiatric Institution as a Theoretical Project**

Although the concept of institutionalization is complex, these identified themes provide a preliminary framework for investigation and analysis into the modern state psychiatric hospital. The multidimensional understanding of institutionalization in the field of psychiatry foreshadows expectations of experience and perceptions among the staff and patients within the institution itself. Therefore any contemporary inquiry into the treatment and care of psychiatric patients should consider the interaction and presence of all four institutional themes.

## PART 3. THEORETICAL FRAMEWORK

The theoretical framework that buttresses this dissertation is based on the placement of the psychiatric institution as a theoretical project in and of itself within the context of Wacquant's modified theory of poverty governance and neoliberal sentiment illustrated in Figure 2.

**Figure 2. Theoretical Framework**



Prior to deinstitutionalization, the psychiatric institution existed as an independent entity, understood as a complex web of restraint, punishment, control, treatment, and moral obligation. Over the course of deinstitutionalization in California, most institutions disappeared leaving only a few withstanding hospitals. The state psychiatric hospital then subordinated itself to the criminal justice system to ensure survival. This relationship possibly cripples the ability to effectively provide treatment for persons with mental illness in a societal context; however little is known about the current treatment provided within the state hospital. The difficulty in accessing forensically committed psychiatric patients and the complicated legal processes that connect them to this system makes scientific investigations with a societal gaze almost impossible. The theoretical framework weds the macrostructural lenses of welfare retrenchment, carceral expansion, and deinstitutionalization incorporated into neoliberalism and the mezzo and micro lens of the psychiatric institution. This framework helps to guide the methodology and analysis of the dissertation. Choosing to conduct an embedded ethnographic study of the role of the modern state psychiatric hospital is therefore the most appropriate investigative method to consider the operations of the hospital, the perceptions of the care provided, and the legitimacy of the mandated treatment and coercion.

# CHAPTER VII. METHODOLOGY

Ethnographic researchers, or those interested in the culture and customs of a specific group of people from their point of view, have a long history recounting the institutional and post-institutional experience of persons with mental illness (Caudill, 1958; Goffman, 1961; Levinson & Gallagher, 1964; Perrucci, 1974). As previously mentioned, the ethnographic research conducted by Goffman helped highlight the lack of rehabilitation and therapeutic value the modern asylum provided its inmates (1961). Understandably, since deinstitutionalization ethnographic researchers shifted their attention to the mental health treatment in community-based settings (Arrigo, 2001; Brodwin, 2013; Estroff, 1981). Simultaneously, the substantial increase of persons with serious mental illness within the criminal justice system has pulled the attention of criminal justice researchers to the overrepresentation of persons with mental illness in the jails and prisons, to the point where medical scholars have named prisons the new "psychiatric asylum" (Steinberg et al., 2015).

Both of these shifts in scholarship have left a gap in ethnographic research in secure institutions. Loïc Wacquant noted that just at the time when ethnographic research is most needed to understand the experience of large populations of incarcerated individuals, there has been a "curious eclipse" of ethnographic research within the criminal justice system ( 2002). The bulk of research that persists within the psychiatric institution follows the trend of civil commitment laws, focusing on risk, violence, and length of stay rather than the institution itself or the processes that contribute to their survival (Quanbeck et al., 2007; Schaufenbil, Kornbluh, Stahl, & Warburton, 2015; Warburton, 2014, 2015; Warburton & Stahl, 2016). In contrast, most penal ethnographies that exist consistently focus on inhumane treatment of persons with mental illness in the prison system and the deleterious effects of solitary confinement on the mental state of confined persons (Testa & West, 2010; Cunha, 2014; Rhodes, 2001; Slovic, 2001). No ethnography exists today that is embedded in the forensic hospital and considers the relationship between deinstitutionalization and mass incarceration. The following sections articulate the rational for the study design and the methods I used to address this line of inquiry.

## PURPOSE

After the review of several bodies of literature that relate to therapeutic treatment within forensic mental health facilities, it is evident that significant gaps in the literature still remain that speak to how the current relationship between the criminal justice system and the state hospital system impacts treatment and how this system relates to the larger genealogies of welfare retrenchment, deinstitutionalization, and mass incarceration. The purpose of this research is to: first, elucidate the treatment provided to persons involuntarily committed to psychiatric care at the state hospital; second, evaluate patient satisfaction with the treatment provided at the state hospital and unearth variations in satisfaction based on commitment type; and third, reveal social welfare considerations (i.e. lack of housing, community mental health treatment, and substance abuse treatment) that impact individual psychiatric treatment. Through this process this research identifies competing social demands between the criminal justice system and the state mental health system and offers insight and solutions for potential restructuring of these fraught systems.

## Research Questions

The research questions are guided by my interest in understanding how treatment is provided to persons with mental illness within California's forensic hospitals. Based on literatures that investigate mental health treatment and the carceral experience several gaps of knowledge still remain. I pose the following questions in an attempt to bridge some of the existing gaps. The first research question is a guiding question that helps lay the foundation for the remaining three research questions and it is based on the participant observation data and institutional data. Questions two through four developed out of the understanding of the organizing principle of the hospital, which is forensic commitment and address the novel inquiry of understanding the impact forensic commitment has on psychiatric treatment for persons with mental illness inside both the criminal justice system and the state hospital system. Table 2 repeats the research questions presented in the introduction and describes the corresponding method of analysis.

**Table 2 Research Questions and Corresponding Method**

| | |
|---|---|
| Research Question 1 | What is the organizing principle of California's state hospital system and Napa State Hospital specifically? *(grounding question)* |
| *Method* | *Participant Observation, Institutional Data* |
| Research Question 2 | How does the organizing principle impact the type of therapeutic treatment provided to patients? |
| *Method* | *Therapeutic Group and Individual Treatment Data* |
| Research Question 3 | How satisfied are patients with the treatment and care they receive at Napa State Hospital? Are there differences in patient satisfaction based on commitment? |
| *Method* | *Patient Satisfaction Survey Data* |
| Research Question 4 | How do patients, clinicians, and administrators perceive the experience of receiving and providing trial competency restoration treatment? |
| *Method* | *Semi-Structured Interview Data, Participant Observation* |

## Hypotheses

To address Research Question 1, based on the known configuration of the Department of State Hospitals, I hypothesize that the organizing principle of the hospital will be forensic commitment. At Napa State Hospital specifically, I hypothesize there will be differences in the process and therapeutic structures of the treatment provided to patients based on commitment.

To address Research Question 2, how forensic commitment type impacts the type of therapeutic treatment provided to patients, I hypothesize that treatment programing will vary based on commitment type and legal standards. Since deinstitutionalization, there has been an unraveling of treatment opportunities available to people based on legal standard and access to care. I hypothesize that there will be more treatment opportunities for

patients found Not Guilty by Reason of Insanity, due to the status as a post adjudication criminal commitment.

Although researchers concerned with service user involvement in forensic settings have found high level of satisfaction, there has not been any research done that can compare satisfaction across commitment type. To address Research Question 3, is there any variation of patient satisfaction based on forensic commitment, I hypothesize that patients found Not Guilty by Reason of Insanity will be more satisfied than either patients found Incompetent to Stand Trial or Civilly Committed patients. I also hypothesize that there will be greater satisfaction among patients who are provided more treatment opportunities, are less symptomatic, and experience less violence.

Finally, to address Research Question 4, how do patients, clinicians, and administrators perceive the experience of receiving and providing psychiatric treatment based on court ordered commitments, I hypothesize that increasing pressure to provide treatment for patients found Incompetent to Stand Trial, including increases in population and pressure to discharge, foment frustration and feelings of ineffectualness among clinicians and administrators. Further, I hypothesize that legal pressure or mandates based on case law will continually shape psychiatric treatment within the state hospital system from the outside, without consideration of the historical and societal disinvestment in social welfare.

## Analytic Strategy and Positionality

As an institutional ethnographic researcher I seek to explore and examine the culture of the institution from the perspective of the human experience. I employ a naturalistic paradigm approach for my analytic strategy asserting that the "truth" is not an objective, knowable fact that can be achieved, but instead the truth is best understood from the advantage of multiple constructed realities (Lincoln & Guba, 1985). Additionally, in this research role, I am not a detached or uninvolved observer, rather I gain insight from my contact with my research subjects, taking into consideration my interactions, conversations, informal and formal interviews, as well as my shared and personal experiences. From my perspective, the only way to study the social and cultural phenomenon of the hospital is to study the hospital in action and the nuanced complexities of the human and social interactions happening within it.

The nature of this research required a unique approach to data collection. Persons currently committed to psychiatric care in state forensic hospitals are considered a vulnerable population. Conversely, they are also considered a dangerous population. Therefore, access within DSH-Napa is limited to state employees and contractors for safety and liability. An institutional ethnography of this nature, necessitates conducting research from the perspective of an embedded researcher, meaning that I held employment as a clinical psychiatric social worker for the California Department of Hospitals, while undertaking a research role as a doctoral candidate in the School of Social Welfare at the University of California Berkeley.

As an embedded researcher, my staff status allowed for identification and implementation of a collaborative research agenda that mutually benefited the hospital and myself as a researcher. A hallmark of embedded research is that it is mutually beneficial for both the academic and host organizations (Cheetham et al., 2018) In this case, I was provided greater access to the host organization, institutional data, and unprecedented access to service providers and users. The host organization received a connection to social welfare academia, networks, and critical approaches to developing organizational policies and practices.

My position as a psychiatric social worker employed and working as a clinician fundamentally shaped the research I was able to conduct over a four-year observation period. As a member of the social work department working on a specialized 52-bed unit for geriatric and medically fragile males found incompetent to stand trial I was able to participate in daily morning reports, treatment team meetings, department meetings, mortality review committee meetings (conducted after the death of a patient), program review committee meetings (held for problematic patients), bioethics meetings, and all other social work duties for 16 patients. These meetings allowed me to develop an institutional vocabulary and gain membership status among the staff and patients. Additionally, my insider knowledge allowed me to have access to staff in multiple positions throughout Napa State Hospital and the Department of State Hospitals.

As an embedded researcher, I must also reflexively acknowledge my role in the research as a clinician. Qualitatively, I am an instrument within the design of the study. All of my prior experiences, assumptions, and beliefs influence my interactions and the research process. As a trained clinician in the critical social work tradition, I bring a structural critique of our macro-level systems of care and control, and a clinical ability to establish rapport and trust with individuals with severe and persistent mental illness. It should also be stated that some of the participating patients had little or no insight into their mental illness and expressed active psychotic symptoms during their interview. Being a trained mental health provider was critical in this endeavor, because I was able to safely elicit answers from the participants, while not disturbing or overly confronting their delusional belief system and inadvertently impede their therapeutic progress.

Finally, as a woman of color and a social worker, I am also aware of the hierarchal and patriarchal dynamics of professionalization that impact organizations and government bureaucracies. While navigating the process of approval for this study from the Research Advisory Council at the hospital, I consistently experienced incredulity at whether the doctorate in philosophy from my granting institution was a research degree and whether the qualitative methods I wanted to employ to study my research questions were rigorous and valuable for the organization. These intersecting identities: insider, Black, social worker, student-researcher, woman etc. all impact my reflexive position and required that I systematically attend to the contextual influence my experience brings to knowledge construction in the institutional environment.

## RESEARCH DESIGN

An extended case study design is an appropriate method to examine the extent to which the criminal justice system shapes therapeutic treatment within the state psychiatric hospital and how patients, clinicians, and administrators react to criminal justice requirements because it is a theoretically driven ethnographic style that allows the researcher to exemplify, modify, and enhance existing theories (Burawoy, 1998; Tavory & Timmermans, 2009). My hypotheses, related to the systemic classifications of marginalized persons take into account the theoretical criticism of welfare retrenchment, carcerality, and the social determinants of mental health disparities (Muntaner et al., 2013, 2015). The extended case study design is particularly appropriate for this investigation because it is an empirical form of inquiry appropriate for descriptive studies where the goal is to describe the features, context, and process of a phenomenon and build empirical knowledge (Yin, 2013; Scholz & Tietje, 2002).

The extended case study method is used to understand the complexity of a case in the most complete way possible and from various angles; thus the use of multiple data collection methods and sources for collecting data is commonly used in the practice. By using multiple sources of data and both qualitative and quantitative methods, this dissertation will obtain the richest possible understanding. The extended case study design allows for the investigation of sub-units within a larger delineated unit, providing a more detailed level of inquiry. (Burawoy, 1998; Campbell, 1975; Bromley, 1986; Scholz & Tietje, 2002; Yin, 2013; Baker & Jack, 2008). I integrated both quantitative and qualitative methods into a single research study to expand the scope of my inquiry and solicit greater depth of data. In this study, Napa State Hospital (DSH-Napa) is considered the main unit of analysis as it represents a particular intersection of the criminal justice and mental health system. The three main forensic commitment types treated at DSH-Napa: Lanterman-Petris-Short [LPS] Act (civil); Not Guilty by Reason of Insanity (criminal); and Incompetent to Stand Trial (civil) comprise the subunits of socio-legal investigation. Additionally, patients, clinicians, and administrators serve as the subunits for the service-provider/user investigation. Within these subunits, treatment programming, patient perspectives, and staff perspectives are analyzed.

*Internal Review Board (IRB)*

California's Office of Statewide Health Planning and Development (OSHPD) initially approved this study on August 3, 2018. The University of California Berkeley's Institutional Review Board (IRB) signed a reliance agreement with OSHPD ceding review to the state-level committee received on December 12, 2018. Prior to submitting an IRB protocol to OSHPD, this study received approval from the Department of State Hospitals—Napa's acting executive director and input from Napa State Hospital's Research Advisory Council. Please see Appendix A. for a copy of the initial approval letter.

## POPULATION, RECRUITMENT, & SAMPLE

*Population*

The California state hospital system is managed by the Department of State Hospitals (DSH) and provides mental health services to patients admitted into DSH

facilities. DSH is comprised of five state hospitals – Atascadero, Coalinga, Metropolitan, Napa, and Patton, with a superintending department located in Sacramento. California Governor Jerry Brown created DSH during the 2012-2013 fiscal year by eliminating the Department of Mental Health and transferring its various functions among multiple departments. All facilities within the state hospital system are fully licensed by the California Department of Public Health. In fiscal year 2018-2019, the department employed nearly 13,000 staff and served 11,752 patients throughout the entire hospital system.

In terms of psychiatric treatment, the patient's 'Treatment Team' determines treatment programing for patients in a collaborative manner related to their respective disciplines. These teams are comprised of at least one member of each of these specialized professions: psychiatry, psychology, nursing, social work, and rehabilitation therapy and takes input from the unit medical doctors. The treatment team is stratified based on the medical model, placing the psychiatrist at the top of the hierarchy and final decisions regarding the patients course of treatment falls under their purview. In addition to these frontline staff members, there are also clinical administrators charged with ensuring that the hospital remains compliant and safe. This staff is generally made of seasoned employees that have worked within the state hospital for ten or more years and have witnessed significant changes in the operations of the hospital. This project will draw its participants from the clinical staff and clinical administrators.

In terms of the patients, patients committed to treatment at DSH-Napa are primary diagnosed with a psychotic disorder. Please see Figure 3 for a comprehensive break down of patient diagnosis for all patients at DSH. Further, most patients served by California's state hospital system are predominately male, over forty-years old, received less than a high school education, and all are mandated to treatment through the court system either criminally or civilly Please see Table 2. for more detail.

**Figure 3. Patient Diagnosis: 2018 One-day Census Total DSH Patient Population, N=6104**

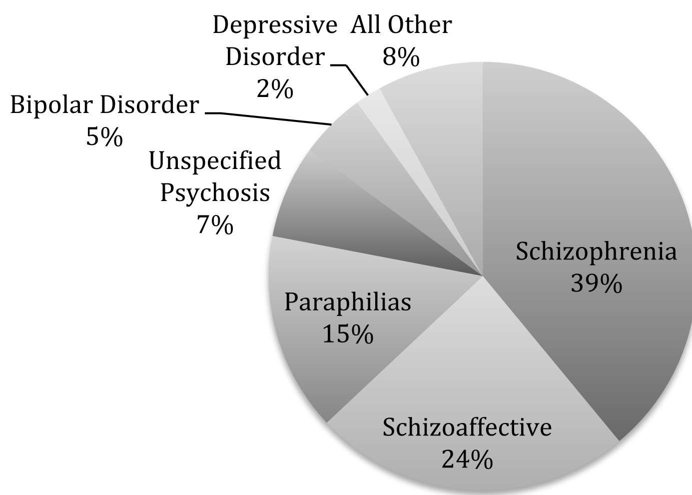


**Table 3. Patient Demographics: 2018 One-day Census Total DSH Patient Population**

| | | | | | | Total 6104 |
|---|---|---|---|---|---|---|
| **Age** | 18-20 | 21-40 | 41-64 | 65+ | | |
| | 1% | 35% | 52% | 12% | | |
| **Citizenship Status** | Yes | No | Unknown | | | |
| | 89% | 5% | 6% | | | |
| **Commitment** | Criminal | Civil | | | | |
| | 89% | 11% | | | | |
| **Education** | < High School | High School | Some College | | | |
| | 78% | 21% | 1% | | | |
| **Race/Ethnicity** | White | Black | Hispanic | Asian | Other | |
| | 42% | 26% | 24% | 4% | 4% | |
| **Language Spoken at Home** | English | Other/ Unknown | Spanish | Tagalog | Vietnamese | |
| | 71% | 24% | 4% | <1% | <1% | |
| **Level of Care** | Unknown | ICF* | Acute | SNF** | Residential | |
| | <1% | 69% | 24% | 1% | 6% | |
| **Marital Status** | Single | Married | Divorced/ Separated | Widowed | Other/ Unknown | |
| | 71% | 7% | 10% | 1% | 11% | |
| **Sex** | Female | Male | | | | |
| | 14% | 86% | | | | |

*Intermediate Care Facility
**Skilled Nursing Facility

Each hospital within DSH has a different commitment composition. DSH-Napa operates approximately 1,255 beds and its composition is based on California's Welfare and Institutions Code, which requires that DSH-Napa not exceed 20 percent civil commitments and the remaining 80 percent of beds are reserved for criminal commitment types. In California, there are technically nine penal code (PC) commitments and eleven welfare and institution code (WIC) commitments. DSH-Napa is legally allowed to provide treatment to eight WIC commitment categories and six PC commitment categories. However the predominate commitments treated at the hospital are patients committed as: not guilty by reason of insanity (47%); incompetent to stand trial (30%); Offenders with Mental Health Disorders (6%); and civil commitments including referrals for full conservatorship under

Lanterman-Petris-Short and murphy conservatorship (17%). In addition to the patient population approximately 2,335 persons are employed at DSH-Napa, providing care and services on a twenty-four hour basis. The clinical staff includes unit psychologists, psychiatrists, social workers, rehabilitation therapists, psychiatric technicians, medical doctors, and registered nurses. Administrative staff classifications include executive administrators, hospital police officers, hospital fire fighters, dietetics, custodial, warehouse workers, and information technology staff.

*Recruitment Procedures*

The mixed method design relies on three sources of data: therapeutic treatment data, survey data, and interview data. The therapeutic treatment data set is comprised of institutional data and did not require a recruitment procedure. For the quantitative survey data, total population sampling was used to recruit patient participants. Total population is a type of purposive sampling technique that examines an entire population that has a particular set of characteristics, in this case any patient committed to treatment at DSH-Napa. The survey distribution and collection were managed under the purview of the Unit Supervisors at the hospital. Survey materials were supplied to Unit Supervisors including survey forms, manila folders for collection, and instructions for administration. Patient representatives on each unit were informed about the survey and reviewed the patient instructions with staff during Client Advisory Council. The patient representatives received training on how to assist in the administration of the survey during Therapeutic Community on his or her respective unit to minimize response bias. The principal investigator trained clinical staff on survey procedure to assist with administration duties and answer any outstanding questions. Data collection occurred during the month of October 2017.

Recruitment procedures for the semi-structured interviews were two-fold and followed a unique purposeful sampling strategy for data collection that combined expert and snowball sampling techniques. Expert sampling as a purposive sampling technique is used to extract knowledge from individuals that have a particular expertise. This was used to identify clinicians and administrators with varying professional identities and roles throughout the hospital; additionally, snowball sampling was then used to identify patients throughout the hospital to participate in the interviews. The initial solicitation process lasted from Jan 1, 2019 through June 1, 2019, and included in-person and email solicitation. For civilly committed patients, a second recruitment email was extended to county conservators requesting permission to allow their conserved patients to participate in the interview.

