

Charge Severity and Aggression during Competence Restoration

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Most competence restoration occurs in secure inpatient settings. As states struggle with strained resources and seek to best utilize restoration services, factors such as charge severity and violence risk remain key considerations in determining the appropriate setting for an individual's competence restoration. This study offers a quantitative analysis of aggressive behavior during inpatient restoration efforts and whether criminal charge severity correlates with inpatient aggression. Results of this study indicate that a substantial minority of defendants engaged in aggressive behavior and required restraint during the initial months of their hospitalizations. Most of those engaged in few episodes of aggression and required few episodes of restraint. Rates of aggression and restraint were higher in individuals with lower severity charges compared with those with higher severity charges. Courts and evaluators may have selected for a more disordered group of defendants with lower severity charges.

J Am Acad Psychiatry Law 50:388–95, 2022. DOI:10.29158/JAAPL.210096-21

Key words: aggression and violence; competency restoration; competency to stand trial; criminal charges; forensic hospital psychiatry

Restoration of competence to stand trial typically occurs in state hospitals.^{1,2} A recent survey of 50 states plus the District of Columbia indicated a national 76 percent increase in the number of forensic patients in state hospitals from 1999 to 2014. For the many states experiencing increases, this rise was primarily due to the increase in patients deemed incompetent to stand trial (IST) and referred for competence restoration.³

The increased demand for restoration services has placed significant pressure on state hospital systems. Judges have become increasingly frustrated with unacceptable delays for restoration services.⁴ In some states, lengthy restoration waitlists have led to federal scrutiny and oversight with demands that states quickly transfer IST defendants to restoration

programs.^{5,6} In addition to efforts to increase hospital capacities for these services, states have sought to develop restoration services outside of traditional inpatient services. Such programs include expanding jail and community-based restoration programs.^{7–11} These programs, however, have limitations. Commentators have argued that jails are not adequately equipped to meet the serious mental health needs of IST defendants.^{12,13} Outpatient programs have focused on nondangerous defendants.^{9,10}

Factors such as charge severity and violence risk remain key considerations for competence restoration programs, and an increased understanding of aggressive behavior during competence restoration will help guide restoration services and settings. The purpose of this study was to quantify aggressive behavior during inpatient competence restoration and determine whether charge severity was related to aggression during restoration efforts. Based on observations that IST defendants with lower severity charges are sometimes more disordered and aggressive than those with higher severity charges, it was hypothesized that defendants with lower severity charges might engage in more frequent aggressive behavior and require more restraint episodes during restoration efforts. If so, courts and evaluators may

Published online July 6, 2022.

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Disclaimer: The views and opinions expressed in this manuscript are solely those of the author and do not necessarily reflect official policies or positions the author's affiliated institutions.

Disclosures of financial or other potential conflicts of interest: None.

have selected for a more disordered cohort of IST defendants with lower severity charges.

Methods

This study was approved by the Indiana University Institutional Review Board. Hospital records of 655 male IST defendants admitted to Logansport State Hospital’s Isaac Ray Treatment Center (2011-2018) for competence restoration were retrospectively reviewed for data including the severity of criminal charges these defendants faced. Behavioral citation sheets and restraint documentation were used to determine an individual’s episodes of verbal aggression, physical aggression, and restraint. When necessary, progress notes and discharge summaries were utilized to clarify these occurrences. Incidents of verbal aggression, physical aggression, and restraint for up to 90 days of hospitalization from admission were calculated.

Individuals were further classified by their most serious charges and grouped by the severity of these charges. Using incidences of aggression and restraint, rates of verbal aggression, physical aggression, and restraint were determined for each charge severity group. Physical aggression was defined by physical aggression toward peers or hospital staff members. Personalized threatening, intimidating, demeaning, derogatory, or sexual comments or gestures constituted verbal aggression. Restraint included episodes of restraint or seclusion necessitated by dangerousness to self or others.

Individuals were combined into groups by charge severity to compare rates of aggression and restraint. Tests of proportions were used to determine whether rates of aggression or restraint significantly differed between individuals with lower and higher severity charges.

Results

Table 1 presents Indiana’s levels of criminal offenses and the sentence ranges and advisory sentences associated with these offenses. Based on the highest severity charge defendants faced, numbers of defendants and percentages of the study group are noted. Defendants faced a spectrum of charges. Most were charged with lesser felony charges. Approximately 10 percent were charged with only misdemeanors. A smaller percentage (4.6%) faced murder charges.

