1993

The effect of the provision of certain treatment programs on length of stay for 1370 commitments

Brooks Benjamin Roll

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THE EFFECT OF THE PROVISION OF CERTAIN TREATMENT PROGRAMS ON LENGTH OF STAY FOR 1370 COMMITMENTS

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

by

Brooks Benjamin Roll

June 1993
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Abstract

The issue of competence to stand trial is the most examined and most controversial issue in the interface of the medical and legal communities. Until the United States Supreme Court decision of Jackson vs. Indiana in 1972, defendants found incompetent to stand trial were committed for an indefinite period. This research project examines the provision of specific treatment modalities and their affect on length of stay for those who have been found incompetent to stand trial. The study utilizes sample populations that were provided specific treatment programs and control groups that were not provided the identified treatments. The populations utilized comprised patients admitted to Patton State Hospital (a state of California forensic facility) between 1972 and 1992. The primary issue is how the provision of specific treatment programs (either the Mock Trial Program or the Court Preparation Project) affected length of stay but several other issues affecting these populations are examined. The results were not statistically significant by Social Science standards but show some interesting trends to shorter length of stay.
Acknowledgements

I wish to thank the Medical Records Staff of Patton State Hospital, the Staff of Information Management Systems of Patton State Hospital, and Laurie Piccolotti, Staff Librarian of Patton State Hospital. Without their concerted assistance this project would never have seen light. I also wish to thank my friend and mentor, Dr. Steven Berman for his unending assistance. Most of all I wish to thank my wife for her patience and understanding.
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**Introduction**

The issue of competency to stand trial is one of the paramount medicolegal and psychological topics addressed in the interface between the mental health and judicial systems. Daniel and Resnick (1987), cite the "Dooms of Alfred " from the last quarter of the ninth century which provided that "if a man be born deaf and dumb so that he cannot acknowledge or confess his offense, his father must make bot [pay] for his misdeeds." This does not specifically address the issue of mental illness but later the issue of muteness and mental illness are linked in both the literature and in practice. Roesch and Golding (1980) cite Robertson's (1974) statement that the issue of competency to stand trial has origins at least as early as mid-seventeenth century noted in English law. During the reign of Edward I, it was recognized that a defendant may be "mute by malice" or "mute by visitation of God". In order to determine whether muteness was voluntary *peine forte et dure*, a procedure which slowly pressed a person to death by using an increasing weight of stones, was used to encourage a plea. This is where the saying 'pressing someone for an answer' has its origin. Blackstone (1783) wrote that a defendant who became "mad" should not be tried because, "how can he make his defense?" Early English law appears to have had a great influence over the decisions and practices of law in the modern United States. Golding (1993), states that other jurisdiction than those influenced by English law handle the issue of competence in a different manner.
The landmark cases in the United States, regarding the issue of competence, of modern jurisprudence are *Dusky vs the United States* (1960), and *Jackson vs. Indiana* (1972). In the first case the standard for competence which is used throughout the United States, although wording varies by state, was set. In *Dusky* the Supreme Court held that:

It is not enough for the district judge to find that "the defendant is oriented to time and place and has some recollection of events," but that the test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding — and whether he has a rational as well as a factual understanding of the proceedings against him. (p.402)

In *Jackson vs. Indiana*, the United States Supreme Court determined that an indefinite commitment for those found incompetent to stand trial is a denial of the *due process* guaranteed by the fourteenth amendment and is a denial of the *speedy trial* guaranteed in the sixth amendment.

Common law criteria, as cited by McGarry. et al,(1972) defines competence to stand trial as:

1) an ability to cooperate with ones' attorney in ones' own defense,
2) an awareness and understanding of the nature and object of the proceeding
3) an understanding of the consequences of the proceedings.(p.73)

In the state of California, the issue of competence is raised by any of the parties, (i.e. the defense, the prosecution, or the court itself). Prior to 1974, California statutes did not address competence but referred to 'present sanity' and did not have the time constraints they now apply. California statutes do not address the issue of what is a *bona fide* doubt of competence. The penal code reads:
A defendant is mentally incompetent .... if, as a result of mental disorder or developmental disability, the defendant is unable to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a rational manner. (sect. 1367)

The law then requires a trial on the issue of competence with reports from a psychiatrist or licensed psychologist. It also requires that the criminal proceedings be suspended until the competence of the defendant is determined. If the defendant is determined to be competent the trial proceeds. However, if the finding is that the defendant is incompetent he is then required to be treated to promote the defendant's speedy restoration to mental competence. Some of those who are found to be incompetent to stand trial are sent to the state hospital for treatment. Others may be treated as outpatients. This study focuses on the defendants who are committed to Patton State Hospital under sections 1368 through 1370 of the California penal code. These sections of the penal code are the statutes that provide for the judicial inquiry into competence, the suspension of trial, and the treatment of those found incompetent to stand trial.