*Sample*

The total number of respondents for the survey was 611 and the response rate was 49.2%. General demographic data was also obtained based on self-identification cross checked with known data based on unit demographics (i.e. if a respondent did not indicate gender or commitment, but the returned survey indicated that it came from an all female incompetent to stand trial unit, then that information would be recorded during the data input phase). Additionally the independent variable treatment commitment was developed to indicate the form of treatment provided to the patient based on unit location which ultimately coincides with commitment treatment for either civil, competency, or insanity

(please see Appendix B. for demographic solicitation method). The sample characteristics from the survey data are presented below in Table 4.

**Table 4. Sample Characteristics- Patient Survey**

| | N=611 | |
|---|---|---|
| | *n* | (%) |
| **Gender** | | |
| Female | 95 | (16.2) |
| Male | 480 | (81.9) |
| Trans/Gender Non-Conforming | 11 | (1.9) |
| TOTAL | 586 | (95.9) |
| **Age Range** | | |
| 18-24 | 19 | (4.1) |
| 25-30 | 54 | (11.7) |
| 31-40 | 97 | (21.1) |
| 41-50 | 85 | (18.5) |
| 51-60 | 105 | (22.8) |
| 61-70 | 78 | (17.0) |
| 70+ | 22 | (4.8) |
| TOTAL | 460 | (75.3) |
| **Race** | | |
| Asian | 38 | (7.0) |
| Black | 128 | (23.4) |
| LatinX | 86 | (15.7) |
| Native American | 14 | (2.6) |
| Other | 32 | (5.9) |
| White | 249 | (45.5) |
| TOTAL | 547 | (90.0) |
| **Commitment Treatment** | | |
| Lanterman Petris Short [LPS] (Civil) | 130 | (21.5) |
| Incompetent to Stand Trial (IST) | 145 | (24.0) |
| Not Guilty by Reason of Insanity (NGRI) | 329 | (54.5) |
| TOTAL | 604 | (98.9) |
| **Treatment (Tx) Time at Hospital** | | |
| 0-1 Years | 141 | (32.5) |
| 1-3 Years | 94 | (21.7) |
| 4-7 Years | 65 | (15.0) |
| 8-15 Years | 65 | (15.0) |
| 16-25 Years | 58 | (13.4) |
| 25+ | 11 | (2.5) |
| TOTAL | 434 | (71.0) |

In addition to the patient satisfaction survey, 62 semi-structured interviews were conducted consisting of 27 patient interviews and 35 staff and administrator interviews.

Characteristics based on primary commitment population at the time of interview and professional status are presented in Table 5; patient sample characteristics are presented in Table 6; and staff sample characteristics are presented in Table 7.

**Table 5. Total Interviews by Commitment and Provider/User Status**

| Institutional Status | Civil-LPS | IST | NGRI | N/A | Totals |
|---|---|---|---|---|---|
| Clinicians | 6 | 9 | 6 | | 21 |
| Administrators | 3 | 2 | 2 | 7 | 14 |
| Patients | 3 | 11 | 13 | | 27 |
| **Totals** | **12** | **22** | **21** | **7** | **62** |

**Table 6. Sample Characteristics--Patient Interview N=27**

| | n (%) |
|---|---|
| **Gender** | |
| Female | 7 (26) |
| Male | 20 (74) |
| **Age Range** | |
| 18-39 | 14 (52) |
| 40+ | 13 (48) |
| **Race** | |
| Asian | 2 (7) |
| Black | 4 (15) |
| LatinX | 4 (15) |
| Other | 2 (7) |
| White | 15 (56) |
| **Commitment Treatment** | |
| Civil (Lanterman-Petris-Short) | 3 (11) |
| Incompetent to Stand Trial | 11 (41) |
| Not Guilty by Reason of Insanity | 13 (48) |
| **Treatment (Tx) Time at Hospital** | |
| 0-1 Years | 6 (22) |
| 1-5 Years | 11 (41) |
| 5-10 Years | 7 (26) |
| 10+ Years | 3 (11) |

**Table 7. Sample Characteristics—Staff Interview N=35**

| | n | (%) |
|---|---|---|
| **Gender** | | |
| Female | 21 | (60) |
| Male | 14 | (40) |
| **Profession** | | |
| Other | 4 | (11) |
| Psychiatry | 10 | (29) |
| Psychology | 7 | (20) |
| Social Work | 14 | (40) |
| **Length of Time Employed at Hospital** | | |
| 0-5 Years | 11 | (31) |
| 5-10 Years | 7 | (20) |
| 10-15 Years | 11 | (31) |
| 15+ | 6 | (17) |

## INSTRUMENTS & DATABASE

### *Patient Satisfaction Survey*

As a student researcher at DSH-Napa, I developed and administered the Napa State Hospital Patient Care Satisfaction Survey data as a function of hospital licensing in 2017. Accreditation requirements of the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) requires that the hospital collect data on patients' perception of care, treatment, and services provided. The survey was adapted from the Civil Inpatient Satisfaction Questionnaire (C-ISQ), a short form survey of the Inpatient Satisfaction Questionnaire (ISQ) which was originally created to meet the accreditation standard of the JCAHO in 2002. The C-ISQ has undergone rigorous survey development and testing procedures to create a valid and reliable measure of patient satisfaction (Shiva, Haden & Brooks, 2009). In addition to the 11-item survey questions, an additional 11 items addressing patient quality of life and substance abuse were added along with the demographic questions. The patients were informed that this survey data would continue to be used to better understand and improve treatment and services. An example of the survey is included in the Appendix B.

### *Semi-Structured Interviews*

Semi-structured interviews were conducted using an interview guide for patients, frontline clinical staff, and clinical administrators. These interviews were formal interviews, scheduled in advance, and both parties recognized that an interview was taking place; however the interviews were opened and allowed for spontaneous questioning. Two semi-structured interview guides were created for both patients and staff as a framework to assess satisfaction with the treatment and care being provided at the hospital as well as

experiences, assumptions, reactions, events leading up to hospitalization, policies for treatment, goals for discharge, and treatment improvement. An example of the staff interview guide is located Appendix C and an example of the patient interview guide is located in Appendix D.

The questions for staff aimed to uncover:

1. The level of experience in different mental health and criminal justice settings.
2. The explicit and implicit satisfaction with job performance and the ability to perform one's job in a forensic mental health setting.
3. The perceptions of the ecological context of court-mandated mental health.
4. The perception of improvement areas for treatment and care at the hospital and in the community.
5. The perceptions of success areas with treatment and care at the hospital and in the community.

The questions for patients aimed to uncover:

1. The day-to-day experience of patients receiving court mandated psychiatric treatment.
2. Access/amount to treatment prior to hospitalization and commitment.
3. The implicit and explicit assumptions of individual responsibility versus community responsibility.
4. The perception of treatment and care provided at the hospital and in the community including areas for improvement and successful areas.
5. Perceptions of personal functioning in the community with system (criminal justice and/or state hospital) assistance.

*Therapeutic Options Database*

The final source of data was developed from the DSH-Napa Wellness and Recovery Model Support System (WaRMSS) an automated system that integrates a variety of wellness and recovery planning processes to support the concept of individual oriented treatment. In addition, WaRMSS is an institutional data bank with a searchable archive of available treatment options and therapeutic groups provided to the patients at the hospital. Individual and group therapeutic opportunities are provided weekly at the hospital based on a quarter-annual system. I created a dataset based on the schedule of treatment groups provided over a one-week period.

For this data set each unit represented an hour of treatment provided to either an individual or a group. I then used classification analysis to identify the groups based on their availability and therapeutic focus, which included:

**Table 8. Treatment Categorization**

| Categorization | Description |
|---|---|
| *Legal/discharge* | Any treatment activity relating to adjudication or community reentry e.g. music competency, CONREP or discharge planning, etc. |
| *Therapeutic/Mental Health psycho-education* | Any treatment activity relating to management of psychosocial stabilization e.g. individual therapy, medication management, anger management, dialectic behavior treatment, etc. |
| *Recreational/leisure/ fitness/social* | Any treatment activity relating to leisure and recreation that was not also identified as having a legal component e.g. art therapy, dance therapy, yoga, bikes, walking, etc. |
| *Vocational/ life skills/educational* | Any treatment activity relating to the development of independent skills or paid work at the hospital e.g. attending groups for GED and college enrollment, cooking class, upholstery, wrapping soaps, beauty shop, recycling center, etc. |
| *Substance abuse* | Any treatment activity relating to the treatment and management of substance abuse and misuse e.g. Alcoholics Anonymous, Narcotic Anonymous, Self-Management and Recovery Training, etc. |

## DATA ANALYSIS

### *Participant Observation, Informal Interviews, Institutional Administrative Directives*

During the first eight months working at the DSH-Napa, I was working directly in the Social Work Department as a graduate student assistant, developing and implementing the patient satisfaction survey. In this capacity, I spent several days per week participating in the daily activities of the social work department, observing staff, patients and administrative meetings. From an ethnographic perspective, participant observers learn by experiencing and immersing themselves within the culture of the institution (Wolcott, 1999). This early form of participant observation allowed me to move throughout the institution as a guest, with few responsibilities. Other than development of the patient satisfaction survey, I was allowed to ask questions and develop an outsider's understanding of the institution. As time passed, I was offered a position as a social worker on the geriatric and medically fragile unit. During this time period, my observational lens shifted from guest to immersive participant, experiencing the professional responsibilities of a caseload and direct clinical care. After two years in this role, I was able to obtain IRB approval to conduct interviews and I began to shift my participant observation activities to conducting formal interviews.

The participant observation activities gave me the opportunity to examine the multiple and varied relationship dynamics occurring within the hospital setting. Being able to observe and participate within the hospital, first as an outside graduate assistant and then as an insider (active employee) allowed me to witness the clinical and administrative processes from multiple perspectives, helped me interpret the hospital practices, and gave context to the data later provided in the formal interviews.

A primary goal of this study is to understand the operations of the hospital as a forensic institution. To begin, I attended therapeutic treatment groups, department meetings, program meetings, program review committee meetings, mortality review meetings, and bioethics meetings. These weekly, monthly, or as needed meetings first gave me insight into the overall organization of the hospital. Later, as a unit social worker, I was able to supplement these observational activities by attending daily treatment team meetings and conducting therapeutic treatment for individuals and groups. My goal during this observational period was to interpret the natural interactions of the hospital. Although my colleagues always knew my status as a researcher, I took care to position my clinical responsibilities above my research activities in order to not detract from the needs of the patients and my ethical obligations as a social worker (Wolcott, 1999).

This two-step participant observation method allowed me to become acquainted with the staff, administrators, and patients over time and ease into the data collection process after navigating and learning the processes and mores of the hospital. My participant observation techniques included: listening to participants talk with one another; watching participants interact with one another; and talking with participants through casual conversation, asking clarifying questions about my observations. Casual conversation is an ethnographic technique used to gather vital information and helps to elucidate nuances and clarification throughout the observational period (Wolcott, 1999). As a clinician these clarifying questions also helped me perform my professional role. In this dual capacity, I am able to understand some of the pressures many of the clinicians faced, while also developing a vocabulary to inquire more deeply into the pressures the patients and administrators face. It is impossible to acquire this level of understanding through interview and survey data alone. As a clinician and member of a treatment team, I was able to experience the role of the job and appreciate some of the stressors inherent in the work. For example, I witnessed and experienced several disagreements between my clinical team and the forensic office regarding competency evaluations; I sat with several families distraught over their loved-one's placement within the hospital; and dealt with several families whose loved-one died while in custody. While providing individual and group therapy to patients, I learned about the stresses of life inside and outside of the hospital and some of the events that lead to their commitment. I also understood how shifts in bureaucracy altered workloads and reporting protocols and how these changes in reporting impacted the clinical treatment on the unit.

As a standard at the hospital, note taking is conducted by all clinicians throughout the day in blue vintage composition journals provided to the staff. This cultural norm within the hospital allowed me to record contemporaneous notes during most meetings with no disruption to the ongoing events. Additionally, I would make note of more casual interactions between staff, patients, and clinicians in my office between scheduled appointments throughout the day. At the end of day, I would synthesize my informal observations into an impression of the overall observed experience.

*Therapeutic Treatment Data*

To determine the availability of treatment based on commitment at Napa State Hospital, I created a dataset based on the schedule of treatments groups provided over a one-week period at the hospital. In this data set each unit of analysis represents an hour of treatment provided to either an individual or a group. During the observational period, I analyzed 875 treatment units. Using ethnographic knowledge of the operations at the hospital, each unit was labeled by commitment type determined by its location and title. Later, the units were labeled using classification analysis to categorize the treatment groups by their primary treatment goal. I then conducted basic statistical analysis to determine the variety of the groups provided and accessibility of the groups cross-referenced by commitment.

*Patient Satisfaction Survey*

The purpose of this investigation is to determine psychiatric patient perceptions of treatment and satisfaction of care with (1) access to therapeutic treatment (2) medical attention and psychopharmacological intervention (3) hospital environment (4) quality of life, and (5) discharge preparation and feelings of fairness. Data for this investigation were obtained from the DSH-Napa Patient Care Satisfaction Survey. Collaborating with the Social Work Department at DSH-Napa, I adapted the Civil Inpatient Satisfaction Questionnaire (C-ISQ), a short form survey of the Inpatient Satisfaction Questionnaire (ISQ) which was originally created to meet the accreditation standard of the Joint Commission for the Accreditation of Hospital Organizations in 2002 (Shiva et al., 2009). The C-ISQ has undergone rigorous survey development and testing procedures to create a valid and reliable measure of patient satisfaction with mandated treatment for both civil and criminal commitments (Shiva et al., 2009).

> "Exhaustive analyses were conducted to evaluate the structure, reliability, and validity of the [Inpatient Satisfaction Questionnaire] ISQ for both the civil and forensic inpatient samples. First, an item analysis was conducted in an effort to identify strong and weak items of the ISQ. Second, a principal components analysis (PCA) with varimax rotation was conducted to assess for the presence of underlying factors of the ISQ and a confirmatory factor analysis (CFA) was conducted to confirm the presence of these factors. Third, internal consistency and test-retest reliability were calculated for the PCA and CFA scales. Fourth, the validity of the ISQ was assessed by comparing it with other satisfaction measures and also for PCA and CFA results." (p. 205, Shiva et al., 2009)

In addition to the 11-item survey questions, 11 items addressing patient quality of life, substance abuse treatment, and readiness to discharge were added to the survey. The response options used a five-point Likert scale where: 1=Strongly Disagree; 2=Disagree; 3=Uncertain; 4=Agree; 5=Strongly Agree.

The Unit Supervisors at DSH-Napa managed the on-unit distribution and collection of the patient satisfaction survey. Under my supervision, paper survey materials were assembled and supplied to each Unit Supervisor. Each package of materials included survey forms, manila folders for collection, and instructions for administration. Patient representatives on each unit were informed about the survey and reviewed the patient

instructions with staff during the Client Advisory Council. I provided training to the patient representatives on how to assist in the administration of the survey. The survey was administered during Therapeutic Community (an all patient group on every unit). I also trained clinical staff on survey procedure to assist with administration duties and answered any outstanding questions. Data collection occurred in October 2017. Every patient receiving treatment at the hospital was offered a survey.

Analysis was performed using the Data Analysis and Statistical Software (STATA) version 13 (StatsCorp LLC, College Station, Texas USA). Any ambiguous response (i.e. both 3 and 4 circled, all items circled etc.) was deleted from the data set. This is a cross-sectional study meant for descriptive purposes. The intention of this study is to describe a point in time assessment of patient satisfaction. I am not making causal claims. The data were first analyzed for all respondents by descriptive statistics including gender, age range, race, commitment type, and length of stay at the hospital; then average scores were calculated by summing each variable and dividing by the total number of respondents for each survey question. The higher the score for each sum variable, the more satisfied a patient is with their care. After determining the average satisfaction score for each response, the differences between groups and associations between patients' background variables (age, gender, race, length of hospital stay, and commitment type) and their satisfaction scores were tested using one-way anova and a bonferroni post hoc test to determine whether any variances in satisfaction by commitment type were significantly different. Following this line of inquiry, a summary of satisfaction experience was calculated by summing the 22 variables for a summary of experience score. Additionally, five therapeutic domains were created to test the Analysis of Variance (A-NOVA) between the three commitment treatments. The five therapeutic domains examined are: THERAPY, which refers to satisfaction with access to therapy (4 questions); MEDICAL-PSYCHIATRY, which refers to satisfaction with medical care and psychopharmacological intervention (3 questions); ENVIRONMENT-STAFF, which refers to general satisfaction with the hospital environment and treatment from staff (5 questions); SOCIAL/QUALITY OF LIFE, which refers to satisfaction with social relationships, positive emotional feelings, and recreation access (6 questions); and DISCHARGE-FAIRNESS, which refers to satisfaction with preparedness to discharge and a sense of being treated fairly (4 questions). Finally, these composite variables were tested using Analysis of Variance (ANOVA) based on commitment treatment.

*Semi-Structured Interviews*

The analysis of the semi-structured interviews required a multiple stage process. The sixty-two recorded interviews were transcribed using a secure transcription service. I then listened to each interview while line-editing each transcript for accuracy. After comparing the accuracy of the transcripts to the audio recordings, I redacted all identifying information within each transcript to ensure confidentiality. I then used the computer assisted qualitative data analysis program ATLAS.ti to evaluate the transcripts. I open coded and analyzed the content, narrative, and discourse of the transcripts for salient description. I then organized the descriptive themes into theme groups or a master list including, but not limited to: treatment, satisfaction, therapeutic alliance, violence, coercion, emotion, justice, institutionalization etc. The master list served as an initial coding list. I then took this master list to a qualitative data advisory panel at UC Berkeley's Institute for the Study of

Societal Issues. Based on feedback from the panel, the master list was revised slightly. Using the revised master list, I employed thematic analysis to help identify conceptual themes that were more complex and abstract than the original open codes (Spradley, 1970). I then presented the thematic codes to a qualitative methods working group, drafting a summary of the data for the second phase of analysis. The feedback I received during this iteration of analysis helped me to focus specifically on the experience of providing competency restoration treatment under the new mandate for clinicians and administrators and focus on the experience of mental health treatment in the community and in the hospital for patients found incompetent to stand trial. I then conducted a more focused analysis, which included rereading transcripts and double coding them for scheme related to experiences, perceptions, opportunities, activities, and structures within the hospital and community for competency restoration patients. These patterns were then compared based on patient demographic groupings which included: commitment type, gender, age, length of stay at the hospital, severity of instant offense, and reported experience with criminal justice system prior to instant offense. After the completion of this focused analysis, I organized the list of codes into a revised list of headings to better conceptualize and understand the impact and clinical limitations of forensic commitment.

*Triangulation, Rigor, and Trustworthiness*

The longitudinal design of the participant observation and interview data allowed me to consider change-over-time when comparing these qualitative data sources. Additionally, the mixed methods inquiry allowed for triangulation of the findings (Lincoln & Guba, 1985). Further, to establish legitimacy within my findings, I engaged in an iterative process of checking and re-checking the data to confirm that the codes remained meaningful and properly captured the full scope of data, which was immense.

As stated in my analytic strategy I employed a naturalistic paradigm approach to understanding the "truth" of the hospital. From this perspective, the truth is not an objective knowable fact that can be achieved from a single analysis, rather it is based on multiple constructed realties (Lincoln & Guba, 1985). To create rigor within the research I needed to adequately represent the ideas, thoughts, and actions of the clinicians, administrators, and patients by demonstrating credibility, confirmability, dependability, and transferability throughout the process (Lincoln & Guba, 1985).

For this research study, I achieved credibility by engaging in all aspects of clinical activities within the organization, including providing individual therapy, group therapy, and attending all administrative meetings at the department, program, and hospital level. I also worked with the social work department and the patients to develop the patient satisfaction survey. All of these field activities were conducted over an extended time period, allowing for me to develop the insider knowledge needed to understand the vocabulary and culture of the hospital using systematic observation methods and multiple sources of data collection (Lincoln & Guba, 1985). I established trust and rapport with the administrators and clinicians by clearly stating my agenda to conduct an ethnographic research study and gaining approval from the Research Advisory Council and the Executive Director, while also addressing the clinical needs of a sixteen-patient caseload. In addition, my practice background in prison and prison-hospital settings and my extensive knowledge of

psychiatric institutional history and related literatures enhanced my credibility. Lastly, I worked closely with a panel of qualitative research experts at UC Berkeley's Institute for the Study of Society Issues as a Graduate Fellow to ensure that I analyzed my data appropriately, ultimately establishing the rigor and trustworthiness required to conduct this naturalistic inquiry (Lincoln & Guba, 1985).