Table 1 Indiana Felony Classifications, Sentence Ranges, Advisory Sentences, Highest Offense Faced by Individuals (N) and Percent of Study Population

Offense*	Sentence Range	Advisory Sentence	N	Percentage
Murder	45 – 65 years	55 years	30	4.6%
Level 1 Felony (Class A Felony)	20 – 50 years (20 – 50 years)	30 years (30 years)	55	8.4%
Level 2 Felony	10 – 30 years	17.5 years	120	18.3%
Level 3 Felony (Class B Felony)	3 – 16 years (6 – 20 years)	9 years (10 years)		
Level 4 Felony	2 – 12 years	6 years	176	26.9%
Level 5 Felony (Class C Felony)	1 – 6 years (2 – 8 years)	3 years (4 years)		
Level 6 Felony (Class D Felony)	6 mo. – 2.5 years (6 mo. – 3 years)	1 year (1.5 years)	209	31.9%
Misdemeanor	Up to one year	None	65	9.9%

*In 2014, Indiana changed its charging structure from a lettered system of four felony levels (A-D) to a numbered system with six levels (1-6). Individuals with charges in the lettered system were counted with the appropriate corresponding numbered system.

Table 2 indicates percentages of study participants displaying verbal or physical aggression or requiring restraint. Verbal aggression was noted in 36.6 percent of subjects, and 34.2 percent engaged in physical aggression. Approximately one-quarter (27.8%) of individuals required restraint.

Table 2 further lists numbers of behavioral incidents and proportions of individuals involved in the incidents. Most individuals had no episodes of aggression or restraint. Those who engaged in aggression engaged in few episodes, typically one to three episodes. Those who required restraint also usually required one to three episodes. It was relatively rare for individuals to engage in more than three episodes of verbal or physical aggression or require more than three episodes of restraint.

Table 3 displays comparisons of defendants with lesser and greater severity charges and shows whether these groups differed in proportions of individuals displaying aggression or requiring restraint. Individuals with the lowest severity charges (Misdemeanor and Level 6 Felony) had the highest rates of verbal aggression (45.6%), physical aggression (41.6%), and restraint (32.1%). The lowest rates of verbal aggression (14.1%), physical aggression (21.2%), and restraint (22.4%) were evident in individuals with the highest severity charges (Level 1 Felony and Murder). In the first Table 3 comparison, rates of verbal and physical aggression significantly differed between these groups.

Charge Severity and Aggression

Table 2 Frequency of Aggression and Restraint

	N	Incidence	Behavior Incidents per Individual				
			0	1	2-3	4-5	>5
Verbal Aggression	240	36.6%	63.4%	16.5%	11.3%	5.3%	3.5%
Physical Aggression	224	34.2%	65.8%	17.1%	10.7%	3.7%	2.7%
Restraint	182	27.8%	72.2%	15.0%	7.6%	2.4%	2.7%

Table 3 Aggression and Restraint Comparisons for Lesser and Greater Severity Charges

		N	Verbal Aggression	Physical Aggression	Restraint
Lowest Severity	Misdemeanor – Level 6 Felony	274	45.6%	41.6%	32.1%
Highest Severity	Level 1 Felony – Murder	85	14.1%	21.2%	22.4%
P			< 0.001	< 0.001	0.088
Lowest Severity	Misdemeanor – Level 6 Felony	274	45.6%	41.6%	32.1%
Higher Severity	Level 5 Felony – Murder	381	30.2%	28.9%	24.7%
P			< 0.001	< 0.001	0.037
Lesser Severity	Misdemeanor – Level 4 Felony	450	41.8%	36.4%	28.7%
Greater Severity	Level 3 Felony – Murder	205	25.4%	29.3%	25.9%
P			< 0.001	0.076	0.459
Lower Severity	Misdemeanor – Level 2 Felony	570	40.0%	36.1%	28.6%
Highest Severity	Level 1 Felony – Murder	85	14.1%	21.2%	22.4%
P			< 0.001	0.007	0.234

Rate of restraint differed between these groups with a significance of $P = .088$.

The remaining Table 3 comparisons include the entire study population and contrast differences in aggression and restraint as this population was divided into groups with lesser and greater severity charges. As groups of individuals with the lowest severity charges expanded to include those with higher severity charges, rates of aggression and restraint decreased.