The Problem

Once a determination of incompetence has been made then the goal is to either restore competence or to determine that competence will not be restored. The central focus for the clinical staff that deals with those patients committed to the state hospital will be to perform these tasks. How are these tasks accomplished? This study will address two specific treatment modalities that are used at Patton State Hospital. Treatment viability has been the focus of research for many years and by many
researchers (Galassi & Galassi, 1973; Powers & Witmer, 1951; Lewin, 1948). The focus of the studies have encompassed such criterion variables as outcome (Eysenck 1952, 1960, 1965, 1966, 1967), and such independent variables as therapist personal style (Krasner, 1962; Swensen, 1971), specific treatment modalities, treatment settings, and patient/client variables (Truax & Carkuff, 1967). The goal of this study is to explore whether the restoration to competence or alternately, the determination of, "....no likelihood that competence will be restored in the foreseeable future" is effectively addressed by the delivery of certain treatment programs. The specific treatment programs are the Mock Trial program (which was provided between 1978 and 1982) and the Court Preparation Project (which is currently a treatment modality utilized at Patton State Hospital). The researcher recognizes, and it is important to note, that these treatment modalities are only one aspect of the multifaceted treatment offered to the patients in this population. These programs are seen as an adjunct or supplement to the overall biopsychosocial treatment approach which includes; chemotherapy, group and individual therapy, group and individual counseling, education, industrial therapy, medical evaluation and treatment, nutritional therapy, milieu therapy.

The Mock Trial Program

The Mock Trial Program was a result of the hospital's determination that it could provide a better product for the patients sent to the hospital by utilizing the treatment format that Atascadero State Hospital was using. The program was developed using information from a Department of Health
Education and Welfare publication No. (ADM) 74-103 and the assistance of a retired California Superior court judge. The purpose of the program was ambitious and included not only the treatment of the 1370 population, but education of the clinical staff on the issue of competence (versus restoration to health) and the decrease in both length of stay and rejection of the hospitals recommendations by the courts. The following is taken from a video tape script by the author written in 1978:

I. Introduction
When the mental health and legal system come in contact, it is frequently the issue of competency which is raised. Competency, as defined by common law consists of three criteria which are:
1) An ability to cooperate with one's own attorney in one's own defense.
2) An awareness and understanding of the nature and object of the legal proceedings, and
3) An understanding of the consequences of the proceedings.

When a doubt arises in the court's mind, a competency hearing is held and if the defendant is found incompetent, the criminal proceedings are suspended and the defendant is then referred to a mental health treatment facility which will promote the defendant's speedy restoration to mental competence. What the state hospital is then ordered to do is to treat the patient for his mental impairment and report on the patient's progress toward recovery within ninety (90) days of the date of commitment. The hospital is generally asked to address itself to four questions in it's report to the court. These questions are:

1) Is the defendant now able to understand the nature of the criminal charges filed against him, and able to cooperate with and assist his attorney in the conduct of a defense?
2) Is the defendant presently a danger to himself or others?
3) If the defendant has not recovered his mental competence, is there a substantial likelihood that he will regain his mental competence in the foreseeable future? If so, within what time frame? and,
4) Has the defendant, during his confinement, been receiving treatment for his mental impairment and will he continue to receive treatment if further hospitalization is ordered?

What we are trying to do with the Mock Trial Program is to make the criteria which make up competency objective, measurable, quantifiable.
entities. The program was initiated at Atascadero State Hospital with the consultation of a retired superior court judge. The program has been enhanced much by the use of material from a report issued under the project number 7R01-MH-18112-01 from the National Institute of Mental Health. The object then, of the Mock Trial Program, is to address itself to two areas. These are: to make the issue of competency a quantifiable, objective measurement, and to familiarize the patient with the courtroom setting and desensitize the patient so that his anxiety does not detract from his ability to understand or cooperate once placed in the actual courtroom setting.

The program consisted of four phases; an initial evaluation, an educational didactic group, a video taped 'mock trial' and a feedback group. The initial evaluation consisted of an individually administered pre-test (see Appendix # 1) proctored by the group provider, as well as a review of the patients' chart by the group provider. The second phase consisted of a review of the courtroom personnel and their roles, court procedures, pleas available in the state of California, the specific charges each patient has pending, possible outcomes of the trial and a post-test consisting of the same information as the pre-test. The third and fourth phases were available only to those patients who passed the post-test with a score of 72% or greater. The third phase was a video taped mock 1372 hearing which was enacted with staff members assuming the various roles of the courtroom personnel, whereas the patient enacted the role of the defendant. The final phase was for the patient to review the video tape and receive feedback from the group leader on his conduct and demeanor in the mock trial. This program was only available to those patients in a specific treatment program and not to all the 1370's admitted to Patton State Hospital during the time frame it was conducted.
The Court Preparation Project (CPP) is a specialized program that serves patients as they transition from a simulated courtroom environment to a real courtroom setting. CPP is designed to prepare patients for the legal process and to enhance their understanding of court proceedings. The program includes mock trials, role-playing exercises, and discussions to familiarize patients with the legal system and court procedures.