To achieve an acceptable level of confirmability, the codes and themes developed during the analysis of this research study are based on a systematic reading and re-reading of the data. The in-depth reading of the data garnered exceptions and contradictions to my previously held assumptions based on the participant observation and literature which, invited further interrogations to better substantiate my claims. The use of multiple data sources including participant observation data, group treatment data, and survey data, as well as interview data from multiple categories of participants invite triangulation of the data sources and enhance the study's confirmability (Lincoln & Guba, 1985). Further, I attempted to boost the confirmability of the study by using unsolicited patient art and participant responses to illuminate the conceptual themes that emerged during analysis.

In order to achieve dependability, portions of my data and emerging analysis were presented at several peer-reviewed professional and academic conferences. Additionally, I presented segments of analysis to members of my committee and academic community at the School of Social Welfare. I was provided critiques around my evidence and the claims I was using to support the themes, which I was able to incorporate into the analysis of the data.

Lastly, to achieve transferability, I present a thick description of commitment type and its relational structure from multiple perspectives including legal, organizational, administrative, clinical, and experiential. This in-depth description from multiple clinician-patient, administrator-patient, and administrator-clinician dyads strengthen transferability (Lincoln & Guba, 1985). The goal of this rich description is to present enough context and detail to the reader so that the reader is able to understand the findings and consider the transferability of the study independently as well as helping to bring light, through report, into one of the darkest recesses of the current criminal justice system. The following chapter is the beginning of that rich ethnographic description of the space, participants, and processes of the state hospital.

# CHAPTER VIII. THE HOSPITAL

In this chapter, I provide a brief overview of the layout of Napa State Hospital, I speak to the current physical environment, as well as recent events, policies, and operations that impact the hospital and create the context of treatment. This description of the physical characteristics of the hospital, the characteristics of the patients, and operations is based on ethnographic observations and is contextualized by theory, literature, and policy. Quotes, images, and examples are used to illustrate the experience of persons receiving mandated psychiatric treatment based on commitment. This chapter addresses my first research question by explicating the organizing principle of California's state hospital system, which is civil and criminal commitment.

**Table 9. Research Question 1, Method, & Findings**

| Research Question 1 | What is the organizing principle of California's state hospital system and Napa State Hospital specifically? |
|---|---|
| *Method* | *Participant Observation, Institutional Data* |
| FINDINGS | Forensic Commitment is the organizing principle of California's state hospital system. Napa State Hospital is organized to treat patients found Not Guilty by Reason of Insanity, Incompetent to Stand Trial, and patients who are Civilly Committed. Treatment is distinct for each group. |

## BEHIND THE FENCE

> *After we built the fence… we had to survive and the way we survived was by saying, "Okay, we're going to convert over to a forensic facility"…I worked with forensic patients from probably the early '90s on, but nobody made such a big deal out of them. Somewhere around the mid '90s, like '95, '96… we only had about three to four hundred forensic patients here, maybe… But once the fence went up… I understood that then it was game on. They just loaded this place up.*
>
> –Male administrator, 30 years experience

In 1998 "the fence" was erected at Napa State Hospital. Twenty feet tall and covered in razor wire, the fence physically defines the boundary between criminally committed and civilly committed psychiatric patients at the hospital and marks a point in time when the psychiatric hospital fundamentally shifted its *raison d'être*. No longer was the primary goal of the hospital treatment for the sake of need and safety, as it had been since its inception, but treatment as defined by the criminal courts was now the primary motivator for rehabilitation and discharge. Consequently, 'behind the fence', and 'inside the fence' became common phrases used to describe the daily functions, management, and therapeutic opportunities at the hospital, starkly contrasting the treatment provided for those who have arrived at the hospital through criminal channels and those that failed to find sufficient treatment in the community for their illnesses.

*Bricks and Mortar Now*

The prototypical gothic asylum[24] of the late nineteenth century was demolished in the mid-twentieth century erasing the known imagery associated with psychiatric hospitals. In its place stand six non-descript buildings that facilitate five programs and thirty-seven units. The population size on each of the units range from twelve beds for the most physically and psychiatrically ill patients to over sixty beds on the larger double units, which usually house younger, criminally committed patients. Configured as modern panopticons, many units situate a nurses' station constructed of Plexiglas in the center of the unit, with hallways of treatment rooms and dorms jutting out allowing maximum visibility (Bentham, 1791). Many units are comprised of multiple-bed dorm rooms; however, single-bed rooms are available depending on status (i.e. two discharge units, seclusion rooms for assaultive behavior, or illness). Grievances over roommates' poor hygiene and erratic behavior are overheard daily and room changes are common requests. Throughout the day, patients and staff can also hear the overhead speaker marking time… "breakfast, morning medications, groups, lunch, afternoon medications, court yard break, canteen…" in a seemingly endless sequence continuing the repetitive institutional conditioning explained in decades past (Goffman, 1961; J. Wing, 2000).

**Figure 4. Napa State Hospital "The Castle"**

(Prestinary & Coodley, 2014)

Currently, Napa State Hospital spans roughly 2,000 acres nestled along the edge of Napa Valley and is located directly across the highway from Napa Community College, a gleaming modern building of cement and glass built in the wake of Measure N in 2002, a local bond that allocated $133.8 million for a new library, performing arts center, and gymnasium (Hoffman, 2009). From the outside, Napa State Hospital also resembles a junior college, but one forgotten in the mid twentieth century. The structures are painted mint green and clay brown, and any new construction consists of modular trailers placed on slabs of concrete, the hallmark of all underfunded California public buildings. Attempts

[24] Napa Insane Asylum opened in 1875 and in 1924, it was renamed Napa State Hospital to reflect changes in the medical model and treatments for psychiatric patients. Originally referred to as the "The Castle," the main building was an ornate and imposing seven-tower structure, constructed with stone and bricks. Facilities on the property included a large farm that included dairy and poultry ranches, vegetable garden, and fruit orchards that provided a large part of the food supply consumed by the residents. The original building was later razed in the early 1960's (Prestinary & Coodley, 2014).

have been made to brighten the drab hallways of the interiors. Murals painted by the patients under the supervision of the art therapists streak the walls, and fun names have been given to off-unit rooms where patients can meet for group therapy like Rio Grande and El Capitan, nods to the history of western expansion that permeates the California psyche and fifth grade curriculum.

The grounds are dotted with native sycamore and valley oak intermixed with Chinese golden rain and Australian bottle trees. Wild turkeys, feral cats, and deer guard the perimeter fence, while buzzards often perch atop the cedars ominously awaiting carrion from the mountain lions quietly stalking the hillsides or the cars racing along the Napa-Vallejo highway, eager to get to the wineries along Silverado trail. Curiously, dozens of blue peafowl live within the fence of the hospital. Rumors circulate among the staff to their origin—an eccentric psychiatrist left his pets after leaving town or a few escaped from a local farm and found their way to the hospital. By now, how they migrated to the hospital is incidental, their stark beauty and iridescent plumes are always remarkable and acknowledgment of their presence is unavoidable. Their mating dance and halting cries shock passersby, and patients and staff delight in the summer months when the baby chicks hatch and follow their mothers around the campus. The birds reveal the true character of the hospital and the patients within. Some patients name the birds, feed them fruit from the bronze loquat trees collected during courtyard break, and are proud to pick up their discarded feathers as they walk the grounds, presenting them to staff as gifts before reentering the building. A few patients show indifference, preoccupied with their own internal thoughts. Still others, with anti-social tendencies, will throw the eggs or lunge at the birds quickly chasing any that are too close to the path. Either way, the peacock has become the unwitting mascot of the hospital, striking and conspicuous, they appropriately symbolize a distinctive body, far from home, vulnerable to the world inside and outside the fence.

### NAPA STATE HOSPITAL PATIENT CHARACTERISTICS AND PROCESSING

The hospital is not a prison. Hospital police do not have guns and the nurses are not correctional officers, but the hospital acts as an arm of the court system and the treatment options available to the patients are primarily based on their commitment or legal status. The patients are committed at the county level and then sent to the hospital for treatment. Although every hospital within the department of state hospitals serves the entire state, Napa State Hospital's catchment area includes roughly thirteen million Californians from a region that stretches east from the San Francisco Bay Area through the Northern Joaquin Valley to the Sierra Nevada and upwards through the Shasta Cascade and North Coast.

Before arriving at the hospital, patients are screened to ensure that DSH-Napa is the appropriate treatment setting. Although Napa State Hospital is a locked treatment facility, patients determined to be flight risks or have a history of attempted escapes are considered not appropriate and are sent to Atascadero State Hospital regardless of their catchment zone. After arrival at the hospital, patients are placed on an admissions unit to acclimate to the hospital environment. Admission units focus on completion of initial assessments and initiate behavioral stabilization. Staff on the unit consists of the treatment team which include a psychiatrist, psychologist, social worker, rehabilitation therapist, and the medical

and nursing staff. The medical and nursing staff include a medical doctor, registered nurses, psychiatric technicians, and the unit supervisor. Patients are oriented to the unit by nursing staff and members of the treatment team meet with patients to develop treatment plans and continue assessments. Once developed, the treatment plan is reviewed regularly by the treatment team and updated as the patient progresses and treatment objectives change. The goals and objectives of the treatment plan are consistent with each patient's commitment status and each unit focuses on a particular population and treatment.

To help clarify the types of patients being treated at Napa State Hospital it is helpful to return to the typography described by Hiday and Burns in Chapter III. (2010). Although there is often overlap between the five typologies, Table 8. reestablishes the general typology previously described, gives examples of the penal code and crimes that may depict the typology, and gives situational examples of patients that would be treated at the hospital. Examples are based on participant observation; all names and identifying information have been excluded for anonymity.

**Table 10. Criminal Justice Contact Typology for SMI with Hospital E.g.**

| Typology Name | Example of Instant Offense from Arrest Reports |
|---|---|
| (1) Nuisance offenses | *Penal Code 422 PC criminal threat* |
| | E.g. the patient made verbal threats at a social security office over misunderstandings about his social security disability check |
| (2) Survival behaviors offenses | *Penal Code 487(d)(1) PC Grand Theft Auto* |
| | E.g. the patient took an automobile from an overflow lot and was arrested after it was reported to police that a man was living in the car near a school and was frequently using the public restrooms |
| (3) Substance abuse related offenses | *Health and Safety Code 11377 HS possession of methamphetamine* |
| | Often charged in addition to a felonious crime from another category e.g. the patient was contacted by police for *Penal Code 290 PC Failure to Register as a Sex offender* and was also found to be in possession of methamphetamine at the time of contact |
| (4) Violent offenses directly related to psychosis | *Penal Code PC 245 PC assault with a deadly weapon not a fire arm, great bodily injury likely* |
| | E.g. the patient was experiencing persecutory delusions and assaulted his mother with a flower pot, an unsheltered patient was experiencing auditory hallucinations and assaulted a stranger in a parking lot with a bat-like object; the patient was experiencing paranoid delusions while living in a group home and attacked another resident with an utensil; etc. |
| (5) Violent crimes due to characterological disorders | *Penal Code 207 PC Kidnapping* |
| | E.g. The patient held a domestic partner against her will in the home for reasons unrelated to his mental illness |

These examples of crimes and the circumstances surrounding the offense help to highlight the tension between crime and system failure for persons with severe mental illness who eventually come into contact with the criminal justice and state hospital system. Crimes that fall into the survival and nuisance offenses almost immediately highlight systemic failures of welfare; whereas substance abuse related offenses and violent offenses directly related to psychosis reveal the complicated relationship between individual responsibility and society's inability to provide adequate pharmaceutical intervention and welfare. Comparatively, patients who commit offenses due to characterological disorders are arguably the most culpable for their actions and alleged offenses, but closer inspection of the psychosocial experiences of these patients often reveal a long history of victimization, macrostructural marginalization, and inadequate psychiatric treatment prior to the alleged crime, further obscuring the line between personal responsibility and prevention.

*Hospital and Programmatic Organization*

Beyond the collection of criminal offenses that catapult criminally committed psychiatric patients to the hospital, the hospital is programmatically organized to treat three primary commitment statuses. As stated previously, roughly half of patients treated at Napa State Hospital were found not guilty by reason of insanity (NGRI), about one third are found incompetent to stand trial (IST), and the remaining fifth are gravely disabled or civilly committed patients under Lanterman-Petris-Short [LPS]. This history and definition of each of these commitments are described in Chapter III. The following section provides a randomly chosen example of a psychosocial assessment of a patient committed as IST, NGRI, or LPS. As a disclaimer, these examples are extreme representations of mental illness; however, they appropriately characterize the patients treated within the state hospital system.

**Patient Journey—Not Guilty by Reason of Insanity**

The typical Not Guilty by Reason of Insanity Patient often committed a serious and violent crime, generally against a family member during a state of psychosis. There is also a minority group of NGRI patients that are considered nuisance/survivor violators. At Napa State Hospital, the nuisance/survivor offenders often come from rural counties with little access to mental health or substance abuse treatment. They often exacerbate their local law enforcement agencies and when they inevitably commit a more serious felony they are often convinced to take a not guilty by reason of insanity plea to avoid a sentence in jail or prison that is lengthier than what they are used to. Mr. Rivers'[25] case history is an example of a typical NGRI patient treated at Napa State Hospital who committed a serious and violent crime.

MR. RIVERS

*Mr. Rivers is a 37-year old Caucasian male committed to the California Department of State Hospitals in 2007 from the Superior Court of Placer County pursuant to Penal Code 1026 Not*

[25] Characterizations are based on case histories, psychosocial assessments, and treatment plans; however, all names, dates, and locations have been changed as well as some identifying details of the crimes and psychiatric history for the sake of anonymity.

*Guilty by Reason of Insanity on charges of PC 187 Murder with a DSL date of 2500. His instant offense happened in 2001 when he bludgeoned his mother to death with a heavy garden rake. At the time of the offense Mr. Rivers presented with symptoms of psychosis, he reported hearing auditory hallucinations and delusional beliefs with religious undertones, stating to police at the time of arrest that he was an archangel with saint like abilities. He was also under the influence of marijuana and alcohol during the commission of the crime. Per his evaluation at admission, Mr. Rivers' psychiatric symptoms began in 1999 and his behavior was noted as having turned violent during the time leading up to his instant offense. In 2001 he was hospitalized twice pursuant to Welfare and Institution code 5150* [72 hour emergency hold for danger to self or others] *in Placer County. Mr. Rivers' cognitive level is in the average range with minimal deficits that affect learning and processing new information. Mr. Rivers is currently diagnosed with schizoaffective disorder, Bipolar Type, Alcohol use disorder severe, and Cannabis use disorder severe.*

Patients like Mr. Rivers that are found not guilty by reason of insanity were able to progress through the entire adjudication process before finally being sent to the Napa State Hospital for treatment. As stated previously, in California, NGRI patients are sentenced to treatment for a period equal to the maximum sentence of their most serious offense, commonly referred to as a Determinate Sentencing Law (DSL). Although there is DSL date associated with all NGRI patients commitment like Mr. Rivers, discharge is based on a subjective determination of violence risk mitigation, meaning that the patient needs to be considered at a low risk for engaging in violent behavior in the community, regardless of the maximum sentence length of their instant offense.

The goal of treatment services for NGRI patients is to assist patients to recognize and manage their psychiatric symptoms. Additionally, patients work on developing socially responsible behaviors, independent living skills and coping skills to address their mental illness and forensic issues. To do this, NGRI patients follow a continuum of care within the hospital whereby after reception and being treated on an admissions unit, they progress through a "long-term," "transition 2," and "discharge" unit before finally be released to California's Conditional Release Program[26] (CONREP). In addition to the general continuum of care, there are also specialty units available to NGRI patients including: Dialectic Behavior Therapy; Sex Offender Treatment; and Intensive Substance Recovery.

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[26] CONREP is a statewide system of community based services which treats patients committed as either: Not Guilty by Reason of Insanity, Incompetent to Stand Trial, Mentally Disordered Offenders, and some parolees who have been released to outpatient status. Funded by the state, CONREP was mandated as a state responsibility in 1984, and began operating in 1986. The goal of CONREP is to ensure public protection while providing effective and standardized outpatient treatment. Once patients are considered no longer dangerous, the state hospital medical director recommends eligible inpatients to the courts for outpatient treatment under CONREP. Individuals must agree to follow a treatment plan designed by the outpatient supervisor and approved by the committing court. The court-approved treatment plan includes provisions for involuntary outpatient services. Individuals who do not comply with treatment may be returned to a state hospital. Treatment includes an intensive regimen of individual and group contact with clinical staff, random drug screenings, home visits, substance abuse screenings and psychological assessments. Each eligible patient is evaluated and assessed while they are in the state hospital, upon entry into the community, and throughout their CONREP treatment. The Department contracts with county mental health programs and private agencies to provide services.

As the patient stabilizes and behaviorally adapts to the institutional environment they receive more privileges and greater access to institutional resources. For patients on long-term treatment units all therapeutic groups are provided on the unit. As the NGRI patients progress they become eligible to receive treatment at the Mall, or the grouping of non-residential buildings that resemble a small public middle school. Mall Services provides a variety of off-unit services including: *Vocational Services,* which provide opportunities for patients to develop job skills and habits, as well as earn funds; *Educational Services,* which enable patients to continue their education, high school or college, and provide skills groups for anger management and development of interpersonal skills. *Rehabilitation Therapy Services* provide groups that harken back to the moral treatment provided to psychiatric patients at the beginning of institutionalization. These therapeutic groups engage the whole patient in wellness activities and aim to improve quality of life through therapeutic music, dance, art, occupational, and recreation. An example of patient art created during one of the therapeutic art groups is depicted in Figure 5. Yellow Face. In addition to therapeutic groups, there are *Medical Ancillary Services* at the Mall, which provide medical services including but not limited to physical, occupational and speech therapies as well as dental, podiatry, neurology, cardiac and obstetrics and gynecology clinics.

**Figure 5. Patient Art | Yellow Face**

**Patient Journey—Incompetent to Stand Trial**

In contrast to NGRI patients, patients found IST have yet to fully pass through the adjudication process. Being IST is a purgatory-like placement within the criminal justice system, dependent on one's mental state leading up to trial; thus, the instant offenses that bring IST patients to the hospital draw from all five of Hiday and Burns' typographies. Although the offenses that lead to an IST commitment vary significantly, there are generally two kinds of psychiatric presentations of competency patients. The first group includes patients that are actively psychotic who are hearing voices and experiencing paranoid symptoms or are having bizarre delusions. These patients can sometimes act erratically and

display violent behaviors. The second group includes patients with a fixed delusional belief system about themselves or their alleged crimes. These patients can present as extremely knowledgeable about courtroom personnel or procedures, but when asked about their alleged crimes or the content of their arrest report they can quickly unravel.

An important note regarding the typical IST patient in California is that nearly half of the patients receiving competency treatment were homeless and did not have access to Medi-Cal for at least six months prior to their arrest (The California Department of State Hospitals, 2018). Therefore many IST patients are not only experiencing symptoms of mental illness and criminal justice pressures, but are also coming from an unsheltered living situation with little to no available resources in the community. Mr. Jones' case history is an example of a disorganized IST patient treated at Napa State Hospital with a history of homelessness and depicts the patient-on-patient violence often encountered at the hospital and begins to detail the revolving door of psychiatric treatment within the criminal justice system

MR. JONES

*Mr. Jones is a 29-year old black male committed to the California Department of State Hospitals by the Superior Court of the County of Sacramento in 2018, pursuant to PC 1370, Incompetent to stand trial with a Commitment Expiration date of 2021. For the alleged charges: (211) ROBBERY: in the SECOND DEGREE, (288.3(A)) UNLAWFUL CONTACT with a MINOR WITH INTENT, (422) THREATEN a CRIME: with intent to TERRORIZE, (647.6) ANNOY/MOLEST a child under 18. The patient does not have an involuntary medication order. Mr. Jones was previously found incompetent to stand trial at Napa State Hospital in 2013 and Atascadero State Hospital in 2011. Upon admission he presented with paranoia, guardedness, thought disorganization, internal preoccupation, and inappropriate affect. Since arriving at the hospital, Mr. Jones assaulted two separate peers, by punching them in the face without provocation due to his level of suspiciousness and internal preoccupation. He was subsequently placed on enhanced observation due to his level of dangerousness. While he appears to have some knowledge about his case his paranoia and other psychiatric symptoms prohibit him from working effectively with his counsel and discussing his case in a reality based manner. Mr. Jones reports a history of homelessness prior to his arrest. He is currently diagnosed with unspecified schizophrenia spectrum disorder; and methamphetamine abuse disorder, mild.*

The treatment efforts for patients like Mr. Jones who are found IST focuses on trial competency restoration, attainment of competency, and a quick return to court for the adjudication of pending charges. Patients participate in a range of mental health groups and therapeutic activities to assist in addressing symptoms and behaviors that may interfere with their ability to understand the court proceedings and to cooperate with their attorney in preparing a defense. In general, IST patients move from admission units to long-term units after ninety days and then discharge back to their county court to adjudicate their charges.