From the standpoint of higher severity charges, rates of verbal aggression increased as groups with higher severity charges expanded to include those with increasingly lower severity charges. Physical aggression and restraint increased as groups of individuals with the highest severity charges expanded to include those with somewhat lesser felony offenses (Level 2 and Level 3 Felonies). An exception to this trend was a decrease in physical aggression and restraint as this group further expanded to include those with still lower felony offenses (Level 4 and Level 5 Felonies).

Across all comparisons, groups of individuals with lower severity charges were more likely to engage in verbal and physical aggression and require restraint. Higher rates of verbal aggression were significant across all comparisons of lower and higher severity

charges. Considering the entire study population, individuals with the lowest severity charges were significantly more likely to engage in physical aggression, and individuals with the highest severity charges were significantly less likely to do so. Individuals with the lowest severity charges were significantly more likely to require restraint.

Discussion

This study quantifies aggression and restraint during inpatient competence restoration and is the first to examine the relationship between severity of criminal charges and aggressive behavior during inpatient restoration. A substantial minority of IST defendants engaged in aggressive behavior and required restraint during the initial months of their hospitalizations. Most of those who did engaged in few episodes of aggression and required few episodes of restraint.

The study's most interesting finding supports the hypothesis that rates of aggression and restraint were higher in defendants with lower severity charges compared with those with higher severity charges. At first, this appears counterintuitive. One might expect defendants facing more severe charges to potentially be more volatile and aggressive during restoration

attempts, but the opposite is observed in this study. It is possible that judicial and forensic evaluator tendencies contributed to these findings, as discussed below.

Inquiry into a defendant's competence to stand trial is costly in terms of time and resources. Such inquiries delay resolving a defendant's charges and may lead to longer detention while competence is assessed and considered. Lower severity charges are more easily deferred to a mental health court or civil psychiatric services, pled to time served or probation, or simply dismissed. For lesser charges, it is likely that a higher degree of impairment is sometimes necessary to oblige a criminal court to seek an evaluation of competence to proceed. Courts, however, may err on the side of caution when ordering defendants with more severe charges to undergo competence evaluation. Following these evaluations, courts also likely consider charge severity when determining whether to ultimately adjudicate defendants incompetent to proceed. The consequences of allowing an impaired defendant to proceed are greater both in terms of risk to the defendant and chance that a conviction may be overturned on appeal.

Forensic evaluators also may factor charge severity into their competence assessments. In a study of clinician reliability and the role of offense severity, Rosenfeld and Ritchie found that misdemeanor defendants were more likely to be found incompetent to stand trial but noted that among those defendants found IST, there was a significant association between charge severity and evaluator estimates of degree of competence. This finding led them to suggest that evaluators may have been more willing to allow marginally fit misdemeanor defendants to proceed while holding defendants charged with more serious offenses to a higher standard of competence.¹⁴ They found no association between degree of competence and offense severity among defendants found competent to stand trial, and subsequent studies have not established a clear link between charge severity and incompetency rates.^{15,16} Moreover, a recent review of competency restoration in different treatment environments "deprioritized crime type . . . because it is not necessarily or fundamentally relevant to a determination of incompetence or restorability" (Ref. 17, p 70).

While a clear empiric relationship between charge severity and competence to stand trial may not be determined, it has been suggested that charge severity

should factor in competence determinations. In this journal, Buchanan argued that evaluators assessing competence to stand trial should consider the seriousness of defendants' charges.¹⁸ Specifically, when the charges are serious, evaluators should seek a greater level of confidence before suggesting that a defendant is competent. He noted that a principle of proportionality or "sliding scale" has been adopted for other areas of legal competence, such as informed consent, making a will, and medication refusal. Graver consequences lead assessors and courts to require evidence of greater mental capacity before individuals are permitted to act (or have others act) in accordance with their stated wishes. Greater capacity is considered necessary when the stakes of the decision are greater.¹⁸

Piel *et al.* also noted that the sliding-scale concept has most commonly been utilized in civil competence assessments, such as medical decision-making, but can be applicable in the criminal sphere. They considered that sliding-scale criteria, in areas such as determination of competence to stand trial, probably are frequently utilized but usually are not so conceptualized.¹⁹

Accordingly, forensic evaluators may consider charge severity in their opinions regarding whether a defendant is competent to proceed. The consequences for defendants facing more severe charges are more serious, and evaluators likely use added caution when opining whether defendants facing harsher criminal penalties are competent to proceed. The above court and evaluator decisions may select for restorees with lesser charges being more disordered than their counterparts charged with greater offenses and illustrate "the myth that defendants charged with misdemeanors are less mentally ill than those charged with felonies" (Ref. 20, p 45).