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The purpose of the project is to assist patients in becoming more familiar with the legal process and to help them develop the skills necessary to function in a courtroom setting. The project provides a supportive and structured environment where patients can practice and develop their legal knowledge.

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covers 5 factors related to trial competency. It is administered by the project psychologist.

b. Trial Competency Test is a 25-item test that is administered by the psychiatric technicians. Both a pre-test and a post-test are given. The first test measures the patient's knowledge of the criminal proceedings upon his/her entry into the Project. The second test measures the patients grasp of the overall content of the legal awareness groups sessions.

c. Mock Court Competency Hearings serve three purposes: (1) it allows the patient to experience the stress of being questioned in a trial-like setting; (2) it allows the staff to observe a patient's behavior in a trial-like setting and to assess his/her trial competency under such circumstances; (3) it permits the staff to assess the patient's understanding of the criminal proceedings and his/her ability to cooperate with counsel in a rational manner in the conduct of a defense.

Patton State Hospital

Patton State Hospital was established in 1892 and began receiving patients in 1893. Over the years the population has varied in both size and focus of treatment. It was not until early in the 1970's that the focus population became one of individuals committed under California penal codes. The population became primarily one of those committed under penal codes after the deinstitutionalization movement of the late sixty's and early seventy's. Pollack, as cited by McGarry et al. (1972) reported that the increase in pretrial competency commitments was six-fold after the passing of the Lanterman-Petris-Short Act in the state of California. At the peak of it's existence Patton State Hospital provided services to a population of approximately six thousand patients. Currently it provides services to a population of approximately one thousand. The commitments are mostly under the California penal code, however there are a few patients who are at the hospital under the Welfare and Institutions code, sections 5304, 5353, 5008 and 5358. This population is involuntary.
tile hospMprovidestiea^ inclodes: individiualand group
counsling, individual and group therapy, chemotherapy, milieu therapy, in
dustry, education, rehabilitaiton therapy, behavior shaping, and
almost all the other treatment modalities available (the hospital does not
provides treatment which includes: individiual and group
The hospM provides treatment which includes: individiual and group
1992 the p.c. 1370 commitments were 78% of all the admissions to Patton
State Hospital, or approximately 8% of total admissions. During
1972 there were 172 individuals committed under p.c. 1370 as
focus of treatment is to facilitate this process as quickly as possible.
but to return them to a level of healthy participation in the real world
incompetent to stand trial, is not to return the patient to the community,
the forensic. The goal with those committed under penal code 1370
are in dangeroussness is much more in
decision making process and the issue of dangerousness is much more in
complain with the current population the goal may be the same but the
complain with the least restrictive
community at the earliest possible point with the least restrictive
committed under the civil codes the focus was to return them to the
committed under the civil primarily penal code patients. For the patients
population of primarily civil commitment had a different focus of
treatment has had to change to accommodate the population it serves. The
delivery of treatment. With the changes in population the focus of
will include all the various disciplines in both treatment planning and
process of implementing a biopsychosocial approach to treatment which
the hospital in the hospital is in the current offer psychotherapy or electro-shock therapy or other therapies
currently offer psychotherapy or electro-shock therapy or other therapies
most of the other treatment modalities available (the hospital does not
only increased in number but in percentage of overall admissions indicating a change in the facilities function. This would therefore dictate the need for a change in focus of treatment.