Competency restoration treatment ranges from large open groups that teach competency with a curriculum, to reading arrest reports with a social worker, to more creative groups like "Law and Order Group" where patients watch *Law and Order* and relate the concepts they viewed to trial competency or their own circumstances. Additionally, there is an off unit room decorated as a criminal courtroom for "Mock Trial" where patients will act out the roles of the judge, jury, and district attorney. In contrast to the art

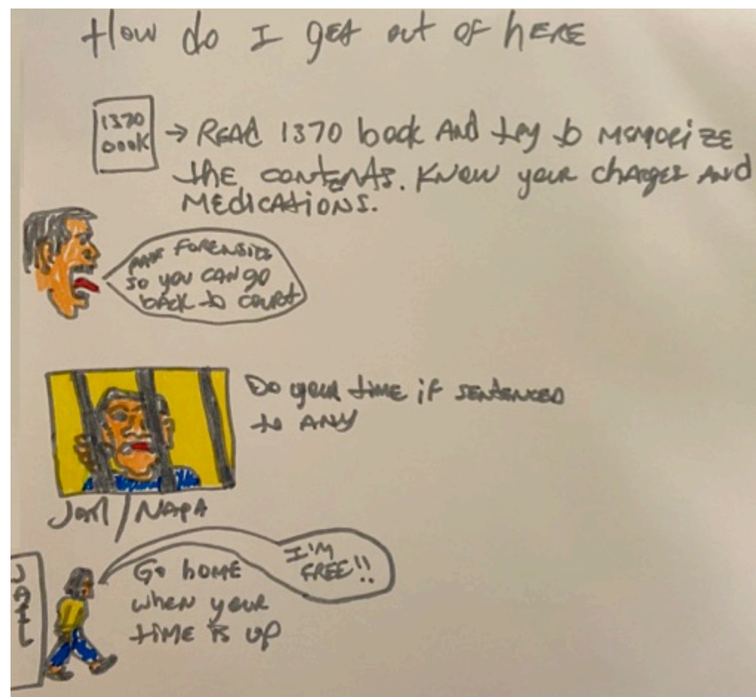
created by NGRI patients, in art competency IST patients are asked to draw pictures related to courtroom procedures and personnel. For example, the patients are often asked to draw the members of the courtroom or diagram the courtroom terminology as depicted in Figure 6. Art Competency | Plea Bargain, which interprets the experience of asking for a plea bargain as begging for your life from an executioner.

**Figure 6. Competency Art | Plea Bargain**[27]

Competency restoration treatment at the hospital and in any treatment setting is singularly focused on stabilizing psychiatric patients to the point of proficient ability to stand trial, meaning that they are capable of understanding the known charges against them, that they understand courtroom procedure and personnel, and are able to rationally assist in their own defense. In addition to psychotropic medication and medical care, all trial competency restoration revolves around these legal concepts. Paradoxical to the concept of hospitalization, need for medical or psychiatric treatment is not factored into the discussion of discharge in regards to trial competency patients: as it is a violation of their constitutional rights to be held beyond the time necessary to regain trial competency or be determined to be unlikely to regain trial competency. Thus, patients may be released in the middle of chemotherapy or other major medical interventions or released with noticeable psychiatric symptoms, as long as the symptoms do not interfere with their ability to participate in trial.

[27] Defendant→"Wait! Can I get a lighter sentence?!"; Executioner→"You have to talk to the DA first!"; chopping block; jail cell

**Figure 7. Patient Art | How Do I Get Out of Here**[28]




Trial competency restoration treatment is repetitive. The information required for treatment is finite and requires a patient to understand: what the four pleas[29] are; where each plea ultimately leads the defendant as a consequence of success or failure[30]; what a plea bargain is, who offers a plea bargain[31] and the rights one gives up as a defendant to accept a plea bargain[32]; what the rules of probation and parole[33] are; what charges are pending and the sentencing range for each charge; and what the role is of the specific courtroom personnel. [34] This information is provided in a variety of contexts, from art group, to music group, to jeopardy group and mock trial. All treatment is designed to address trial competencies and accelerate a patient's time spent in treatment at the hospital. Figure 7 is an example of artwork created during an art competency group that details the competency restoration process, prompted by the question "how do I get out of here?"

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[28] How do I get out of here; 1370 Book (treatment book provided to patients explaining trial competency) → Read 1370 Book and try to memorize the contents; Know your charges and medications; Meet Forensics so you can go back to court; Do your time if sentenced to any Jail/Napa; [JAIL] "I'm Free!!" Go home when your time is up.

[29] e.g. guilty, not guilty, not guilty by reason of insanity, and no contest

[30] e.g. a successful not guilty by reason of insanity plea leads to treatment at the state hospital for an undetermined amount of time; whereas an unsuccessful not guilty by reason of insanity plea leads to detention at a state prison or jail for a determined amount of time

[31] i.e. the district attorney

[32] e.g. the right to appeal, the right to call witnesses on your own behalf, etc.

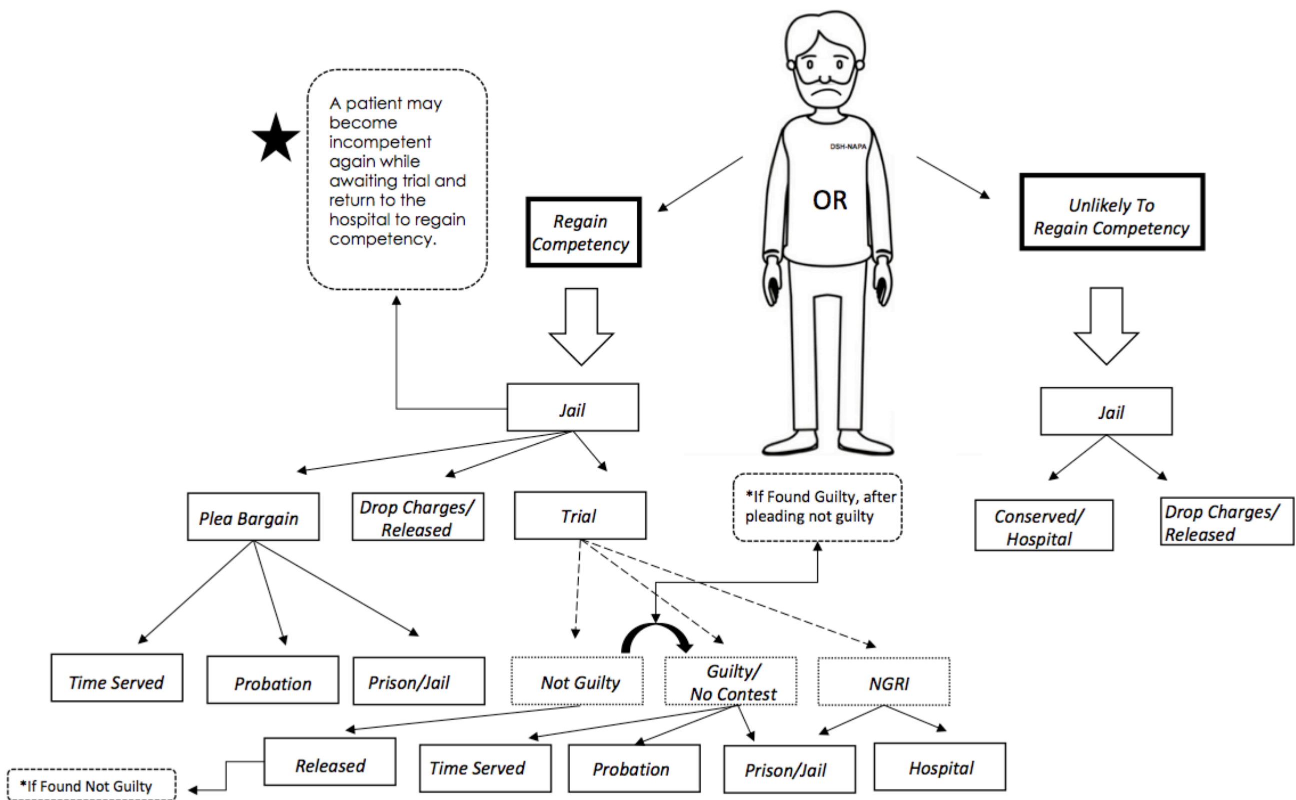
[33] e.g. agreement to: meet with your probation officer as often as required, participate in any mandated treatment or therapy, submit to drug testing, submit to peace officer searches of your person or property with or without a warrant, comply with orders not to associate with known felons, obey all laws, restrict movement to within the county of commitment unless given formal permission from one's probation officer, and not posses any weapons

[34] i.e. judge, jury, bailiff, district attorney, defense attorney, court reporter etc.

Once a patient is found competent to stand trial or is determined to be unlikely to be restored to competency, his or her referring county is notified and they have two weeks to transport the patient back to the county jail by sheriff. After returning to jail there are several adjudication options for the patient as depicted in Figure 7 Flow Chart After Discharge. These options include: accepting a plea bargain for a reduced sentence or time served; having one's charges reduced or dropped; or proceeding to a criminal trial with a variety of outcomes.

Although not fixed, reasons for patients being found unlikely to regain competency are usually due to psychiatric symptoms that do not respond to three drug trials or a neurocognitive disorder that impedes memory or ability to learn new material. At the beginning of data collection a patient could be held at the hospital for up to three years. During the course of data collection for this project (2016-2019) the California State Legislature changed the maximum time an IST patient could be treated at the hospital from three years to two years from the date of commitment. This policy went into effect beginning of January 2019.

**Figure 8. IST Flowchart After Discharge**[35]




[35] Flowchart uses a modified image of a male figure designed by grmarc (image14767487) at VectorStock.com

**Patient Journey—Civilly Committed (Gravely Disabled; Lanterman-Petris-Short)**

Civilly committed patients and patients with medical needs beyond what can be provided on Intermediate Care (ICF) units are treated outside of the Secure Treatment Area (STA) or the fence (i.e. acute medical and skilled nursing (SNF) units). Besides the specialized medical units, civilly committed patients progress from admissions units to long-term units similarly to IST patients. The intention of treatment for civilly committed patients is to provide a highly structured treatment environment for re-socialization and preparation for an open treatment setting or community placement. At the hospital, civilly committed patients are often described as the most psychiatrically ill patients at the hospital. The treatment provided to civilly committed patients is dependent not only on the clinical opinion of the hospital, but also on the opinion and capacity of their conservator or referring county. Similarly, civil commitment discharge criteria are based on hospital recommendation, county prerogative, and an annual renewal of the commitment order. Ms. Garfield's characterization demonstrates the severity of psychiatric illness common among gravely disabled patients and the difficulty in providing placement in a lower level of care.

MS. GARFIELD

> *Ms. Garfield is a 31-year old Caucasian woman re-admitted to the California Department of State Hospitals in 2016 pursuant to WIC 5358, LPS Conservatorship from Contra Costa County Superior Court. Ms. Garfield was referred to the hospital for self-injurious behavior and treatment non-compliance at a lower level of care. Per her conservatorship letters and orders, Ms. Garfield does not have the right to refuse or consent to treatment for her grave disability nor does she have the right to refuse or consent to routine medical treatment unrelated to her grave disability. Ms. Garfield has an extensive history of suicidal behavior resulting in numerous emergency psychiatric hospitalizations. More recently, Ms. Garfield swallowed various small items including paper clips, pen caps, batteries, and a disposable razor replacement head. For this she was admitted to emergency medical services for medical evaluation and treatment and is now admitted to DSH-Napa for continued psychiatric care. Ms. Garfield suffered the loss of a sibling when she was seven-years-old. She also reports an extensive history of sexual abuse throughout her childhood. Ms. Garfield first received psychiatric treatment in Contra Costa County at age 16. At age 25, Ms. Garfield discovered that her romantic-partner was soliciting sex workers. In response to this event, Ms. Garfield walked onto a highway. She was hit and dragged by oncoming traffic, resulting in a traumatic brain injury and over 20 broken bones. Ms. Garfield has had numerous contacts with mental health services including: 47 visits to emergency psych services; 15 contacts with Acute Psych Hospitalization; 2 State hospital admissions; 5 admissions to IMD facilities* [Institution for Mental Disease], *1 placement at a Board and Care; and 23 stays at Crisis Residential programs. She is currently diagnosed with: Major Depressive Disorder, recurrent episode, Severe; Borderline Personality Disorder; Posttraumatic Stress Disorder; Alcohol Use Disorder, Moderate; Cocaine Use Disorder, Mild; and a Personal history of a traumatic Fracture (healed).*

Treatment for patients like Ms. Garfield is provided on the unit, but also provided in an off-unit building referred to as Stepping-Stones, which provides treatment similar to the Mall Services, but on a much smaller scale. However, this treatment facility is only available to patients deemed medically and psychiatrically safe enough to be treated off of the unit. Many civilly committed patients are not appropriate for this kind of intervention and only

receive treatment on their unit. For a summary of commitment Typography and programmatic organization please see Table 9.

**Table 11. Patient Typography by Commitment and Associated Treatment Program**

| COMMITMENT | NGRI | CIVIL | IST |
|---|---|---|---|
| **Current Mental Status** | Varied<br>Actively Psychotic➔ Psychiatrically Stable | Psychotic, Lower Functioning, Extreme Symptoms; Medical | Psychotic and/or Delusional |
| **Discharge Goal** | Conditional Release Program | Lower level of care in the community | Jail/Adjudicate Pending Charges |
| **Location** | On-Unit;<br>S-Complex | On-Unit;<br>Stepping Stones | On-Unit |
| **Treatment Content** | Varied | Somewhat Varied; Directed Towards Lower Functioning | Forensic |
| **Length of Stay** | 2.5 years➔life<br>(6 months min.) | Renewed Yearly➔life | 2 weeks➔<br>2 years max. |

Although you can typify the patients at the hospital by their commitment type, these categorizations are less stringent and much more porous than they appear on the surface and a single individual can easily traverse all commitments and treatments throughout their life. Take Mr. Sandoval and an example.

MR. SANDOVAL

*Mr. Sandoval is a 51-year-old Latino male committed to the California Department of State Hospitals pursuant to being found Not Guilty by Reason of Insanity on charges of PC 664/187(a) Attempted Murder, and PC 422 Threats of Death or Bodily Injury. The offense occurred in 2006 when Mr. Sandoval, was a conserved patient from San Mateo County at Napa State Hospital. Mr. Sandoval grabbed a nurse in a stranglehold and threatened to break her neck. Mr. Sandoval was subsequently deemed Incompetent to Stand Trial pursuant to PC 1370 and placed at Atascadero State Hospital to gain competency, after he returned to court to adjudicate his instant offense Mr. Sandoval was then found Not Guilty by Reason of Insanity. Mr. Sandoval has a lengthy mental health history including assaultive behavior, self-injurious behavior, a history of substance abuse, and suicide attempts. He does not have an involuntary medication order. He is currently diagnosed with Schizophrenia, Alcohol Use Disorder, Moderate, Cannabis Use Disorder, Moderate.*

Mr. Sandoval's experience crisscrossing the civil and criminal commitments reveals an almost arbitrary association between commitment and treatment. Realizing this, it then becomes a point of interest to determine the treatment availability for patients based on their commitment status.

## CONCLUSION

This overview of the hospital layout, the characteristics of the patients being treated at the hospital, and the programmatic structure of the hospital address the primary research question of what is the organizing principle of Napa State Hospital. Understanding the institutional structure of the hospital and that this hospital is completely shaped by patient commitment is the first step within this embedded ethnographic inquiry and creates the foundation for a deeper investigation into the operations of the hospital to address my remaining research questions. The next chapter addresses the differences in therapeutic treatment available to patients based on forensic commitment.

## CHAPTER VII. AVAILABILITY AND ACCESS TO TREATMENT

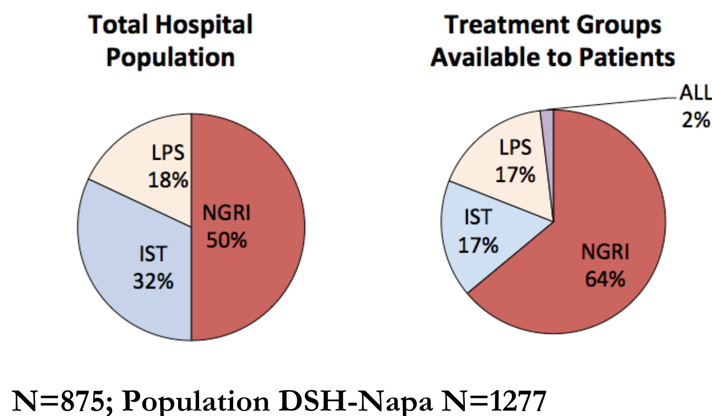
Understanding that the programmatic structure of the hospital is based on forensic commitment begs the question of how does forensic commitment impact the availability and access of treatment for patients via their commitment status? In this chapter I relate the findings of the therapeutic data from the DSH-Napa Wellness and Recovery Model Support System (WaRMSS) by comparing the available treatment options and therapeutic groups provided to the patients at the hospital based on commitment.

**Table 12. Research Question 2, Method, & Findings**

| Research Question 2 | How does the organizing principle impact the type of therapeutic treatment provided to patients? |
|---|---|
| *Method* | *Therapeutic Group and Individual Treatment Data* |
| FINDINGS | Access to treatment varies by commitment type. The kinds of treatment offered to patients vary by commitment type. Patients found not guilty by reason of insanity have more psychiatric treatment options than patients found incompetent to stand trial and civilly committed patients. |

After the therapeutic treatment groups (N=875) were categorized by commitment: Not Guilty by Reason of Insanity (NGRI); Incompetent to Stand Trial (IST); and Civilly Committed under Lanterman-Petris-Short (LPS) a comparison of proportion was conducted. At the time of observation, the one-day total population at Napa State Hospital was 1277 patients and 50% of these patients were committed as NGRI; however NGRI patients had access to 65.5% (n=557) of all the treatment groups at the hospital in comparison to 19.0% (n=166) for the IST patients, who comprise 32% of the hospital patient population. In contrast, LPS patients are offered 18.7% (n=164). This figure, roughly translates to an equal amount of treatment availability in relationship to the proportion of the population they represent at the hospital, which is 18%. For more detail, please see Figure 8.

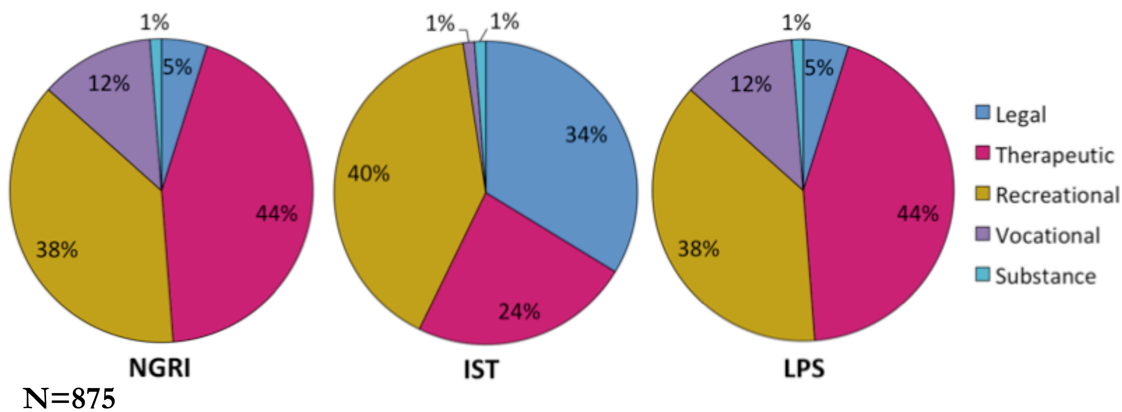
**Figure 9. Treatment Group Availability**




**N=875; Population DSH-Napa N=1277**

Analysis of treatment content or variety was also conducted. Therapeutic treatment groups were categorized in either one of five categories: (1) legal/discharge (n=92); (2) therapeutic/mental health/psycho-education (n=258); (3) recreational/leisure/fitness/social (n=278); (4) vocational/life-skills/educational (n=186); and (5) substance abuse (n=61). After this content analysis was completed, a clear difference in the availability of therapeutic treatment groups is found by comparing the proportion of treatment groups offered to each commitment. NGRI patients receive a wider variety of treatment than patients committed as IST or LPS.