Perhaps this selection is apparent in individuals eventually referred for competence restoration, and evaluators may consider charge severity before certifying incompetent defendants as restored. Competence restoration studies have found offense severity to be a factor in restoration success. Among other factors, Mossman found that a misdemeanor charge was related to a decreased likelihood of restoration, and Colwell and Gianesini identified nonrestorable patients as having lower-level charges.^{21,22} In a long-term restoration study of individuals not restored to competence within six months, increased charge severity was a positive predictive factor for eventual restoration.²³

These studies are indicative of a possible relationship between charge severity and competence restoration, though the reason for this potential relationship is unclear. Mossman suggested that shorter allowable periods for restoration may result in misdemeanor defendants being less often restored.²¹ Alternatively, Gillis *et al.* questioned whether incompetent misdemeanor defendants may experience more severe psychiatric symptoms that preclude their ability to assist counsel and understand their legal proceedings.²⁴ The results of their study of misdemeanants treated for competence restoration, however, lessened this concern with their finding that almost 70 percent of defendants were restored to competence. When restorable, defendants achieved competence, on average, in less than three weeks.²⁴

There is overlap in impairments that may lead to arrest, incompetence to stand trial, and inpatient aggression. Individuals with serious mental illness are at risk for arrest and incarceration and are overrepresented in jails.^{25–28} Psychotic, affective, cognitive, and intellectual disorders are associated with both inpatient violence and incompetence to stand trial.^{15,29–32} This study's finding that individuals with lesser severity charges were more aggressive may be reflective of these individuals experiencing an increased and more chronic instability, both in the community and during hospitalization, than their counterparts facing greater charges. This may lead to increased volatility and propensity for aggression during restoration efforts.

These findings have implications for forensic systems attempting to meet high demands for restoration services and seeking to refer IST defendants to appropriate settings for competence restoration. An initial assumption would be that IST defendants with higher severity charges require higher security treatment settings. From a perspective of aggression during restoration efforts, however, this study does not support that contention. Safety concerns cannot be minimized, and programs must consider factors such as an individual's potential for violence, the circumstances of alleged offenses, and risk of absconding. Individuals with higher severity charges should be treated with appropriate caution; however, some of these individuals may not require the highest security restoration settings.

In their survey of outpatient restoration programs, Gowensmith *et al.*, noted that program administrators have been conservative in selecting participants,

seeking to include the “least risky” individuals and placing them in programs with high levels of structure to limit negative outcomes.⁹ This group further noted that none of the outpatient restoration programs identified serious criminal or violent activity by participants. After these programs have built track records of success, they have been better able to expand in scope and size. The current study's finding of decreased frequency of aggression in individuals with higher severity charges lends support to programs seeking to expand eligibility to defendants with higher severity charges.

Conversely, violence potential should not be underestimated in individuals with lower severity charges. A state's interest in prosecuting and restoring incompetent defendants increases with the severity of their criminal charges.³³ This is reflected by many states linking allowable restoration periods to the severity of criminal charges and more states moving toward this model.^{34,35} States such as New York do not attempt to restore defendants charged solely with misdemeanor offenses,³⁶ and other states allow courts to dismiss misdemeanor charges against incompetent defendants.^{37,38} Fundamental fairness concerns for individuals with minor charges may factor in these legislative decisions, but budgetary constraints and the need to devote limited resources to defendants with higher severity charges probably are the greater driving forces. A recent report from the Council of State Governments Justice Center highlighted excessive costs for competence restoration, often for individuals with minor charges. This group emphasized the need to focus restoration resources on individuals facing more severe charges and suggested that jurisdictions may determine that, for certain charges, the benefit of restoring a person's competence to face that charge is not worth the cost.³⁹

When states deprioritize restoration efforts for individuals with lower severity charges, it is imperative that their statutes and services divert such individuals into sufficient civil treatment services to treat their often substantial impairments. Poor access to treatment and limited oversight contribute to destabilizing factors such as treatment nonadherence and substance use. Under these conditions, individuals with lesser charges, more easily released from legal holds, continue cycles of community instability, arrest, and repeated referrals for restoration services.