<table>
<thead>
<tr>
<th>Year</th>
<th>#1370 Admissions</th>
<th>Total Admissions</th>
<th>%1370's</th>
</tr>
</thead>
<tbody>
<tr>
<td>72</td>
<td>172</td>
<td>2216</td>
<td>7.76%</td>
</tr>
<tr>
<td>73</td>
<td>370</td>
<td>1872</td>
<td>19.76%</td>
</tr>
<tr>
<td>74</td>
<td>407</td>
<td>1181</td>
<td>34.46%</td>
</tr>
<tr>
<td>75</td>
<td>288</td>
<td>1196</td>
<td>24.08%</td>
</tr>
<tr>
<td>76</td>
<td>301</td>
<td>1451</td>
<td>20.74%</td>
</tr>
<tr>
<td>77</td>
<td>302</td>
<td>1450</td>
<td>20.83%</td>
</tr>
<tr>
<td>78</td>
<td>347</td>
<td>1487</td>
<td>23.34%</td>
</tr>
<tr>
<td>79</td>
<td>333</td>
<td>1218</td>
<td>27.34%</td>
</tr>
<tr>
<td>80</td>
<td>313</td>
<td>982</td>
<td>31.87%</td>
</tr>
<tr>
<td>81</td>
<td>360</td>
<td>982</td>
<td>36.66%</td>
</tr>
<tr>
<td>82</td>
<td>326</td>
<td>711</td>
<td>45.85%</td>
</tr>
<tr>
<td>83</td>
<td>337</td>
<td>696</td>
<td>48.42%</td>
</tr>
<tr>
<td>84</td>
<td>359</td>
<td>698</td>
<td>51.43%</td>
</tr>
<tr>
<td>85</td>
<td>367</td>
<td>705</td>
<td>52.06%</td>
</tr>
<tr>
<td>86</td>
<td>333</td>
<td>666</td>
<td>50.00%</td>
</tr>
<tr>
<td>87</td>
<td>415</td>
<td>613</td>
<td>67.70%</td>
</tr>
<tr>
<td>88</td>
<td>385</td>
<td>619</td>
<td>62.20%</td>
</tr>
<tr>
<td>89</td>
<td>443</td>
<td>574</td>
<td>77.18%</td>
</tr>
<tr>
<td>90</td>
<td>470</td>
<td>609</td>
<td>77.18%</td>
</tr>
<tr>
<td>91</td>
<td>492</td>
<td>613</td>
<td>80.26%</td>
</tr>
<tr>
<td>92</td>
<td>534</td>
<td>690</td>
<td>77.39%</td>
</tr>
<tr>
<td>Total</td>
<td>7654</td>
<td>21,229</td>
<td>36.05%</td>
</tr>
<tr>
<td>Average</td>
<td>364.476</td>
<td>1010.904</td>
<td></td>
</tr>
</tbody>
</table>
Graph 1

Graph no. 1 depicts the changes in both overall population and the increase in the percentage of P.C. 1370 admissions. This information must not be taken out of the context within which it happens. Penrose, cited in Geller et al. (1991) found an inverse relationship between the use of prisons and psychiatric institutions to incarcerate those that society sees as deviant. That is, the more use of prisons the less use of psychiatric institutions and the greater the use of psychiatric institutions the less use of prisons. With the changes in the civil commitment laws and the financial restraint that is demanded of the state, the police do not have the option readily available to get the 'deviants' off the street by taking them to the state hospital for confinement. They must utilize the criminal courts to hospitalize mentally ill criminals. What this indicates is the use of
incarceration as a tool of social control. In the aforementioned article by Geller et al., it is mentioned that their research found literature which supported the idea that hospital staff become confused when confronted by a patient admitted for evaluation for competency to stand trial. They found that staff is criticized because they ignore the clinical needs to attend to the specific criminal commitment or they ignore the criminal commitment and attend only to the clinical needs. The authors also indicate, (and the researchers first hand experience corroborates), that staff are resentful of the manipulativeness of a segment of these patients and the way that this same segment preys upon some of the more disturbed and relatively helpless other patients. The programs outlined here not only address the confusion of the patient over his role but also informs the staff about their role in relationship to the patient.

**Length of Stay**

Studies in which length of stay of institutionalized people is the criteria variable, emphasize a variety of causative factors from the client who does not want to be defended (Miller and Germain, 1987), to patient characteristics (Heiman and Shanfield, 1980, Doherty, 1975, Horn et al, 1986, Mezzich and Koffman, 1985), to environmental factors, such as Medicaid (Frank and Lave, 1985) and the provision of aftercare (Levine, Weiner and Carone, 1978). It must be recognized that the factors influencing length of stay are as varied as those factors influencing outcome in treatment. One of the realistic constraints in the criminal justice system is the court
calendar and statutory time frames. Just as the courts must perform their tasks within time frames so must the hospital perform their assigned task of evaluation and treatment within time constraints.

The California penal code requires that a patient can be hospitalized with the criminal case in abeyance for up to three years or, the length of time the person could serve if found guilty for the most severe charge against him; whichever is less (California Penal Code section 1370 (c) 1). The Jackson decision utilized language which the state of California chose to interpret by limiting the length of stay to those time frames noted in the previous sentence - three years or the maximum time for the most severe charge, whichever is less. This provides that at the end of the three year period the court must utilize civil procedures, with all its incumbent protections, if they are to continue to involuntarily hospitalize the individual.