**Figure 10. Treatment Variety by Commitment**




**N=875**

LEGAL/DISCHARGE

A closer examination of the treatment variety based on groups that focus on treatment activities relating to adjudication, community reentry, or discharge planning shows that 33.7% (n=56) of treatment offered to IST (n=166) patients is related directly to legal content for discharge, in comparison to the 5.2% (n=30) of treatment offered to NGRI patients (n=573) and 4.8%(n=8) of treatment offered to LPS patients (n=164). Most legal groups in this category are related to competency restoration; however groups related to community reentry are offered to NGRI and LPS patients. Of the ninety-two legal and discharge related groups offered at the hospital, IST patients receive 59.8% of all the groups in a comparison of 31.5% offered to NGRI patients and 7.6% of LPS patients. Overall 10.5% of all groups provided at the hospital focus on legal issues, discharge planning, and community reentry. For more detail please see Table 13.

**Table 13. Legal/Discharge Treatment Groups by Commitment**

| GROUPS BY COMMITMENT | ALL n=14 | NGRI n=559 | IST n=152 | LPS n=150 | TOTAL N=875 |
|---|---|---|---|---|---|
| n(%) | 1(1.1) | 29 (31.5) | 55 (59.8) | 7(7.6) | n=92(10.5) |

### THERAPEUTIC/MENTAL HEALTH/PSYCHO-EDUCATION

Looking at treatment groups that focus on treatment activities relating to management of psychosocial stabilization including individual therapy, medication management, anger management, dialectic behavior treatment, etc. shows that 23.5% (n=39) of treatment offered to IST (n=166) patients are related directly to therapeutic or mental health education, in comparison to the 22.7% (n=159) of treatment offered to NGRI patients (n=573) and 43.9% (n=72) of treatment offered to LPS patients (n=164). Therapeutic, mental health, and psychoeducational groups in this vary widely, but all have a similar goal of helping the patient to better understand his or her mental illness and better manage their symptoms or negative behaviors. These groups are considered the most traditional therapy groups for persons with mental illness. Of the 258 therapeutic, mental health, and psychoeducation related groups offered at the hospital, IST patients receive 15.1% of all the groups in a comparison of 61.6% offered to NGRI patients and 27.9% of LPS patients. Overall 29.5% of all groups provided at the hospital focus on mental health, traditional therapy, and psychoeducation. For more detail please see Table 14.

**Table 14. Therapeutic Treatment Groups by Commitment**

| GROUPS BY COMMITMENT | ALL n=14 | NGRI n=559 | IST n=152 | LPS n=150 | TOTAL N=875 |
|---|---|---|---|---|---|
| GROUP n(%) | 6(2.3) | 153 (59.3) | 33(12.8) | 66(25.6) | N=258(29.5) |

### RECREATIONAL/LEISURE/FITNESS/SOCIAL

An analysis of the treatment groups that focus on treatment activities relating to leisure and recreation that was not also identified as having a legal component e.g. art therapy, dance therapy, yoga, bikes, walking, etc. shows that 40.4% (n=67) of treatment offered to IST (n=166) patients are related directly to recreation, leisure, fitness, and social activities in comparison to the 28.1% (n=161) of treatment offered to NGRI patients (n=573) and 37.8% (n=62) of treatment offered to LPS patients (n=164). Leisure, social, recreational, and fitness groups vary widely at the hospital. They are often referred to as "fun groups" at the annoyance of the rehabilitative therapists that generally run them. However, these groups are often considered by the patients and staff to give the most community-like experience to the patients at the hospital. Of the 278 recreation, leisure, fitness, and social sills related groups offered at the hospital, IST patients receive 24.1% of all the groups in a comparison of 57.9% offered to NGRI patients and 22.3% of LPS patients. Overall 31.8% of all groups provided at the hospital focus on recreational, leisure, social activities, and fitness or psychical well-being. For more detail please see Table 15.

**Table 15. Recreational Treatment Groups by Commitment**

| GROUPS BY COMMITMENT | ALL n=14 | NGRI n=559 | IST n=152 | LPS n=150 | TOTAL N=875 |
|---|---|---|---|---|---|
| GROUP n(%) | 6(2.2) | 155(55.8) | 61(21.9) | 56(20.1) | N=278(31.8) |

### VOCATIONAL/LIFE-SKILLS/EDUCATIONAL

Considering the treatment groups that focus on treatment activities relating to the development of independent skills or paid work at the hospital e.g. attending groups for GED and college enrollment, cooking class, upholstery, wrapping soaps, beauty shop, recycling center, etc. shows that 1.3% (n=2) of treatment offered to IST (n=166) patients are related directly to vocational training, life skills, or education in comparison to the 29.0% (n=166) of treatment offered to NGRI patients (n=573) and 12.2% (n=20) of treatment offered to LPS patients (n=164). Vocational, life-skills, and educational groups help the patient earn money while being treated at the hospital in addition to preparing them for a life outside of the hospital. Of the 186 vocational training, life-skills, and education related groups offered at the hospital, IST patients receive 0.1% of the opportunities to participate in these groups in a comparison to 89.2% offered to NGRI patients and 10.8% of LPS patients. Overall 21.3% of all groups provided at the hospital focus on life-skills, vocational training, and educational advancement. For more detail please see Table 16.

**Table 16. Vocational Treatment Groups by Commitment**

| GROUPS BY COMMITMENT | ALL n=14 | NGRI n=559 | IST n=152 | LPS n=150 | TOTAL N=875 |
|---|---|---|---|---|---|
| GROUP n(%) | 1(0.5) | 165(88.7) | 1(0.5) | 19(10.2) | N=186(21.3) |

### SUBSTANCE ABUSE

An analysis of the treatment groups that focus on treatment activities relating to the treatment and management of substance abuse and misuse e.g. Alcoholics Anonymous, Narcotic Anonymous, Self-Management and Recovery Training, etc. shows that 1.2% (n=2) of treatment offered to IST (n=166) patients are related directly to therapeutic or mental health education, in comparison to the 9.9% (n=57) of treatment offered to NGRI patients (n=573) and 1.2% (n=2) of treatment offered to LPS patients (n=164). As detailed in the literature review on community mental illness, substance use plays a large role in criminal behavior and exacerbates symptoms of mental illness. The hospital has made a formal effort to provide substance abuse treatment to patients treated at the hospital; however it is evident that substance abuse treatment is almost exclusively offered to NGRI patients. Of the 61 substance abuse related groups offered at the hospital, IST and LPS patients each receive 3.3% respectively of all the substance abuse groups in a comparison to 93.4% offered to NGRI. Overall 7.0% of all groups provided at the hospital focus on substance use and abuse management and education. For more detail please see Table 17.

**Table 17. Substance Abuse Treatment Groups by Commitment**

| GROUPS BY COMMITMENT | ALL n=14 | NGRI n=559 | IST n=152 | LPS n=150 | TOTAL N=875 |
|---|---|---|---|---|---|
| GROUP n(%) | 0(0.0) | 57(93.4) | 2(3.3) | 2(3.3) | N=61(7.0) |

## CONCLUSION

An analysis of the availability and variety of treatment groups provided at the state hospital helps to paint a deeper picture of the operations at the hospital and clearly defines the different treatment opportunities available to patients based solely on commitment. These disparities in treatment availability and variety have never been considered as impacting the experience of persons mandated to treatment at the state hospital, although they clearly shape the daily experience of every patient. The next chapter will focus on the overall satisfaction of patients at the hospital and investigate any differences in satisfaction based on commitment type.

## CHAPTER IX. PATIENT SATISFACTION

As a large state forensic hospital, Napa State Hospital provides psychiatric treatment tailored to specific commitment types. In the previous chapters, I explained how patients receive forensic commitments in the court systems, the general characteristics of the patients based on their commitment status, and the differences in the types of treatment available to them based on their commitment status. In this chapter, I begin to unearth the perceptions of patients committed to the hospital by analyzing their responses to the patient satisfaction survey and addressing my third research question of how satisfied are the patients in general and whether the patients have different levels of satisfaction based on their commitment?

**Table 18. Research Question 3, Method, & Results**

| Research Question 3 | How satisfied are patients with the treatment and care they receive at Napa State Hospital? Are there differences in patient satisfaction based on commitment? |
|---|---|
| *Method* | *Patient Satisfaction Survey Data* |
| Results | In general patients at DSH-Napa are satisfied with the treatment and care they receive at the hospital. Analysis of patient satisfaction based on commitment reveals significant differences. Patients found not guilty by reason of insanity are significantly more satisfied with the treatment and care they receive at the hospital in comparison to either patients found incompetent to stand trial or patients civilly committed. |

### SAMPLE CHARACTERISTICS

Of the participating patients (N=611, response rate was 49.2%) 81.9% the respondents (*n*=586) are male. Patients whose treatment time at the hospital is equal to three years or less are approaching 50%. Approximately 16% of all participating patients are in the age range 18-30; 40% are between the age range 30-50; and 45% are older than 50 years. The three largest racial groups are White, Black, and LatinX; for all participating patients they represent 46%, 23%, and 16% respectively. The commitment treatment for all participating patients is: 21.5% Lanterman Petris Short [LPS] (Civil Commitments), 24.0% Trial Competency (IST), and 54.5% Not Guilty by Reason of Insanity (NGRI). The sample characteristics for all participating patients are displayed in Table 4.

### ANALYSIS OF PATIENT SATISFACTION

In order to provide insight into the determinants of patient satisfaction with mandated psychiatric patients, several indicators concerning patient satisfaction were examined in this study. Overall, patients are generally satisfied with treatment and services provided at the state hospital, with averages for all respondents (n=611) ranging from 3.38-4.06 on a 5-point Likert scale, indicating patients were generally very satisfied with the mandated treatment they were receiving. Besides feeling ready to discharge, the question

with the strongest positive endorsement of 4.06, patient satisfaction was highest in the domains related to the general hospital environment and being treated well by staff followed by social experience and quality of life. Patients were most satisfied with having enough food (3.78); their relationships with other patients (3.77); the staff being helpful (3.72); and their living environment feeling clean and comfortable (3.70). Patients reported low satisfaction in having the side effects of their medications explained (3.39) and feeling comfortable at the hospital (3.38). Satisfaction rates for all respondents are shown in Table 19.

**Table 19. Distribution of Patients' Assessments Across Five Treatment Domains Of Satisfaction**

| Survey Topics | *n* | 1 | 2 | 3 | 4 | 5 | M | SD |
|---|---|---|---|---|---|---|---|---|
| | | % | % | % | % | % | | |
| THERAPY | | | | | | | | |
| There are enough opportunities for therapy at the hospital | 568 | 21.9 | 13.2 | 18.1 | 28.0 | 27.8 | 3.45 | 1.36 |
| I receive enough substance abuse treatment here | 540 | 15.6 | 7.2 | 15.6 | 29.4 | 32.2 | 3.56 | 1.40 |
| This is a good place for me to discuss my problems | 569 | 13.9 | 10.5 | 16.5 | 31.1 | 27.9 | 3.49 | 1.36 |
| I receive enough therapy while I am here | 565 | 12.2 | 11.5 | 14.3 | 31.3 | 30.6 | 3.57 | 1.35 |
| MEDICAL-PSYCHIATRY | | | | | | | | |
| Medications are used by the doctors to help patients calm down only when it is necessary | 566 | 14.7 | 10.3 | 18.6 | 30.4 | 26.2 | 3.43 | 1.36 |
| My medical (non-psychiatric) needs are met on the unit. | 573 | 13.6 | 9.4 | 14.8 | 32.5 | 29.7 | 3.55 | 1.36 |
| The side effects of my medication were explained to me. | 559 | 17.4 | 11.3 | 14.9 | 28.1 | 28.4 | 3.39 | 1.44 |
| ENVIRONMENT-STAFF | | | | | | | | |
| I am comfortable here. | 569 | 15.5 | 12.5 | 14.8 | 22.6 | 23.7 | 3.38 | 1.37 |
| My living environment is comfortable and clean. | 570 | 10.2 | 8.4 | 12.5 | 38.8 | 30.2 | 3.70 | 1.26 |
| I feel safe here. | 570 | 13.2 | 10.5 | 18.3 | 30.0 | 28.1 | 3.49 | 1.35 |
| The staff is working to help me. | 567 | 9.4 | 7.2 | 16.1 | 36.1 | 30.9 | 3.72 | 1.24 |
| I get enough to eat | 560 | 11.1 | 7.2 | 11.8 | 32.5 | 37.5 | 3.78 | 1.32 |
| SOCIAL/QUALITY LIFE | | | | | | | | |
| I have good social relationships with other patients | 570 | 6.8 | 6.8 | 17.7 | 39.5 | 29.1 | 3.77 | 1.14 |
| I have good communication with family members | 567 | 14.1 | 8.3 | 11.5 | 28.9 | 37.2 | 3.67 | 1.41 |
| I am happy and satisfied with my life | 566 | 13.1 | 14.0 | 15.9 | 27.0 | 30.0 | 3.47 | 1.38 |
| My spiritual/religious needs are being met | 568 | 14.8 | 11.8 | 17.6 | 29.6 | 26.2 | 3.41 | 1.38 |
| I have access to recreational activities | 562 | 12.1 | 8.2 | 16.7 | 36.3 | 26.7 | 3.57 | 1.29 |
| There is enough to do here during the day to keep me busy. | 566 | 12.2 | 13.07 | 17.7 | 29.5 | 27.6 | 3.47 | 1.34 |
| DISCHARGE-FAIRNESS | | | | | | | | |
| I am treated fairly here | 553 | 11.2 | 9.6 | 15.7 | 35.1 | 28.4 | 3.60 | 1.29 |
| My rights as a patient were explained to me when I got here. | 573 | 15.0 | 10.7 | 14.3 | 29.1 | 30.9 | 3.50 | 1.41 |
| My groups help me to reach my discharge goal. | 563 | 11.2 | 8.7 | 21.0 | 29.5 | 29.7 | 3.58 | 1.30 |
| I am ready to be discharged | 559 | 8.2 | 4.5 | 14.3 | 18.6 | 54.4 | 4.06 | 1.27 |
| **TOTAL** | **611** | | | | | | | |

(Legend: M – median value, SD – standard deviation)

## ANALYSIS BASED ON COMMITMENT TYPE

In continuing the research, I sought to verify the relationship between the programmatic organization of the hospital and the level of patient satisfaction based on the configuration of the hospital, namely commitment treatment and patient satisfaction. For this purpose, one-way variance analysis (ANOVA) was used to determine whether there were any statistically significant differences between the means of the independent groups (treatment commitment). A composite variable of total satisfaction was created to test the Analysis of Variance (A-NOVA) between the three commitment treatments in addition to composite variables based on the five treatment domains. A test performed to establish internal consistency (reliability) showed that, despite the modifications made to the ISQ survey, the new survey reliably measured levels of satisfaction with mandated psychiatric patients. The Cronbach alpha coefficient for the summary of experience is 0.951, and the figures for the domains are: therapy 0.833; medical-psychiatry 0.758; environment-staff 0.849; social/quality of life 0.844; and discharge-fairness 0.742. The recommended minimum value of the Cronbach alpha coefficient is 0.700. Results from the A-NOVA determined that the mean for the summary of experience for Civil treatment was (M=63.83, SD=18.22); Competency treatment was (M=64.29, SD=19.37); and Insanity treatment was (M=78.75, SD=22.78). Means and standard deviations for all therapeutic domains and the summary of experience are shown in Table 12.

**Table 20. Treatment Commitment Therapeutic Domain Satisfaction Means and Standard Deviations**

| THERAPEUTIC DOMAINS | CIVIL | COMPETENCY | INSANITY |
|---|---|---|---|
| | M (SD) | M (SD) | M (SD) |
| THERAPY | 10.3 (5.84) | 12.06 (5.31) | 14.35 (4.77) |
| MEDICAL-PSYCHIATRY | 8.18 (4.80) | 9.01 (3.89) | 10.46 (3.65) |
| ENVIRONMENT-STAFF | 14.9 (7.78) | 16.30 (6.14) | 17.84 (5.57) |
| SOCIAL/QUALITY LIFE | 16.24 (9.98) | 19.05 (7.23) | 21.58 (6.54) |
| DISCHARGE-FAIRNESS | 11.87 (6.17) | 12.96 (5.10) | 14.51 (4.44) |
| SUMMARY OF EXPERIENCE | 61.49 (31.68) | 69.38 (24.78) | 78.75 (22.78) |

An analysis of variance among patient satisfaction scores showed that the effect of commitment treatment is significant. The results of the variance analysis depicted in Table 13. One-way analysis of variance based on commitment treatment indicate that the effectiveness of the hospital programmatic organizational model or the type of psychiatric treatment provided to patients based on their court commitment has a statistically significant ($p < 0.000$) impact on satisfaction indicators in all five therapeutic treatment domains and overall summary of experience.

**Table 21. One-Way Analysis of Variance Based on Commitment Treatment**

| THERAPEUTIC DOMAINS | SS | Df | MS | F | p-value |
|---|---|---|---|---|---|
| THERAPY | 1675.98 | 2 | 837.99 | 31.64 | 0.000 |
| MEDICAL-PSYCHIATRY | 553.92 | 2 | 276.96 | 17.27 | 0.000 |
| ENVIRONMENT-STAFF | 864.38 | 2 | 432.19 | 11.10 | 0.000 |

| SOCIAL/QUALITY LIFE | 27775.62 | 2 | 1387.81 | 26.09 | 0.000 |
|---|---|---|---|---|---|
| DISCHARGE-FAIRNESS | 718.24 | 2 | 359.12 | 14.27 | 0.000 |
| SUMMARY OF EXPERIENCE | 29957.33 | 2 | 14978.66 | 23.19 | 0.000 |

(Legend: SS – sum of squares, Df – degrees of freedom, MS – mean square)

Post hoc tests were also done to evaluate the discrepancies in the satisfaction of patient groups. The results of the post hoc tests indicated that patients who receive Civil commitment treatment are statistically significantly ($p < 0.000$) less satisfied with their treatment and care than patients that receive Insanity commitment treatment across all therapeutic domains and summary of experience. Conversely, patients receiving Civil commitment treatment are statistically significantly ($p < 0.05$) less satisfied with the access and quality of their therapy treatment, with their quality of life and social interactions, and their summary of experience than patients that receive Competency commitment treatment. Finally, the comparison between patients receiving criminally committed treatment reveal that patients that receive Competency commitment treatment are statistically significantly ($p < 0.05$) less satisfied than patients receiving Insanity commitment treatment across all therapeutic domains and summary of experience. Details from the analysis are depicted in Table 14.

**Table 22. Results of Post Hoc Tests- Impact of Commitment Type and Patient Satisfaction**

| THERAPEUTIC DOMAIN | Commitment Treatment (I) | Commitment Treatment (II) | M difference | p-value |
|---|---|---|---|---|
| THERAPY | Civil | Competency | 1.76 | 0.015 |
| | Civil | Insanity | 4.05 | 0.000 |
| | Competency | Insanity | 2.28 | 0.000 |
| MEDICAL-PSYCHIATRY | Civil | Competency | 0.82 | 0.263 |
| | Civil | Insanity | 2.27 | 0.000 |
| | Competency | Insanity | 1.45 | 0.001 |
| ENVIRONMENT-STAFF | Civil | Competency | 1.40 | 0.193 |
| | Civil | Insanity | 2.94 | 0.000 |
| | Competency | Insanity | 1.55 | 0.039 |
| SOCIAL/QUALITY LIFE | Civil | Competency | 2.82 | 0.004 |
| | Civil | Insanity | 5.35 | 0.000 |
| | Competency | Insanity | 2.53 | 0.002 |
| DISCHARGE-FAIRNESS | Civil | Competency | 1.10 | 0.213 |
| | Civil | Insanity | 2.64 | 0.000 |
| | Competency | Insanity | 1.54 | 0.006 |
| SUMMARY OF EXPERIENCE | Civil | Competency | 7.887 | 0.031 |
| | Civil | Insanity | 17.26 | 0.000 |
| | Competency | Insanity | 9.37 | 0.001 |

## CONCLUSION

Statistical analysis of the patient satisfaction survey data revealed that in general patients committed to psychiatric treatment at Napa State Hospital are positively satisfied

with their treatment and care. An analysis of variance also revealed that being committed as not guilty by reason of insanity is positively associated with being more satisfied with the treatment and care provided at the hospital in comparison to either patients committed as incompetent to stand trial or civilly committed patients. This result is compelling in light of the court mandate that went into effect during my data collection phase, which put more pressure on the hospital to treat incompetent to stand trial patients at a faster rate. In light of this event, the next chapter will consider the impact of this mandate and present the perspectives of patients, clinicians, and administrators on trial competency restoration treatment.