Study Considerations

Like most states, Indiana is attempting to develop alternatives to inpatient competence restoration. During the study period, however, all Indiana IST defendants were referred to state hospitals for inpatient restoration efforts. Despite the U.S. Supreme Court *Jackson v. Indiana* decision limiting a state's ability to commit a defendant solely because of incompetence to stand trial,⁴⁰ Indiana's statutes and courts have maintained a rigid approach to competence restoration. As described in previous competence restoration studies in Indiana,^{23,41} Indiana's statutes do not address low restoration likelihood, and the Indiana Supreme Court has not been willing to allow for the possibility of permanent incompetency prior to a trial of restoration efforts.⁴² Unlike many states, Indiana also does not link restoration time limits to the severity of defendants' alleged offenses. While prosecutors are more likely to dismiss less serious charges after extended hospitalizations, they are not obligated by statute to do so. In 2008, the Indiana Supreme Court ruled that a trial court judge may unilaterally dismiss charges for a defendant opined permanently incompetent who has remained confined for the maximum length of the criminal sentence to which the defendant may be subject.⁴³ To date, this decision continues to have had little impact on restoration practices in Indiana. Like courts in other states, Indiana courts may also regard greater than zero probability of restoration success to be "substantial" enough for restoration efforts.³¹

The U.S. Supreme Court's *Sell v. U.S.* decision,³³ outlining the conditions necessary for involuntary psychotropic medications to restore competency, also has the potential to affect restoration studies with treatment refusals potentially confounding reports of restoration outcomes. The *Sell* decision, however, has had little impact on competence restoration in Indiana. Indiana courts and state hospitals continue to follow the paradigm that court-ordered restoration includes psychotropic medications to promote these efforts, and the onus has been placed on IST defendants to prove that involuntary medications are inappropriate.

While there are arguments for and against Indiana's referral and treatment practices, these practices have strengthened the current study. Sample bias was limited with the hospitalization of all IST

defendants, and individuals with little restoration potential were not selected out of the subject population prior to hospitalization. Allowable restoration time limits also did not differ based on severity of referral charges and did not allow charge severity to influence how quickly hospital evaluators were required to form competency determinations. Treatment bias was limited since it was difficult for IST defendants to refuse suggested treatment. These practices have allowed the study of a full range of IST defendants with varying charges and restoration potentials who predominantly received suggested treatment for their psychiatric illnesses.

Limitations of this study likely include an underreporting of verbal aggression. An inpatient physical altercation often also involves verbal aggression. When hospital staff log such episodes, however, verbal aggression is often subsumed within the citation for physical aggression. Verbal aggression is not trivial. It can result in charges of assault or intimidation. At a minimum, it can be highly disruptive to treatment and restoration efforts. Rates of verbal aggression are likely higher than captured in this study. This likely underreporting of verbal aggression almost certainly affected individuals at all charge severities and is not expected to change the significant differences revealed between groups with higher and lower severity charges.

As above, individuals in this study received treatment in a secure state hospital setting and predominantly received suggested treatment for their psychiatric illnesses. They were less subject to destabilizing factors such as treatment non-compliance and substance use. It is possible that inpatient structure, supervision, and treatment adherence resulted in less instability and risk for aggression than the subjects may have exhibited in a community setting. Consequently, a similar study population may have engaged in more aggression in a community setting.

This study focused on numbers of episodes of aggression and restraint. The circumstances of specific episodes (e.g., potential injuries caused) were not consistently available. Thus, aggression in this study reflects frequency and volume of aggression, rather than magnitude. Future studies should seek to further describe aggression during competence restoration and identify potential diagnostic, clinical, and demographic factors that may contribute to aggression and restraint during these efforts.

Conclusions

Results of this study indicate that a substantial minority of IST defendants engaged in aggressive behavior and required restraint during the initial months of inpatient competence restoration. Most of those patients engaged in few episodes of aggression and required few episodes of restraint. Rates of aggression and restraint were higher in defendants with lower severity charges compared with those with higher severity charges, and courts and evaluators may have selected for a more disordered group of defendants with lower severity charges. When considering dispositions for IST defendants, courts and forensic systems need to recognize that higher severity charges alone do not appear to indicate an increased risk for aggression during restoration. Defendants with lesser charges also may represent a more impaired and volatile IST population. Efforts to employ individualized risk assessments will likely better serve systems endeavoring to match restoration venues with safety and security needs. Further study and understanding of aggressive behavior during competence restoration will help guide restoration settings and services.

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