The issue of competence can be brought before the court at any point in the process from the initial complaint hearing to the sentencing hearing and can entail such issues as competence to confess, competence to waive certain rights, such as right to effective counsel, the right to cross examine witnesses, and the right to remain silent or to testify on one's own behalf. The issue of competence is a complex issue that may be best viewed as a construct which is situation dependent. Roesch and Golding (1980), state "...no absolute set of facts is ever dispositive of competency." In the same publication they find that only one of three defendants examined for competence is then found incompetent to stand trial. Most of the studies on competency are descriptive, addressing demographics such as sex,
diagnosis, and charges, and address issues of predictive abilities based on the demographics and not treatment modalities. Roesch and Golding, as cited in Weiner and Hess (1987), point out that 24 states continue to have indefinite commitments for those found incompetent to stand trial in apparent conflict with the *Jackson* decision. Currently there is much debate over the use of medication in the name of maintaining competence, especially for those defendants who will be testifying. In *Riggins vs Nevada* the issue of 'forced' medication was a basis for appeal. The State Supreme Court reversed the court trial finding on the ground that the State of Nevada unconstitutionally forced an antipsychotic drug upon the defendant during the trial. The defendant was accused of robbery and murder and had been found competent to stand trial while being treated with an antipsychotic medication. The defendant, on appeal, contended that he did not receive a fair trial because the jurors had not seen his 'true mental state'. The effect this decision will have on the interface of the judicial and psychiatric communities has yet to be seen.

There are currently several evaluative tools available for the forensic psychologist, psychiatrist, or social worker who is called upon to perform competency assessments. Among these are the Competency Screening Test (CST), The Competency Assessment Instrument (CAI), The Interdisciplinary Fitness Interview (IFI), The Georgia Court Competency Test, the modified Georgia Court Competency Test (GCCT-MSH) and the newly developed Computer-Assisted Determination of Competency to Proceed (CADCOMP). The CST and the CAI were developed during a five-year project (number 7R01-MH-18112-01) funded by the National
Institute of Mental Health and copyrighted by Lissitt and Lelos. The Interdisciplinary Fitness Interview was developed by Schreiber, Roesch and Golding (1987) when they determined that a more appropriate instrument was needed to be that would integrate both legal and mental health professionals expertise into a more balanced medicolegal perspective. The GCCT was developed by Wildman et al. (1978) to serve as a rapid quantitative measure of competence which utilized 17 questions to measure knowledge in several areas. The GCCT-MSH is a modification of the GCCT which was developed at Mississippi State Hospital in 1988 and has 21 questions covering the same domains.

Nicholson and Kugler (1991), evaluated the results of 30 different studies on competence dating from 1967 to 1989. Their study found that the most significant correlates of incompetency were:

a) poor performance on psychological tests specifically designed to assess defendants' legally relevant functional abilities,
b) a psychotic diagnosis, and

c) psychiatric symptoms indicative of severe psychopathology (pg. 363)

The tests that they examined in their study were the IFI, the CST, the CAI, and the GCCT. They also found that the examiners were not equating psychosis with incompetence. Only half of those with a psychotic diagnosis were found to be incompetent to proceed to trial. One finding was that these individuals examined for incompetence were primarily persons who were single, unemployed and poorly educated.
Method

The samples used in this study were taken from patients admitted to Patton State Hospital under California Penal Code section 1370 between 1972 and 1992. The first sample was taken from those admitted and discharged between 1972 and 1976. The second sample consisted of those admitted and discharged, who had attended the Mock Trial program, between 1978 and 1982. The third sample consisted of those admitted and discharged between 1984 and 1988 and the fourth and final group consisted of those who had been admitted and discharged between 1989 and 1992, when the Court Preparation Project was in progress. The variables gathered included: length of stay which was measured by subtracting the date of admission from the date of discharge, provision of the specified treatment programs or lack thereof, age at admission, county from which the patient is committed, sex, ethnicity, religion, marital status, discharge unit, previous commitments to Patton State Hospital, discharge diagnosis, criminal charges, discharge physician, and veteran status. The information was archival data gathered from the admissions record of Patton State Hospital, individual face sheets, individual patient records (closed files) and the files of the Mock Trial Program and the Court Preparation Project as well as the Information management system. Length of stay and the provision of the specified treatment programs are the criterion variables with all other variables being independent.

There were two records from the first sample of 101 that were not considered because the length of stay indicated was beyond that allowed by the statutes and therefore was, in all probability, in error. In the second
sample there were initially 101 subjects but three records were not considered because they exceeded one thousand days length of stay (the maximum stay allowed by statute) and were therefore discarded. In sample three, one hundred records were reviewed and six were deleted for the same reason. Sample set four consisted of ninety four cases which were originally ninety-seven until three were deleted for the same reason.