## CHAPTER X. INCOMPETENT CALIFORNIA

This chapter takes a pointed look at the incompetent to stand trial population and trial competency restoration treatment as a therapeutic treatment from all involved including administrators, clinicians, and patients. I base this chapter mostly on data gathered from the semi-structured interviews, but I also use information obtained through participant observation to ground the findings. Focusing this chapter on trial competency restoration treatment necessitates a consideration of the Stiavetti mandate that went into effect during the data collection period. In this chapter I address my final research question of how the administrators, clinicians, and patients at the hospital perceive trial competency restoration treatment?

**Table 23. Research Question 4, Method, & Findings**

| Research Question 4 | How do patients, clinicians, and administrators perceive the experience of receiving and providing trial competency restoration treatment? |
|---|---|
| *Method* | *Semi-Structured Interview Data, Participant Observation* |
| FINDINGS | Patients, clinicians, and administrators are aware of the dangers of not providing mental health treatment in the jails. However, all groups perceive that trial competency restoration treatment ignores the therapeutic needs of the patients. For clinicians providing trial competency restoration treatment the experience lacks clinical meaning and creates tension in the clinical role. Clinicians and administrators are able to state a conscious frustration with the current mental health, welfare, and criminal justice system and consider the current arrangement to be broken for patients found incompetent to stand trial. Patients found incompetent to stand trial express frustrations navigating welfare, criminal justice, and mental health systems, but show more complacency and less outrage at the current system than the clinicians or administrators. |

### EXPERIENCES IN JAIL

As the mandate from the Stiavetti case went into effect during the data collection period, it was important to get an understanding of the experiences patients at the hospital had in jail prior to coming to the hospital. These experiences fortifying the importance of decreasing or minimizing the wait time for persons found incompetent to stand trial to receive competency restoration treatment and also demonstrate the lack of accessibility of mental health treatment in the community. Over the course of investigation, I became privy to many examples of patients being poorly or insufficiently medicated and even abused. One patient described his experience in the jail setting prior to coming to the hospital for treatment:

*"Jail was not good for me. It was pretty…it was probably one the worst things I've been through…There was people like just being crazy like animals, acting like animals in jail, but it was just not good."*

He also described an attack he experienced in custody at the hands of the guards and explained.

*"I don't know why they did it. I was in my cell trying to go to sleep and then they just came to my cell. Then they pulled me out. They put the cuffs on me and they just dragged me down the stairs and into this room and just started beating me up with nightsticks."*

—Black Male IST Patient, 24 years old
Diagnosis: Schizophrenia
Charge: Robbery 2nd Degree;
Grand Theft from a Person
Length of Stay: 7 Months

This horrific experience details not only the non-therapeutic environment that detainees with serious mental illness are expected to stay in, but also the inability of guards in the jail to properly manage the behavior of a person with severe mental illness without relying on violence and further traumatization.

What became clearer during the course of the investigation at the hospital was that the concern and the ramifications of improperly managing and medicating jail detainees with mental illness were never lost on the staff at the hospital, as they are often firsthand witnesses to the consequences of providing substandard psychiatric treatment. One administrator who has experience working for both the California Department of Corrections and Rehabilitation and the California Department of State Hospitals explained his concern for severely psychotic patients not receiving proper treatment in the jail setting.

*"There's a lot of the population that think it's horrible and cruel to medicate people against their will. I've done this work for 35 years. To me, it's cruel not to! I won't say the gentleman's name, but we have somebody* [omitted] *who was very psychotic. He was in the* [omitted] *county jail. They were not medicating him and he pulled his own eye out. He would never have done that if he had been properly medicated."*

—Male administrator, 7 years experience (at NSH)

Understanding the severity and potentially horrific effects of not providing mental health treatment is evident and the fight for speedy treatment is valiant. What shifts in this work is not the question of advocacy or fighting to provide psychiatric treatment to people in state custody quickly, but rather what is trial competency restoration treatment and is this adequate psychiatric treatment for persons suffering from severe and persistent mental illness in the criminal justice system?

### IGNORING THERAPEUTIC NEEDS

Based on the findings demonstrated in other chapters and the results of the patient satisfaction survey, trial competency restoration treatment is extremely narrow. Arguably,

treatment for psychiatric and all persons with severe and persistent mental illness is fundamentally similar and in addition to psychopharmacology it would include psychotherapy, social skills, supported employment, education, treatment for substance use disorders, and treatment for trauma, or well-rounded interventions that meet a variety of needs beyond trial competency. However, the treatment provided for competency restoration treatment is limited and perceptible to the patients receiving it.

An interview with one patient who had received treatment in multiple state hospitals in California and other western states described the experience of receiving trial competency treatment and a how he experiences a typical week.

> *"Typical week is eating, and sleeping, and studying… I study my competency packet. Most of the time, and then in the evenings I might watch a little bit of TV. I've been watching more TV lately than usual because I'm getting kind of bored… I already studied the* [competency] *packet like, ten thousand times. I kind of know all the groups by now."*
>
> —Asian Male IST Patient, 45 years old
> Diagnosis: Schizophrenia
> Charge: Battery; Serious Bodily Injury
> Length of Stay: 4 Months

This patient was living in a motel at the time of arrest. According to his arrest report he allegedly battered a fast food worker during an altercation at the restaurant. He has an extensive history of mental health treatment in a variety of hospitals and has cycled through periods of hospitalizations, homelessness, and precarious housing throughout his adult life. When I spoke to him, he appeared psychiatrically stable. I asked the treating social worker her thoughts on whether he was already competent and she believed that he was close and would likely be found competent at his next interview with the forensic office[36]. He also had been found incompetent to stand trial previously and his lack of interest in learning trial competency material speaks less to a lack of motivation or inability to retain the information and more to an institutionalization reaction of receiving the same information over-and-over. From a clinical perspective this patient displayed low affect. His tone was modulated and his response time to questions was slow and deliberate. This patient obviously required more stimulation at the hospital and more services for his mental illness in the community.

As treatment providers contemplated the clinical experience of providing trial competency restoration treatment, the majority of clinicians overwhelmingly felt that this form of treatment did not meet the therapeutic needs their patients would benefit from most. Consistently clinical staff indicated that the trial competency material lacked depth of therapeutic care especially in comparison to the treatment provided to patients mandated to the hospital under different commitment types. One social worker whose only experience at the hospital was with patients found incompetent to stand trial did not point to any specific therapeutic treatments she wanted to provide trial competency patients when asked how to improve treatment at the hospital, rather she decried competency restoration

[36] The forensic office at DSH-Napa is comprised of psychiatrists and psychologists that are independent from the treatment team. They are responsible for writing the formal competency evaluation letter to the court and are compelled to meet with the patients every six months until a determination of competency is made.

treatment as deficient and expressed desire to just give the patients more therapeutic treatment in general.

> *"More in-depth therapeutic care… I think just more therapeutic care, competency is just, I'm trying figure out how to word it…competency is just competency. Its just… you can't treat the whole person, we're not treating the whole person…we're missing pieces with just the competency…"*
> —Female Social Worker, 2 years experience

Another social worker that has clinical experience working with multiple commitments at several state hospitals expressed a desire to provide more trauma informed care for patients committed as incompetent to stand trial when asked the same question.

> *"I think something like trauma could impact someone that's committed pursuant* to [Not Guilty by Reason of Insanity] *and to* [Incompetent to Stand Trial] *and we're able to go down a path of treating that for the* [Not Guilty by Reason of Insanity] *patient; whereas, with the* [Incompetent to Stand Trial] *patient we are much more restricted"*
> —Male Social Worker, 4.5 years experience

Coupling these quotes reveal the glaring lack of traditional therapy provided to patients found incompetent to stand trial.

Patients also indicated that their therapeutic needs were not being met and are aware that the hospital is not able to provide the kind of treatment or therapy that may be helpful to them. Returning to the patient who had experienced trauma and abuse in custody at the county jail for allegedly shoplifting at a large corporate pharmacy, he disclosed that since being arrested and in jail, his mother passed away and his brother, who is also diagnosed with schizophrenia, was arrested. He also experienced several bouts of homelessness, but was in a sheltered living condition at the time of his alleged crime. When asked about the therapeutic groups he is offered and the treatment he was receiving at the hospital he replied.

> *"That's what they tell me…you got to not sleep, so I go to groups. I started going to groups. I stopped sleeping as much as I could but I still got to lay down for a lot of time in the day because there's not like…Like drum circle. When you going through something like, you lost a loved one or you are incarcerated or going through stuff like jail, you don't necessarily want to play drums you know? I try to drag myself out of bed to do that type of stuff, because it's better than thinking about doing wrong things or trying to make sure that I don't come back to a place like this. That's how I feel, but there's not words I could really explain that would explain what I'm going through…"*
>
> —Black Male IST Patient, 24 years old
> Diagnosis: Schizophrenia
> Charge: Robbery 2nd Degree; Grand Theft from a Person
> Length of Stay: 7 Months

Suffering from severe trauma and grief in addition to symptoms related to schizophrenia this patient did not feel that he was working towards therapeutic goals that would enable

him to lead a more productive and autonomous lifestyle or receiving treatment that was individualized, rehabilitative, and strengths-based. In these instances, especially for patients that are from precarious housing arrangements prior to arrest, the hospital is acting as a custodial agent, stabilizing and holding patients to prepare them for the processes of the criminal justice system and their therapeutic needs are going unmet.

LACK OF CLINICAL MEANING & ROLE TENSION

The inability for competency restoration treatment to provide comprehensive mental health care to patients often leads frontline clinicians to feel a lack of clinical meaning or role tension in their work. When clinicians had experience working with multiple commitments, and a point of comparison, they would often state that they enjoyed working with the patients found not guilty by reason of insanity, because they were able to provide the therapeutic care they had been trained in. For example, one social worker stated:

> *"The* [trial competency treatment] *feels more like an extension of jail or prison…the* [not guilty by reason of insanity] *guys, it feels like you're working at a mental hospital, because they're typically higher-functioning and you can actually do some pretty intensive one-on-one work. That's actually been the most gratifying part of my job…because I'd see guys change and become whole-like…less incongruent,*[37] *coming together, healing, so it felt like you're really helping folks. And the* [trial competency treatment] *was basically like turn 'em and burn 'em: more just paperwork, dotting I's crossing T's and moving people forward."*
>
> —Male Social Worker, 2 years experience

Consistently clinicians with experience with more than one commitment type often remarked that working with long-term commitments brought more value to their clinical experience in comparison to competency restoration treatment. The only exception to this sentiment was one clinician that had worked on a low functioning not guilty by reason of insanity unit that had few discharges and little population movement.

Additionally, working in a forensic environment where the focus of treatment is determined by the courts can lead to professional role tension. A psychiatrist with experience working in another state hospital outside of California describes the difference and tension of practicing psychiatry in a forensic setting as a non-forensic psychiatrist. When asked why he chose to work in a forensic setting he stated:

> *"I had a state hospital experience and so I didn't know what forensic is, right. So, I didn't want* [to] *join just to become forensic. I am geriatric and psychiatric, but not forensic…so everybody who is a* [trial competency psychiatrist] *working inside the unit, to the best of my knowledge none of these are forensic psychiatrist…we have…*[a] *few psychiatrists who are forensic psychiatrists…outside the fence…they're thinking is designed differently. You know, they're trained to think that way. We are not… I look from a medical point. I look much better at the medical. What is happening...how much* [the] *medication is impacting physical …I don't see me as a forensic psychiatrist even though I am working as a forensic psychiatrist. I mean, I can easily be qualified as a forensic psychiatrist with my experience, but that's not what I do."*

[37] Incongruence in psychology refers to a lack of consistency or appropriateness, as in inappropriate affect or when one's subjective evaluation of a situation is at odds with reality.

The tension of being compelled to medicate or use specific psychiatric medications that may have adverse side effects deeply distressed this psychiatrist and made him protective and frightened of losing his psychiatric license.

> *"We are not lawyers. We are not trained as lawyers…we are trained as a doctor. And the many times, you know, that environment is so stressing that we are compelled to do certain things which we are not comfortable with."*
>
> —Male Psychiatrist, 5 years experience (DSH-Napa)

Over the course of this ethnography this psychiatrist transferred to a non-trial competency unit to avoid the court pressures and uncomfortable oversight of hospital administration in connection to the court mandate. This lack of clinician meaning and role tension can often lead to burnout[38] and dissatisfaction with the job. In this case, the interests of trial competency restoration are overriding the original clinical intention of the mental health providers, and are potentially hastening job turnover and contributing to rote professional interactions.

SYSTEM BREAKDOWN & FRUSTRATION

> *"These individuals are often in an unsheltered homeless condition not accessing mental health services, and getting arrested because of that circumstance, either getting arrested because they're floridly psychotic in the community, or trespassing, homeless, and so restoring their competencies so they can continue down this criminal justice pathway. I mean, it's better to do it in the community than to be sending everybody to the state hospitals, but it's not fixing the problem. The problem is these people shouldn't be arrested in the first place! The problem is these people shouldn't be homeless in the first place! And the problem is these people shouldn't be untreated in the first place!"*
>
> —Female administrator, 14 years experience

Overwhelmingly, clinicians, administrators, and patients all perceive trial competency restoration treatment as a breakdown between the mental health and criminal justice systems. When the administer quoted above was asked about the rising incompetent to stand trial population and the Stiavetti case in particular she replied with extreme frustration at the responsibility of the state hospital system to fix the overwhelming social problems made by a cobbled social welfare system and overreaching criminal justice system.

Although trial competency restoration treatment is not considered an intervention for homelessness or community mental health, it is being used as one. Taking a magnifying glass to trial competency restoration as a psychiatric treatment modality heightens our understanding of the long-term implications of deinstitutionalization and mass incarceration. Fifty percent of patients found incompetent to stand trial in California were in an unsheltered living condition prior to arrest (The California Department of State Hospitals, 2018). This population represents the most vulnerable and marginalized persons in society and they are being regulated by the criminal justice system as a means of control

[38] In the literature, burnout in state behavioral health systems is considered costly and economically inefficient due to the expense of recruiting and retaining competent staff (Morse et al., 2012).

and custody reinforcing the centurion state of a weakened welfare system and intensified criminal justice system.

> *"Well, here's the thing …most of us we're trying to treat the mental illness, right? Not necessarily the legal commitment. What are the differences? It's taken a lot of time to figure out what is really needed because of the pressures of the community needs, right?...I think we don't have any capability as a society…I think in the old days, there was places for people. I think they did have more homeless shelter beds … I think there was a little bit more…but using the* [incompetent to stand trial] *system now, people just say, "Not in my neighborhood!" …You don't really have the services that should have been put in place anyway, whether its board-and-cares being built, locked facilities where they have much more of a protective way of taking care of these people, because when you think about it, this place is called an asylum, and the word asylum really means protection essentially, right? --We left that idea to protect these people …essentially, we changed our societal norms"*
>
> —Male administrator, 30 years experience

Economically, it is extremely expensive to provide treatment to a patient in the state hospital setting. During the 2013-2014 fiscal year, the cost of care per bed ranged from $225,205 to $282,875 depending on facility and whether the treatment was intermediate, acute, or skilled nursing (California Department of State Hospitals et al., 2015). This compares dramatically with the $81,203 it costs to incarcerate someone in California's prison system (California Legislative Analyst's Office, 2019). Obviously, the price differential is not an endorsement of incarceration as an alternative to treatment in the state hospital system; rather it should be considered an additional cost as patients cycle through the hospital on a regular basis via the criminal justice system. The high cost of care for patients treated within the state hospital is particularly problematic when considering that the treatment imparts little to no long-term improvement for patients as articulated by a high level administrator.

> *"[R]estoring someone's competence to stand trial does not equate to comprehensive mental health care. It means you teach them what a judge is; make sure they can cooperate with their attorney. And then spit them right back out into the same situation they were in, having conferred no benefit upon them in terms of their long-term mental health stability. So, the entire situation is ridiculous, and we're doing this at a cost, 200,000 to 300,000 dollars a year per bed."*
>
> —Female administrator, 14 years experience

The lack of nuance in this rationale in addition to the lack of funding and energy directed at mental health treatment prohibits the exploration and development of alternative treatment programs[39]. This system configuration outrages the clinicians forced to

[39] Although beyond the scope of this dissertation, it is important to note that mental health courts are frequently mentioned as a viable alternative to criminal justice processes for persons with mental illness. To be clear, mental health courts are designed to bridge social services agencies and systems to defendants that are in need of services; nonetheless, mental health courts vary widely in their eligibility criteria with many only focusing on defendants with misdemeanor charges; also, specialized mental health and substance abuse courts are often only available in more populated counties (Almquist & Dodd, 2009; Johnston & Flynn, 2017; Redlich et al., 2005). Every patient receiving competency restoration treatment at DSH-Napa has a felony charge. However, the severity of the charge a defendant receives is a subjective response of the district attorney, and is based on the account of the responding police officers and the available evidence. This evidence may or may not be submitted in court later, and many severe charges are dropped or lowered during the course of a plea bargain. Therefore, many defendants in the early stages of the adjudication process that are charged with

give psychiatric treatment under these conditions as articulated by a psychiatrist when asked about his experience providing treatment to incompetent to stand trial patients.

> *"The whole purpose is justice can be served…but the criminal, the forensic style justice is not going to be served in that way, because these people need a different kind of facility than a prison or a psychiatric hospital… Once they get discharged from here, they need proper rehabilitation services, proper placing. Maybe they need an outpatient-based court for forced medication so they can stay on medication…it's almost like open door policy. You know, where you discharge them. They come back in few months. They're back!"*
>
> —Male psychiatrist, 5 years experience (at NSH)

Clinicians also demonstrate frustration with the broken system of mental health care in relationship to the community and patient families. With the lack of access to mental health treatment in the community, families that have exhausted the few options available to them can mistakenly view the trial competency intervention as an opportunity for real treatment. Recalling that criminal justice interventions are often the first, last, and only resort of many families trying to help loved ones battling severe mental illness the lack of comprehensive mental health treatment can be shocking and disheartening when they realize the intent of the psychiatric treatment being provided at the hospital. A social worker who also works part-time at a county jail as a mental health screener described her frustration in explaining the purpose of trial competency restoration to the families of patients.

> *"We get calls from families all the time about how they wish their son could stay there for a long time to get real help and get real treatment and we have to explain this is how it works, this is what we are looking for with competency and unfortunately the system is not always set up to help, right? The guys are kinda stuck and we are kinda stuck, like 'I hear what you are saying and I can offer you information and services when or if they do get out of jail, but unfortunately he's here for competency' and we just do our best to stabilize the acute symptoms and get them back to where they need to be."*
>
> —Social Worker, Female 2 years experience

In contrast to the administrators and the clinicians who express their frustration about competency restoration treatment as outrage at the broken system, incompetent to stand trial patients acknowledge the broken system by expressing feelings of either hope that the system will work for them once they return to the community or gratitude that the system worked at one point. For example, this patient was living in a single residency occupancy situation prior to arrest and being found incompetent to stand trial. Allegedly, he believed that another female occupant was stealing from him and he assaulted her. When asked about how the hospital could and was helping him he described his need for social services, support, and his reliance on broken systems of care.

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felonious crimes are unable to participate in problem solving or mental health courts and end up in the state hospital system for treatment. This absence of effective community treatment or diversion exacerbates feelings of frustration with the current system.