The information was encoded in such a way that there were 16 diagnostic categories. These categories were based on the discharge diagnosis which may or may not have corresponded with the admitting diagnosis. The time span from 1972 to 1992 spanned the use of three diagnostic and statistics manuals, therefore prohibiting the use of a particular manual. Charges were arranged into 17 categories, one of them being "unknown". Discharging physician were noted and encoded as well as the unit from which the patient was discharged. Where the information was unavailable or unknown, it was so noted. In order to provide for anonymity and the confidentiality of individual records the information was encoded so that the identifiers were not removed from the hospital. The data was entered into the Epi-5 data system then converted into the SPSS-PC+ system for evaluation.

**Results**

The mean, mode, median and standard deviation for length of stay (los) for all four sets are presented in Table 2. Length of stay was a minimum of six days to a maximum of eight hundred fifty seven, with both extremes in set one. The mean length of stay seems to indicate a
shorter length of stay for those in set four (The Court Preparation Project). Twenty-six of California's fifty-eight counties were represented in the population. The counties with the greatest representation were Los Angeles and San Diego county in that order. The majority of patients were single and white while set two had the largest group of single patients, (73.5%).

Though the majority of patients were white, minorities were over-represented in relationship to the overall population of the state of California. The 1990 Census of the state of California placed the population breakdown as 68% - White, 7.5% - Black, 25.8% - Hispanic ("may be of any race") and 23.6% - Other. The ethnic population in set four most accurately reflects the current breakdown of the overall population of Patton State Hospital as described in the Hospital Administrative Directives of the hospital.

"White 51%  Black 27%  Hispanic 18%  Other 4%"

There were 19 categories identified under religion with one category for none and another for unknown. The religions represented in the chart are: 1 - None, 3 - Protestant, and 4 - Catholic. The diagnoses represented on the chart are: 2 - Schizophrenia, Chronic, Undifferentiated Type, 3 - Schizophrenia, Chronic, Paranoid, 7 - Drugs/Alcohol, 10 - Other Psychosis. There were seventeen categories of charges with the following being represented on the table: 1 - Unknown, 2 - Misdemeanors, 5 - Assault with a Deadly Weapon, 8 - Robbery, 9 - Drug crimes (possession, sales, or under the influence), 11 - Burglary. The chart indicates a decrease in the number of known veterans being hospitalized, although the one
hundred percent in set three is because the veteran status was not recorded for this group. The record keeping system at the time did not include the recording of veteran status. The table also provides a brief glance at some of the variables and their trends within the identified population.

Table 2
A Brief Overview of the four sets

<table>
<thead>
<tr>
<th></th>
<th>Set#1</th>
<th>Set #2</th>
<th>Set #3</th>
<th>Set #4</th>
</tr>
</thead>
<tbody>
<tr>
<td>los mean</td>
<td>181.3</td>
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<td>34.2</td>
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<tr>
<td>Yes</td>
<td>48.5</td>
<td>22.4</td>
<td></td>
<td>18.1</td>
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<td>No</td>
<td>47.5</td>
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<td>4</td>
<td>39.8</td>
<td>100</td>
<td>19.1</td>
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The chi square for length of stay and the different treatment conditions as well as the degrees of freedom and the significance are noted below:

<table>
<thead>
<tr>
<th>Chi square</th>
<th>D.F.</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>691.13961</td>
<td>645</td>
<td>.1014</td>
</tr>
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</table>

Over ninety percent of the total sample was under the age of fifty (91.1%).

Forty percent of the total sample came from Los Angeles county. Only 11.5% of the total sample population was female. Twenty eight percent of the sample population had a diagnosis of Schizophrenia, Chronic, Undifferentiated type, and more than fifty eight percent of the population had a diagnosis that included schizophrenia. The following categories of criminal charges had a greater than 10% frequency in the sample population; Unknown (13.5%), Misdemeanors (14.1%), Assault with a deadly weapon (14.3%) and Burglary (13.5%). The crime of murder was only 6.3% of the sample population. There were more than sixty eight doctors identified as being the discharging physician with the sample population. When the top and bottom five length of stay scores for length of stay are removed from each set the results are as follows:

<table>
<thead>
<tr>
<th>Set 1</th>
<th>Set 2</th>
<th>Set 3</th>
<th>Set 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean los</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>181.2121</td>
<td>177.357</td>
<td>210.321</td>
<td>148.976</td>
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</tbody>
</table>
Discussion

An analysis of the data would suggest that set 4 (the Court Preparation Project) had an appreciably lower stay than set one and considerably shortened over that of set 3. One may then ask if the population in set 4 was significantly different than the other sets. There are obvious differences pointed out in Table 2, such as diagnosis and frequencies of specific charges, but the affect these have on length of stay is not factored out. Set one had the greatest percentage of those patients whose charges were unknown (37.4%), while set 4 had only 5.3% with unknown charges. Set one had 12.1% with misdemeanor charges and 4% charged with murder, and set four had 11.7% with misdemeanor charges and had 5.3% charged with murder. What effects these differences had on length of stay was not factored out. While the Chi Square test for the difference in treatment approach and length of stay does not provide a level of significance acceptable in the social sciences (.05), the significance between the approach used and length of stay (.1014) is of interest. One would consequently tend to think that a more careful analysis of the many variables which contribute to length of stay (political, economic, administrative, organizational, etc.) might suggest a relationship between the approach to restoring competence and length of stay.