*"Getting my disability back on track. Wanting to mostly be safe. They ask me all the time, well* [NAME] *is you suicidal? Do you want to hurt somebody? Do you want to hurt yourself? I tell them all the time no I don't want to hurt nobody. I don't want to hurt myself. If I'm in the hospital like this, or I'm in a hospital on the street, or I'm doing something that more or less like doing for myself; they are going to always take care of me, because I can't read or write. So I trust people. I trust people with myself. I trust people to* [be] *good but they just got to find out where that goodness is at, from me to them. So I think that it's okay."*

—Black Male IST Patient, 57 years old
Diagnosis: Schizoaffective Disorder Bipolar Type
Charge: Assault with a deadly weapon
Length of Stay: 16 Months

Legally blind and lower-functioning, this patient understands that he needs supportive services, but he continues to experience inconsistent care in the community, moving him from one inadequate and unsafe treatment facility in the community to the jail, to the state hospital, and back again. For him the system is not keeping him in a stable living situation and he is hopeful that the system that has failed him before will one day start supporting him.

Even for high functioning persons with mental illness the welfare system appears difficult to navigate and broken leaving them vulnerable to incarceration. A high-functioning patient and veteran described his experience obtaining social services in the community prior to his arrest and hospitalization. Appreciative of the assistance, he stated that he benefited most from housing, soup kitchens, social security, disability, and free clothes. He also described how he *'lucked'* into receiving permanent housing in San Francisco prior to his arrest, which changed his life and his outlook. When asked if he was ever homeless, before receiving supportive housing he stated:

*"Yeah. Well, living in the shelters homeless. I never lived in the streets because it was too dangerous in the street. I tell people I live a sheltered life, haha (laughter)…And it's funny because I've never asked for money. I never have. I didn't think I was eligible to get money for disability, so I had resigned myself just to live in shelters for the rest of my life. That's just the way it is."*

—White Male IST Patient, 58 years old
Diagnosis: Unspecified Bipolar and Related Disorder
Charge: Felony Vandalism, 1st Degree Burglary
Length of Stay: 2 Months

Again this patient did not display outrage at the broken system that ushered him into his current situation in a similar fashion to the clinicians and administrators, rather he expressed gratitude for the services he had received and a hope that they would be reinstated when he returned to the community.

## Conclusion

For staff and patients providing and receiving trial competency restoration treatment, the clinical experience is devoid of meaning beyond jurisprudence and lacks any ability to confer mental health benefit. In regards to case laws promoting the acceleration

of this type of treatment, undoubtedly it is best to get actively psychotic psychiatric patients access to mental health treatment as quickly as possible, but it is faulty to think that trial competency restoration treatment is comprehensive or in service of persons experiencing mental health issues. As such, trial competency restoration treatment ignores the vast needs of individuals who are found incompetent to stand trial, strips clinical meaning from practitioners, and frustrates administrators devoted to serving persons with severe and persistent mental illness. The following chapter discusses the findings and results from this mixed-method inquiry.

# CHAPTER XI. DISCUSSION

The result of using both qualitative and quantitative data for this study was a thick, rich description of psychiatric treatment within the modern state psychiatric hospital as well as the role the state hospital plays within the context of the broader criminal justice and welfare system. The state psychiatric hospital serves a unique population. The experience and treatment provided to this population has long been ignored over the course of the last half-century. Research, which draws from service users and providers, help elucidate the current role the psychiatric hospital plays within the context of failed social welfare and intensified criminal justice reliance. This study was able to capture a unique moment in the long interconnected genealogies of institutionalization and incarceration. From this study, new insights into the current relationship and processes of the state hospital and criminal justice system are understood within the context of community mental health and social welfare failings and with reference to the individual's lived experience. First, the study explored the organizational and programmatic arrangements of Napa State Hospital in relationship to the criminal justice system and determined that the organizing principle of the hospital is based on commitment type namely: not guilty by reason of insanity; incompetent to stand trial; and civil commitments. Second, the study determined that treatment groups are impacted by commitment type and patients committed as Not Guilty y Reason of Insanity (NGRI) receive more treatment and a greater variety of treatment than either incompetent to stand trial (IST) and civilly committee patients. Third, the study determined that there were significant differences in patient satisfaction based on commitment type at the hospital. Explanations for these differences in patient satisfaction include: therapeutic programming, adjudication anxiety, length of stay, unit violence, psychiatric stability, and cognitive function, which will be discussed in this chapter. Fourth, increasing pressure to provide treatment to patients found incompetent to stand trial is not considered a comprehensive mental health treatment by clinicians, administrators, or patients and highlights the lack of community mental health treatment and welfare resources available to persons with mental illness in the community. Finally, Napa State Hospital, which represents one of the last publicly funded mental health providers, is able to provide comprehensive therapeutic treatment and care to persons with severe mental illness; however this level of care is rarely accessible to the public, and is controlled and overly influenced by criminal justice requirements.

This study can help identify areas of improvement and areas for intervention within the current system as well as shine a critical light on intention of the treatment services currently being provided. The current study assesses whether the configuration of the state hospital, as an outpost of the carceral archipelago, meets the needs of the individual and society in addition to uncovering assumptions that reinforce the relationship between the state hospital and the criminal justice system. I argue that the neoliberal legacy of social welfare and mental health access is an important link to the current operations at the state hospital in the context of the criminal justice system. Thus, it should be examined and considered in the advent of future policy relating to the treatment and care of persons with mental illness within the criminal justice system.

The relevance of these findings has import for criminal justice, mental health, and welfare policy. By clearly demonstrating how persons with mental illness are funneled

through the criminal justice system, clarifying the proverbial revolving door; the almost arbitrary use of court mandated psychiatric commitments; and the need for a more robust welfare system, large macrostructural flaws become unmistakable and actionable. The remainder of this discussion details the major finding of this dissertation, their implications for policy, future research, and limitations before providing a brief consideration of the impact of COVID-19 and a personal reflection of conducting this work.

## Patient Satisfaction and Treatment Discussion

The aim of the patient satisfaction survey was to investigate the relationship between commitment type and patient satisfaction with care at a state psychiatric hospital. In general, patients are satisfied with their treatment and care at the state psychiatric hospital, which coincides with the literature on psychiatric patient perceptions of satisfaction. One interpretation of this finding is that for Not Guilty by Reason of Insanity (NGRI) patients the alternative to treatment at the state hospital is imprisonment and the hospital has more freedoms. Many incompetent to stand trial (IST) patients are chronically homeless before arriving at a state hospital setting and their immediate prior living situation was a county jail and the hospital has more comforts. Lastly, most civilly committed patients often cycle in and out of institutional care at varying levels of restrictiveness and the hospital provides more permanency. Another important finding is that while patients were generally satisfied with care, patients across all types were less satisfied with the side effects of their medications being explained to them

As to the question of whether commitment type plays a role in patient satisfaction, it was shown that there is a significant difference between commitment types. The greatest difference in satisfaction is between patients committed for treatment as NGRI compared to civilly committed patients who were significantly less satisfied. Patients found NGRI were also significantly more satisfied than patients found IST in all domains. Lastly, Patients found IST were significantly more satisfied than civilly committed patients in the domains of therapy, social/quality of life, and summary of experience. These findings reaffirm the need to consider psychiatric patients in the context of their commitment treatment.

Possible explanations for these findings include differences in commitment based on: cognitive functioning, psychiatric stability, medical function, and violence exposure; where the civilly committed patients are the most impaired and witness the most violence and are therefore least satisfied; followed by patients committed as IST; and finally patients committed as NGRI. Another interpretation of these findings suggest that patients committed as NGRI had more agency throughout the adjudication process, and therefore NGRI patients are more likely to be more satisfied with the treatment provided at the hospital. Based on the survey data, patient functionality, psychiatric presentations, health status, are not measured and are all individual factors related to satisfaction. Exposure to violence is a micro-mezzo factor and is also not measured by the satisfaction survey.

A preliminary interpretation of these findings is based on therapeutic treatment availability. As demonstrated in previous chapters, patients found NGRI are able to access more therapeutic treatment groups and have the broadest variety of therapeutic treatment groups compared to both Civil and IST committed patients. This finding suggests that

patients who are given more chances for therapeutic engagement and a variety of therapeutic activities may be more satisfied with psychiatric treatment.

Considering forensic commitment as the foremost organizing principle for psychiatric treatment at Napa State Hospital allows for a formerly ignored analysis of mental health treatment to surface. The results from this investigation suggest that commitment status is a significant contributor to patient satisfaction in mandated psychiatric settings. Without this analytic frame the overall results from the study would suggest that patients in the study were mostly satisfied with their treatment and care at the hospital and expressed strong agreement with feeling ready to discharge from the hospital; and that special attention should be paid to explaining the side effects of medication to patients and improving overall comfort, as these were the items respondents were the least satisfied with. These findings are similar to findings from studies of voluntary and involuntary psychiatric patient satisfaction, adding little worthwhile information to the greater body of literature.

This study differs in its analysis of satisfaction due to its larger scale, which allows for an analysis of satisfaction based on patients' commitment type. Based on the finding that there are significant differences in satisfaction with treatment and services based on commitment type, more attention needs to be paid to commitment type and accompanying treatment. This study found striking differences between the three different treatment commitment groups. Data from the therapeutic group treatment database demonstrated differences in the treatment availability and variety for the three groups. This suggests that developing psychiatric inpatient care to meet standards of criminal and civil commitment type has an influence on the perceptions of satisfaction among patients. Further, developing psychiatric inpatient care to meet the needs of the criminal justice system raises questions of whether patients are getting the treatment they need.

## THEORETICAL DISCUSSION

Expanding the analysis away from the operations at the hospital to the current distortion of the criminal justice system as a provider of mental health treatment, commitment type becomes a crucial analytic lens to consider. With inadequate community mental health and welfare services, jails become the main entry point for mental health treatment. This complicates the provision of psychiatric treatment by making clinical services subservient to legal processes. Critically examining the impact of the law on mental health treatment is a radical departure from the current orthodoxy. Most scholars of psychological jurisprudence consider how the law can work as a therapeutic agent assisting in the diversion of individuals into treatment and the potential humanizing aspects of law (Wexler, 2000; Winick, 1997). This framework, which examines the law's potential influence on individual behavior, ignores the unbridled power that the law has to distort other systems and the long history of welfare retrenchment that continuously influences the lives of persons with mental illness. Therefore, it is imperative in the battle for equitable mental health treatment: to acknowledge the law as a social force which influences and produces consequences on a systemic level; examine how the law is currently reshaping the mental heath system; and consider whether a mental health system mired in legal restrictions and requirements respects our contemporary values of care, justice, and due process.

This study produced a substantial volume of findings that are multilayered and relational. Thus, for clarity of argument and agreement with social welfare scholarship the major findings have been grouped into three levels of analysis: the mezzo level of the hospital; the macro level of genealogic and structural interplay; and the micro or individual level of the patient.

At the analytic level of the hospital, the organizing principle is court commitment, treatment variety and availability provided to patients based predominately on commitment rather than on their need or chance of benefit. In written policy, the state psychiatric hospital subordinates itself to the criminal justice system with a crippling effect on its ability to provide comprehensive psychiatric treatment. As the law is written, contested, and modified by case law and social ideals, the psychiatric treatment provided to the patients changes to meet them. This was seen historically as the civil commitment laws changed from an emphasis on treatment to an emphasis on dangerousness; and during this study's data collection period, when the Stiavetti ruling went into effect regarding patients found incompetent to stand trial. Shifting treatment emphasis reactionarily based on legal thinking and criminal justice needs has a profound impact on the hospital's ability to provide treatment, because the two institutions have competing theoretical goals—psychological rehabilitation and justice respectively, with criminal justice ultimately dominating the narrative of appropriate psychological treatment.

Drawing lightly from organizational theory, the New Institutionalists see the fated essence of the institution as the pursuit of legitimacy, rather than a rational progression of functional problem solving and the routines and protocols that develop. As institutions struggle for legitimacy they begin to appear and act similarly, in a process referred to as *isomorphism* (DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Powell & DiMaggio, 1991; Scott et al., 2007). State and legal requirements create a coercive isomorphism and the law is recast as a master institution, which ultimately shapes other organizations (DiMaggio & Powell, 1983; Powell & DiMaggio, 1991). Thus as the California state hospital system struggled for legitimacy after deinstitutionalization and realigned itself with the department of corrections it began a process of isomorphism. This coercive isomorphism raises concern because pressed to the extreme it has the ability to fully undermine the legitimacy of the primary institution (Heimer, 1999).

In contrast to the New Institutionalists, behavioral decision theorists argue that institutions are comprised of individual actors and that these individual actors are fundamental to how routines and protocols develop within an organization; thus, some decisions will be prioritized or delayed for various reasons based on the individual decision-making and the actors within an institution have the ability to shape and navigate competing institutional pressures (Brodwin, 2013; Heimer, 1999; Lipsky, 1980). Evidence for this is apparent in the clinicians' attempts to provide more comprehensive treatment to patients found incompetent to stand trial, despite little institutional support and the excellent medical care provided to the patients at Napa State Hospital. However, in hospital settings the law trumps medical institutional routines when the law is actively evoked (Heimer, 1999).

As a forensic institution, the law is constantly evoked at Napa State Hospital and as an institution; the hospital has completely taken on legal standards as the guiding principle for programmatic organization. Conversely, as the jail system is being asked to care for an increasing number of persons with mental illness it subsequently becomes increasingly reliant on the state hospital system to nominally care for this population. In this instance, the definitions and requirements imposed on the state psychiatric hospital by the criminal justice system, and the criminal justice systems' ability to only provide psychiatric treatment after legal definitions have been met, create a parasitic symbiosis rather than a traditional isomorphism: where not only does the state hospital system need the criminal justice system, but the criminal justice system in turn needs the state hospital system to perpetuate existence. Thus, this parasitic relationship shapes treatment at the state hospital in the mode of a penal institution, reliant on legal commitment, and simultaneously asks the criminal justice system to act as a rehabilitative and psychiatric institution, providing crucial psychiatric treatment. Detecting this parasitic and subservient relationship as the primary principle for mental health services necessitates a societal reckoning to redefine the motivation for providing psychiatric.

Returning to Loïc Wacquant's revelation that the excessive use of criminal justice systems is a reaction to social insecurity fostered by the fragmentation of wage labor and the confrontation of the ethnoracial hierarchy in the United States after the Civil Rights movement of the 1960's, one can reexamine the role of the state psychiatric hospital and view it as a specialized tool that enhances and expands the punitive range of the centaur state. Under a philosophy of moral behaviorism, American penalization aims to curb the urban disorders wrought by economic deregulation, or welfare retrenchment, by focusing on a misconstrued spectacle of poverty and crime attributed to the working class. For persons with mental illness, the theater of civic morality focuses on perpetrators of sexual violence and psychotic homicide, propagating the wrongful view that persons who commit heinous and distasteful crimes are incapable of reform to legitimate the need for punitive justice rather than treatment. Ultimately, this social attitude towards mental illness eschews any social and economic protection that persons with mental illness might be entitled to.

The finding that competency restoration treatment is seen as an inadequate mental health support system suggested the need for less criminalization of persons with mental illness and more social welfare resources beyond mere access to mental health treatment in the community. Housing, occupational resources, medication, education, substance abuse treatment, and case management are all mentioned and welcomed by the clinicians, administrators, and patients as necessary for true rehabilitation in conjunction with psychopharmacological interventions. By bringing Wacquant's theoretical understanding of the developments in welfare and criminal justice into a single analytic framework for understanding the health needs of persons with mental illness in the criminal justice system, and at the state hospital specifically, then the lack of welfare resources and mental health treatment in the community becomes extremely dire and reveals the extent of the neoliberal erosion of any welfare safety nets.

Scoping inward from the larger policy and societal pressures that impact the hospital, this study reveals that on the individual level the experience of persons with mental illness in the criminal justice system is seeped in systemic negligence. The consistent

finding among all patients at the hospital, regardless of whether they appreciated the treatment and care they were currently receiving, was an exposure to a variety of indignities in the community and in the criminal justice system due to a lack of diversion, earlier intervention, and supportive services prior to coming to the hospital. Every patient treated at Napa State Hospital has a tragic personal history that speaks to the absolute failures of our current system and could possibly be avoided in the light of policy reform.

MENTAL HEALTH AS A SOCIAL RIGHT—IMPLICATIONS FOR POLICY

What remains, regardless of noise, is the aggressive use of the criminal justice system, the undermining of welfare services, and the unfulfilled attempt to establish a community mental health system, which is an ethical and societal obligation to care for persons with mental illness. The findings from this study have implications for mental health policy that promote specific aspects of mental health treatment in a variety of settings. Consistent with the data and the critical social welfare perspective presented throughout this dissertation, I will focus on the macrostructural implications for mental health policy to raise critical awareness of seemingly immovable institutions. To do this, I reconsider mental health treatment and welfare as a social and economic right to help establish policies that not only protect the individual, but also support their ability to thrive.

Modern human rights are an amalgamation of several different entitlements with broad conceptualizations. The most prominent of these rights are political and civil rights, which borrow the familiar ideas of freedom, justice, and a right to individuality and are used to protect political and civil liberties. These rights contrast social and economic rights, which include the rights to adequate food, to adequate housing, to education, to health, to social security, to water and sanitation, and to work (Office of the High Commissioner on Human Rights, 1966). In the context of mental health delivery, and a weak welfare state, attempts to promote human rights for persons with mental illness often overly promote political and civil rights and downplay social and economic rights. As seen with deinstitutionalization, these instances lead theoretical advancements in mental health treatment to become compromised and paradoxical and the consequence of these innovations lead to greater social distortion. For example, most political rights developed as a way to counteract intrusive governments and stressed the extent to which the government was allowed to intrude on individual liberty. This thinking ultimately led to the restrictions on civil commitments to help persons with mental illness stay out of indefinite institutional confinement. But, with no other mental health options in the community, this pursuit led to the inability of persons with mental illness to access psychiatric treatment in the community unless they were a danger to themselves or others. Other examples of restrictive rights include, the right to a fair trial, the abolition of arbitrary arrest, and the abolition of cruel and unusual punishment. These duties of restraint were a reaction to abusive power and explained what citizens should not accept from their government. However, within the world of mental health treatment and criminal justice, their emphasis leads to the meager psychiatric treatment provided to patients found incompetent to stand trial. Therefore, relying on early conceptions of positive duties, political rights, and civil liberties ignore social and economic problems such as poverty, exploitation, disease, restricted access to education, and discrimination. This disproportionately disregards the needs of persons with mental illness. Currently, mental health policy continues to emphasize equality before the law and civil liberties, rather than promoting other egalitarian concepts like universal health

care, protection against discrimination, and economic rights (Burns, 2009). Reframing mental health policy as a social and economic right may lead to effective changes that hit at multiple levels of intervention. Guided by the findings from this dissertation, the following policy implications are envisioned as an expansion of social and economic rights for persons with mental illness.

*Raise Awareness and Education*

Symptoms of many mental health conditions including psychosis first appear in youth and young adults (Kessler et al., 2007). However, like many of the patients that are being treated at DSH-Napa, few receive adequate mental health services at a young age, when treatment is most effective. Policy that promotes mental health education and awareness in schools can help identify the early warning signs of an emerging mental health condition and link students with effective services and supports that target medication compliance and education along with supportive services. In addition to policy that supports training of faculty and staff on the early warning signs of mental health conditions and how to link students to services, curriculum should be introduced for all students that addresses identifying mental health symptoms for themselves as well as their peers and family members to help to diminish the stigma of mental illness and promote a culture of mental health awareness. Integrating comprehensive services and support throughout every grade level that assess mental health needs through universal, selective, and targeted interventions should be the policy standard to better ensure access to appropriate behavioral and mental health services and programs. Additionally, to increase access, there needs to be an expansion of services for mental health, that include funding for schools, as well as community clinics and telepsychiatry to better serve both rural and urban areas.

*Universal Diversion Programs for Substance Use and Mental Health*

As presented throughout this dissertation, persons with behavioral serious mental illness and substance use disorders are more likely than the general population to be represented in the criminal justice system. Although many of the patients at Napa State Hospital committed a violent offense that prompted their incarceration, most patients prior to their instant offense committed at least one non-violent crime or came into contact with the criminal justice system as a consequence of either poverty or their behavioral health disorders. Additionally, the experiences described by many of the patients in this study highlight the ineffective system cycling that often occurs for persons with mental illness and substance abuse issues. This repetition is not conducive to recovery and costly to society; thus, intervention at the first point of contact with police and diversion from the criminal justice system is necessary for adequate reform.