The length of stay appears to be decreased in that set of patients who have been provided with the Court Preparation Project and this is certainly a desirable effect for the patient as well as the hospital. The elimination of
the top five and bottom five scores on length of stay (outliers), give credence, though not validity, to the hypothesis that the provision of the designated treatment programs had an direct effect on length of stay. That direct effect appears to be a decrease in the length of stay. Whether these were a result of the programs is still a highly debatable subject since there are so many variables that could not be controlled for. Some of these would include the medication regimen, the length of stay and degree of participation in the treatment programs provided, the effect of other treatment modalities, the effect of budget constraints upon the department of mental health, the funding of the county jails and other factors which may impact on a relationship between length of stay and treatment provisions.

The statistical analysis shows trends towards a decreased length of stay. However, the results are not of a statistically significant nature. Even when an artificial dichotomy of length of stay as 1 = 6 thru 180 days and 2 = 181 thru 857 days is introduced the chi square = 4.61285 and the significance is only .2024. Analysis found a statistical relationship between length of stay and discharge diagnosis (significance =.02) in set one. I was unable to determine what the relationship was because of the frequencies of the two variables.

Is trial competence a fixed point or does it exist on a continuum, is only one of the questions raised by the information. The current project personnel have verbalized that it does exist on a continuum, with a lesser degree of competence required for the person facing a plea bargain than what may be required for the patient facing a long and complicated trial
where he may have to confront witnesses and testify on his own behalf. The issue of competence to stand trial has been examined in this paper and the examination has resulted in more questions than answers. The resulting questions give other researchers information from which to draw.

We may never be able to factor in all the variables that affect the length of stay of patients in forensic facilities. The amount of pressure placed on a particular case by the media and by political considerations may not be measurable. The bureaucratic delay in the provision of monies to provide certain treatments, the increase or decrease in staffing levels, the development of new medications, the increased provisions for training all have affects which are not addressed in the current study. These affects may have little to do with the competence of the patient but may have much to do with the speed with which the patient is returned to court to face the pending criminal charges. A recent decision by the department to charge counties for patients staying past ten days after the determination of competence has been made by the hospital is an example of one of the budgetary considerations on length of stay.

When the Mock Trial program was in effect there were eventually two nursing staff provided to the program. In the current Court Preparation Project there are two full-time nursing staff, a full-time MSW, who is the director of the project, and a half-time psychologist. This ratio of staff to patients as well as the provision of other treatments has not been adequately addressed by the research but provides opportunity for further inquiry.
The issue of maintaining competence, once it has been restored is one which has been addressed both by statute and by the interface of the hospital and the jails. The penal code provides that the hospital may make a recommendation that competence can be maintained only through the continued provision of mental health services and that returning the patient to the jail setting would "create a substantial risk that the patient would again become incompetent" (California penal code section 1372 (e)). This would result in the patient being maintained in a mental health facility rather than the county jail if the director of mental health for the county approves. This may depend on the amount of monies the counties have and the degree of security their facilities may provide. Los Angeles as well as Orange county have a mental health facility within the jail itself. The continued competence of a patient is often based on the provision of medication, an issue that is being much more adequately addressed than it has been in the past. The present system provides for both written and telephoned communication with the jail facilities to maintain the medication regimen that has been effective. During the researchers first few years working with this population there were several occasions where the determination was made that a patient had been restored to competence and the medication regimen was then changed by the treating physician or the jail did not maintain the regimen and the patient deteriorated to incompetence.

The overabundance of minorities in the sample population reflects the same over-representation of minorities in the report of the adults arrested by race/ethnicity in California Criminal Justice Profile of 1990. Minorities
were 58% of the adults arrested in 1990. It would then seem to equate that the population which were arrested would have a determining influence on those that were found incompetent to stand trial and it did not equate. The population of those arrested, when compared with the population found incompetent, appears to show an overabundance of whites being found incompetent as compared to minorities. It appears that whites are treated differently than minorities in regard to the issue of competence to stand trial. This seems to me to be an area that could provide an abundance of knowledge about both the criminal justice and the mental health systems but that is a topic for further research.