A policy recommendation to address the dysfunctional use of the criminal justice system is the promotion of diversion programs that engage the county prosecutor and local police agencies, promoting all jurisdictions to have access to both pre-booking and post-booking diversionary approaches. Pre-booking diversion redirects the individual to treatment services at the point of initial contact with law enforcement through Crisis Intervention Teams and Mobile Crisis Units and happens before a person is formally

charged with a crime. These teams are usually comprised of trained mental health providers. As policy, the trained mental health and substance abuse specialists that work in pre-booking diversion programs should be considered part of the police force with similar representation and union protection, making pre-booking diversion a permanent feature of community engagement.

In comparison to pre-booking diversion, post-booking diversion models redirect the individual after arrest and booking of charges and may take the place of prosecution or as a condition of a reduced sentence or charge. Jail-based diversion programs are a form of post-booking diversion, where individuals in jail who may have a mental illness are identified and evaluated and, if found eligible for diversion, are connected with mental health treatment. Usually, this form of diversion requires the agreement of the prosecutor, judge, and defense attorney. Diversion programs housed within the county prosecutor's office have the benefit of the prosecutors' office coordinating the diversion effort, working with the court, defense counsel, and mental health providers. When these programs are not based in the prosecutor's office there is an adversarial element to the implementation of services in lieu of pursuing charges. Similar to situating pre-booking diversion within the police, positioning post-booking and jail based diversion programs within the prosecutors office may help to change the adversarial culture of criminal prosecution for persons with mental illness and substance use disorders and help the prosecutors office to use their discretion to intervene earlier in the adjudication process, keeping people from cycling in and out of jail and preventing more serious or violent crimes from occurring (Gill & Murphy, 2017)

*Vocational Rehabilitation*

The enthusiasm demonstrated by many of the patients at Napa State Hospital for work opportunities and the ability to make more than nominal salaries while institutionalized compel an ethical, social and clinical motivation for helping persons with severe mental illness with vocational training and providing the chance to work. Pre-vocational Training and Supported Employment are two different approaches to helping severely mentally ill people obtain employment and may be effective as a supplement to diversion programs. As stated in the literature review, persons with severe mental disorder experience high rates of unemployment, which may lead to criminal behavior and survival crimes. The high rate of unemployed persons with mental illness reflect not only the disability caused by psychiatric symptoms, but also the discrimination and the low priority given to employment by psychiatric services. As previously acknowledged, workfare is often tied to welfare, yet employment services for person with mental illness are not supplemented or considered vital to their rehabilitation and welfare despite surveys consistently showing that most person with severe mental illness want to work (Crowther et al., 2001; Wacquant, 2009). From a clinical, social, and ethical standpoint there is a dignity associated with work in an industrialized society that helps with inclusion, socialization, and rehabilitation (Crowther et al., 2001).

*Housing*

For many of the patients experiencing an unsheltered living condition, especially those who are incompetent to stand trial, symptoms of their mental illness make it difficult

to maintain a stable home without additional help. As previously mentioned in the literature review, living without stable housing can worsen health, preventing chronic physical health conditions from being addressed, while also exacerbating symptoms of mental illness, and increasing the likelihood of continued substance use, which inevitably lead to the use of emergency rooms and jail facilities for treatment.

As a policy implication, radical changes to housing must me addressed to support persons with severe mental illness maintain stability in the community. Incorporating a supportive housing model as a standard for persons with mental illness can help promote this change. Supportive housing as a policy is a highly effective housing strategy that combines affordable housing with intensive coordinated services to help people struggling with chronic physical and mental health issues maintain stable housing and receive appropriate health care.

Supportive housing for persons with mental illness should be permanent and affordable in the sense that tenants should not pay more than thirty percent of their income for rent. Tenants should have the right to privacy, the lease in their names, and should be protected from unlawful evictions. To help persons with mental illness thrive in the community, a variety of housing options should be available to help families and individuals live independently in either group homes, board and care residences, single residence occupancies, apartments, or single-family homes depending on their needs and their level of symptom severity. These housing options should be well maintained, attractive, safe, and in residential neighborhoods with access to public transportation, grocery stores, parks, and other neighborhood amenities. Additionally, there should be a low barrier to enter housing programs without benchmarks of the use of intense surveillance (Culhane et al., 2002).

*Comprehensive Case Management*

To incorporate all of these policy recommendations comprehensive case management should also be used to link mental health resources and education to vocational opportunities and housing. In general, case management is described as a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet the comprehensive needs of an individual or family.

For persons with mental illness, in regards to housing, case management services should aim to help clients find suitable housing, build relationships with their landlords, and understand their rights and responsibilities. Case managers should also intervene to prevent evictions. Case managers should also support clients in regards to their physical and mental health, substance use conditions, and general welfare by helping clients apply for Social Security benefits, gain employment, and connect to physicians, mental health practitioners and substance use specialists, when needed.

The services provided to clients with mental illness should be flexible enough to address each individual client's needs, which may involve multiple service agencies working together. Additionally, case managers should provide voluntary, but assertive services. For example, clients should not lose their housing or any kind of supplemental income simply because they do not participate in services. However, case managers should offer their

supportive services *assertively*, meaning that they will continually check and offer a client services regardless of whether they are requested.

This type of intensive case management with housing, mental and physical health treatment, and vocational assistance is similar to the services provided by the Conditional Release (CONREP) program provided to patients found not guilty by reason of insanity. Most patients were thankful to be provided this type of program when they returned to the community. Allowing more persons to be diverted away from the criminal justice system and allowed to access comprehensive care that includes mental health and substance use treatment along with vocational and housing opportunities with assertive and concerned case managers should help to alleviate the use of criminal justice system as the primary provider of mental health treatment.

*Differentiated State Hospital System by Civil Commitment Expansion*

The final policy recommendation gleaned from the evidence presented in this dissertation is to differentiate the state hospital system from the criminal justice system as much as possible and incorporate a permeable access point to high-level treatment. The state hospital plays a vital role in the continuum of care for persons with mental illness within the criminal justice system, which is not a reasonable access point for treatment. In contrast, patients that are civilly committed as gravely disabled under the Lanterman-Petris-Short act are often extremely ill and lower functioning. These patients discharge at an extremely low rate and may need the high level of care that the hospital provides permanently.

I am proposing a policy that allows the community mental health system to access the care of the hospital for persons with mental illness on a mandated basis within a new civil commitment law, similar to the mandated treatment provided to a Penal Code § 1608 Temporary Admission Not Guilty by Reason of Insanity (TANGI) patient in the CONREP program. Although a full review of the CONREP program is beyond the scope of this dissertation, for a patient on CONREP who was treated at the hospital, they may be required to return to the hospital from the community for a variety of reasons including: needing extended inpatient treatment; psychiatric decompensation; refusing to accept more outpatient treatment; possibly being a danger to the health and safety of the community; committing a new crime; using an illegal substance; leaving the county without permission; or not complying with the treatment contract. These conditions are more stringent than the policy recommendation I am proposing, however it provides some insight into how a recommendation could be facilitated through a new civil commitment law that creates more treatment opportunity on a need basis that is less binding and incapacitating. For example, a client that is participating in the comprehensive community mental health system is observed by an assertive case manager to be declining psychiatrically. That case manager may recommend to the court that they receive treatment at the hospital for stabilization, which could last from a few days to a few months, providing appropriate intensive psychiatric treatment as needed. If they are participating in the supportive hosing program, their housing accommodation would be protected while they are receiving treatment at the hospital, allowing them to quickly return to the community once their psychiatric symptoms stabilize.

As radical as this may appear on its surface, this kind of differentiation process would alter the philosophical rationale of the hospital away from criminally committed patients to a true continuum of community care. This kind of shift is not unprecedented. The long arc of institutionalization has shown that a change in attitudes and culture is not unreasonable, and if minded carefully and funded fully, there could possibly be an effective and positive transformation.

### Limitations

This study contributes many important findings to the general knowledge on institutional care of persons with mental illness within the criminal justice system; however it is not without limitations. First, this study primarily focused on only three psychiatric commitment types, excluding the treatment provided to Offenders with Mental Health Disorder (formerly known as Mentally Disordered Offenders) and Sexually Violent Predators, both of whom are treated within the California State Hospital System. Also, due to the lack of examination of macrostructural interactions between the criminal justice and mental health systems from within the institution, this study takes the long and broad view of that relationship in order to provide a new starting point for critical analysis. With this approach, there was less ability to critically examine the role that race plays in the treatment provided to patients at the state hospital.

### Future Research

The findings from this study and the stated policy implications encourage future research to focus within several areas. First, a mixed-methods inquiry into the experience and variations of CONREP and its scalability outside of the criminal justice system could be employed to determine feasibility as an alterative program for incarceration. This type of research, in conjunction with the research that is being conducted on diversion programs, could foster a deeper understanding of the outcomes and needs of persons coming into contact with the criminal justice system with severe mental illness and substance use issues that are provided services rather than punishment. Secondly, a comparative study examining the use of psychiatric commitments among all counties in California could give a deeper understanding of the urban and rural divide among community mental health treatment. Third, inline with the call for more prisons ethnographies, future research should conduct more in-depth qualitative studies that examine the experience of persons with mental illness inside both the prison and state hospital systems to better understand this contemporary institutional phenomenon and the experience of other commitment types. Lastly, future studies should continue to explore the dual-role distortions that providing mental health treatments within the criminal justice context foster to help determine which elements of mandated treatment are most disruptive to the therapeutic alliance.

### A Note on COVID-19 and Black Lives Matter

Although the data collection period ended a year prior to the global pandemic, the bulk of the analysis and writing of this dissertation happened during shelter-in-place orders and the social unrest in reaction to the police killing of George Floyd in Minneapolis, Minnesota and the inexplicable shooting and subsequent paralyzing of Jacob Blake Jr. in Kenosha, Wisconsin.

At the current moment, I am still employed at Napa State Hospital and was able to witness the impact of the novel coronavirus on the operations at the hospital. To be clear, in comparison to the prisons, Napa State Hospital took immediate and important measures to help curtail the spread of the infection and this note is not a criticism of the pubic health measures implemented to protect the staff or patients. Rather, this note is in recognition of the grand and coordinated efforts that can be employed when considered necessary and important, making many of the sweeping policy implications I outlined more feasible. In light of COVID-19 and the continued over-policing of Black people, it is time to rethink the punitive nature of the criminal justice system that unnecessarily incapacitates and denigrates vulnerable persons in inescapable and crowded institutions.

## PERSONAL REFLECTION

In order to support embedded ethnographic inquiry with hard to access populations, I feel it is important to share some personal experiences that reflect the intense and difficult nature of conducting this kind of work in these kinds of places. To begin, there needs to be a level of fortitude among any researcher who attempts this work. There is an element of risk, danger, and violence I encountered conducting this research that cannot be ignored. For example, although my primary unit was a geriatric and medically fragile unit with few violent incidents, I, as well as all other staff at the hospital, are often required to run to alarms on other units to help control violent incidents creating a culture of hypervigilance that is appropriate and omnipresent, because the awareness and stress of random assaults is inescapable.

Additionally, I cannot escape the images of patients in five-points screaming on the floor or against a wall. I also cannot escape the off-key singing of Amazing Grace and Barry Manilow's Copacabana, two songs sung by different patients on the units to ameliorate their psychotic symptoms. Tragically, I also cannot escape the arrest reports that detail the murders, rapes, and child molestations that my patients allegedly committed, crimes that are real and crimes that have victims.

As I reflect on my experience conducting this work, I would also like to be cautious of othering or problematizing persons with mental illness and only considering the mental health of those that encounter the criminal justice system. In my second year working at the hospital, my unit colleague took her own life through self-immolation due to severe post-partum depression. I still think about it and I still wonder whether she would be alive if her insurance covered a longer inpatient stay.

All of these experiences changed me as a person and scholar, and at times weigh heavy on my soul. You cannot witness the edges of humanity without it leaving a mark.

## IN CLOSING

What is commonly referred to as mental illness is a state of existence that is ultimately a part of the human experience; an experience that may lead people to bizarre behavior or make it difficult to participate in a competitive capitalistic society, but a human experience nevertheless. As a community in modern society we share a moral obligation to

care for those that have difficulty functioning. Rather than allowing the retrenchment of welfare services to leave persons with mental illness vulnerable to the punishments of the criminal justice system, we should provide them with basic human needs without the sword of incarceration or imprisonment hanging ominously above their necks.

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# APPENDIX A. IRB APPROVAL

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY EDMUND G. BROWN JR., *Governor*

**COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS**
400 R Street, Room 369
Sacramento, California 95811
(916) 326-3660 FAX (916) 322-2512

10/09/2018

Renee Mack, MA, MSW, PhDc
424 Staten Ave #304
Oakland, CA 94610

Project Title: Evaluating Treatment Programming and Satisfaction with Services at a State Psychiatric Hospital
Project Number: 2018-169

Dear Ms. Mack:

The Committee for the Protection of Human Subjects (CPHS) has reviewed and approved the above new project. Included with the approval are the following item(s) beginning with project type:

Common rule/Human subjects
Consent form
Minimal Risk

This approval is issued under the California Health and Human Services Agency's Federalwide Assurance #00000681.

Pursuant to 45 CFR 46.109(e), CPHS cannot approve a project for more than one year at a time. Therefore, a project must be renewed yearly. To continue your research or data analysis, submit a Continuing Review request by your project's deadline date, 07/03/2019. If your project is not approved again (renewed), it will expire on 08/02/2019. Once a project is expired, all research, including data analysis, must cease (unless discontinuance will have an adverse impact on research subjects).

You will receive courtesy email reminders from CPHS to renew your project. It is the Principal Investigator's responsibility to submit their Continuing Review request on time and to notify CPHS of any changes in contact information.

If a project has been completed or is no longer active, it must be submitted to CPHS for completion approval or withdrawal approval. Instructions for these processes can be found in our Instructions for Researchers located on the CPHS Homepage.

Any unanticipated problems, adverse events, protocol deviations, and breaches in data security must be reported to CPHS via a Report Form within 48 hours of the event. File a report by logging into IRBManager and clicking on the protocol's "Protocol ID" number. Choose 'start xform' and choose the 'Report Form: Unanticipated Problems or Adverse Events' from the list. Once you have completed that form, sign and submit.

If you have any questions, you may call our office at (916) 326-3660 or email us at cphs-mail@oshpd.ca.gov.

Sincerely,

Lucila O. Martinez, Administrator
(916) 326-3661
lucila.martinez@oshpd.ca.gov

## APPENDIX B. DSH-NAPA PATIENT SATISFACTION SURVEY

# NAPA STATE HOSPITAL
# PATIENT CARE SATISFACTION SURVEY

To help us better serve you, please complete this survey by **circling the item** that best describes how you feel and return it to your CAC rep, unit supervisor, or the facilitator of the meeting.

**PLEASE CIRCLE THE ANSWER THAT BEST DESCRIBES HOW YOU FEEL ON THE SCALE**
**1=Strongly Disagree; 2=Disagree; 3=Uncertain; 4=Agree; 5=Strongly Agree**

| Item | | | | | |
|---|---|---|---|---|---|
| 1. I am comfortable here. | 1 | 2 | 3 | 4 | 5 |
| 2. There are enough opportunities for therapy at the hospital. | 1 | 2 | 3 | 4 | 5 |
| 3. My groups help me to reach my discharge goal. | 1 | 2 | 3 | 4 | 5 |
| 4. My living environment is comfortable and clean. | 1 | 2 | 3 | 4 | 5 |
| 5. The side effects of my medication were explained to me. | 1 | 2 | 3 | 4 | 5 |
| 6. Medications are used by the doctors to help patients calm down only when it is necessary. | 1 | 2 | 3 | 4 | 5 |
| 7. This is a good place for me to discuss my problems. | 1 | 2 | 3 | 4 | 5 |
| 8. I receive enough therapy while I am here. | 1 | 2 | 3 | 4 | 5 |
| 9. There is enough to do here during the day to keep me busy. | 1 | 2 | 3 | 4 | 5 |
| 10. My rights as a patient were explained to me when I got here. | 1 | 2 | 3 | 4 | 5 |
| 11. I feel safe here. | 1 | 2 | 3 | 4 | 5 |
| 12. The staff is working to help me. | 1 | 2 | 3 | 4 | 5 |
| 13. My medical (non-psychiatric) needs are met on the unit. | 1 | 2 | 3 | 4 | 5 |
| 14. I get enough to eat. | 1 | 2 | 3 | 4 | 5 |
| 15. I am happy and satisfied with my life. | 1 | 2 | 3 | 4 | 5 |
| 16. My spiritual/religious needs are being met. | 1 | 2 | 3 | 4 | 5 |
| 17. I have access to recreational activities. | 1 | 2 | 3 | 4 | 5 |
| 18. I have good social relationships with other patients. | 1 | 2 | 3 | 4 | 5 |
| 19. I have good communication with family members. | 1 | 2 | 3 | 4 | 5 |
| 20. I receive enough substance abuse treatment here. | 1 | 2 | 3 | 4 | 5 |
| 21. I am treated fairly here. | 1 | 2 | 3 | 4 | 5 |
| 22. I am ready to be discharged. | 1 | 2 | 3 | 4 | 5 |

**PLEASE FILL OUT BOTH SIDES**

Page **1** of **2**

**INSTRUCTIONS**: Please **check the box or fill in the blank** that best describes you.

1. **Unit:**

2. **How do you identify? :**
   ☐ Male ☐ Female ☐ Gender non-conforming ☐ Transgender

3. **Race/Ethnicity:**
   ☐ African American/Black
   ☐ Asian/Pacific Islander
   ☐ Caucasian/White
   ☐ Hispanic/Latino
   ☐ Other:_______________

4. **Religious Affiliation:**
   ☐ **Christianity**
   ☐ **Judaism**
   ☐ **Islam**
   ☐ **Other:**____________________

5. **How old are you?**

6. **How long have you been a patient at DSH-Napa?**

7. **What is your current commitment?**
   ☐ Incompetent to Stand Trial
   ☐ Not Guilty By Reason of Insanity
   ☐ Mentally Disordered Offender
   ☐ TANGI
   ☐ Civil Commitment
   ☐ Murphy's Conservatorship
   ☐ I Don't Know My Commitment
   ☐ Other:____________________

**What else would you like us to know about your experience here?**

**PLEASE FILL OUT BOTH SIDES**

## APPENDIX C. STAFF INTERVIEW GUIDE

************************************************************************************

1. How long have you worked at the hospital?

2. What is your role (how would you describe it)?

3. A. Which commitment types have you worked with? (check all that apply)
   - ☐ PC 1370 Incompetent to Stand Trial
   - ☐ PC 1026 Not Guilty by Reason of Insanity
   - ☐ PC 2972 Mentally Disordered Offender
   - ☐ LPS Conservatorship
   - ☐ Murphy Conservator
   - ☐ Other________________________________

   B. How would you rate on a scale of 1-10 your experience working with____________ (*fill in population response i.e. PC 1026, PC 1370, etc. get response for each group indicated*)? Please explain.

4. The Social Work Department administered a patient satisfaction survey to all the patients at the hospital in 2016 and 2017. Results from that survey indicate that there are differences in satisfaction with the treatment and care at hospital based on commitment type. How do you interpret these results? *(Explain results of survey if asked to clarify e.g 1026 are most satisfied, 1370 are least satisfied, LPS are somewhere in between)*

5. What do you see as the most effective services or treatments we provide for the populations that you are familiar with?

6. What areas of treatment would you like to see improved?

7. How has treatment changed during your <u>(refer to question 1)</u> years here?

## APPENDIX D. PATIENT INTERVIEW GUIDE

****************************************************************************

1. How long have you been a patient here at the hospital?

2. How would you describe your typical week here at the hospital? [Prompt if needed (What do you do Mondays? How about the weekend?)]

3. Which treatment groups do you find helpful? Why?

4. If you could change anything about your groups, what would it be?

5. What are your discharge goals?

6. What is the hospital doing to help you reach your discharge goals?

7. A. **(If 1026)** What are some of your thoughts when you think about returning to the community with CONREP or on your own?
   B. **(If 1370)** What are some of your thoughts when you think about returning to the court to face your charges?
   C. **(If LPS)** What are some of your thoughts about leaving the hospital and returning to your county for treatment?

8. Do you have a mental illness?
   A. **(If YES)** How does the hospital help with your mental illness?
   B. **(If NO)** How does the hospital help you?