This inquiry did not address the issue of what is the modicum of time that is needed to provide a patient with adequate treatment for restoration of competence. Further inquiry into this area may provide other researchers with grist for their research. The state of California has made an arbitrary decision when it mandates that the longest time a person may spend in the pursuit of competence is three years. This time frame addresses the requirements of the Jackson decision but may not reflect the realistic needs of the patient/defendant. Other states continue to utilize language which allows for indefinite commitments of those found incompetent, despite the Jackson decision.

One of the most important issues that both the Mock Trials and the court preparation Project address is the difference between mental health and the judgment of restoration of competence. Competence to stand trial is a specific area of inquiry. The issue of competence can come into question from the moment of arrest to the time of sentencing. One does
not have to be restored to mental health to be judged competent to stand trial, just as one does not have to be mentally healthy in order to be competent in other areas. The courts do not allow for treatment against ones' will. The statutes provide that if a patient is to receive treatment for injuries or other physical illness and the patient does not agree to the treatment, even if the patient is incompetent, a specific judgment by the court as to competence on this issue must be made or the provision of treatment must hinge on the immanent danger of death. This may seem ludicrous to some, but the issue of competence extends to many other areas including the ability to enter into contracts, the ability to drive, the ability to own a gun, the ability to offer a confession, the ability to represent ones' self (pro per), the ability to confess, and even the ability to stand for sentencing.

The issue of competence to stand trial will continue to be the issue of major importance in the interface between the mental health and judicial systems. We, as mental health professionals, will be called upon to make decisions about competence and must therefore have an adequate knowledge about what is required to be competent. This particular task may, at times, seem distasteful and at times in contrast to the training we are provided. However, it may be argued that the empowerment of the individual to actively participate in the trial process is one which we must recognize and help to provide. Where it may become a more ethical and sensitive issue is when we are preparing someone to return to face criminal charges which may result in the patients death.
Deinstitutionalization is a word that has been favored since the late sixties and early seventies. How this may affect the population of mentally ill has not received a complete and thorough examination. It has a very strong effect on this population because greater than 60% of those patients returned to court to stand trial are released to the community within six months. It has certainly discouraged the use of long-term hospitalization for any segment of the mentally ill population. It has, in turn, put people back out into the community unprepared to deal with their life situation. It appears the community has abandoned their responsibility to the mentally ill by forcing them to cope with freedoms they are not prepared for. It seems the community been sold a bill of goods in the deinstitutionalization of the mentally ill. We are certainly concerned about the plight of the mentally ill population, but are we doing them or ourselves a favor by turning them back into the community unprepared to provide for their own needs? The provision of care in the community certainly has it's merits and is a noble idea, but at what cost to the patient? Recidivism rates are cited as a tool to measure the ineffectiveness of our current mental health policies, but is it more important that we return people to the community or that we make them so healthy that they need never return to the hospital? These and other questions need to be the subject of further research. The inquiry into efficacy and efficiency of treatment is an area that will continue to have great importance in this time of fiscal restraint. We, as citizens and taxpayers, are going to want to spend our money in the most efficient way and this will result into some inquiry into how our dollars are being spent. We will, hopefully, continue to add to our fund of
knowledge that will increase the mental health both in those identified as patients and in the community as a social entity.
Appendix

Questionnaire for Orientation Group

Judge:
(  ) He determines the order of the court.
(  ) The judge can make you testify.
(  ) He determine if the defendant is capable of standing trial.

Prosecuting Attorney (D.A.):
(  ) If you testify for your attorney and refuse to testify for the D.A.,
   he can have all of your testimony stricken.
(  ) The D.A. is just seeking the truth and is not your adversary in the
   courtroom.
(  ) Gathers evidence to prosecute the defendant.

Defense Attorney (P.D.):
(  ) The P.D. can find out about the D.A.'s case before the trial starts.
(  ) A public defender is not a lawyer.
(  ) Needs the cooperation of the defendant.

Bailiff:
(  ) Has the same status as a Peace Officer.
(  ) He enforces order in the court.

Court Clerk:
(  ) In a misdemeanor case you must pay the court clerk the entire amount
   of the fine or remain in jail.
(  ) Serves the judges meals.
(  ) Keeps official documents.

Court Reporter:
(  ) Gives news releases on your case to the newspapers.
(  ) Keeps a transcript of the trial.

Jury:
(  ) If only one juror disagrees, the verdict of the jury can still be imposed
   by majority rule
(  ) There are 10 people on a jury.
(  ) You will receive a jury trial unless you request a trial by judge.
(  ) Finds a verdict of guilty or not guilty at the end of the trial.

Defendant:
(  ) As a person judged incompetent, you will be more closely watched than
   the "average" defendant from the community.
Pleas:
( ) A plea of no contest is a guilty plea.
( ) A plea of not guilty means you admit the charge is true.
( ) If you plead "not guilty, not guilty by reason of insanity" and you are found to be innocent you are still held over for a sanity hearing.
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