THE EFFECT OF TIME ON COMPETENCY TO STAND TRIAL EVALUATION OUTCOMES

A Dissertation

Presented to

The Faculty of the Department of Psychology & Philosophy

Sam Houston State University

In Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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by

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August, 2019

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ABSTRACT

Bryson, Claire N., *The Effect of Time on Competency to Stand Trial Evaluation Outcomes*. Doctor of Philosophy (Clinical Psychology), August, 2019, Sam Houston State University, Huntsville, Texas.

No empirical studies, or clinical, ethical, or legal guidelines, have examined what effect time may have on the outcomes of competency to stand trial (CST) evaluations, despite rising court orders for these evaluations increasingly straining states to conduct them in a timely manner. Short time frames may be inefficient for CST evaluations and artificially inflate rates of incompetency opinions for several reasons – defendant continued intoxication, acute symptomatic presentation, stress related to recent incarceration, or insufficient time for psychotropic medication to stabilize the defendant. This study examines the relationship between time from court order to CST evaluation on evaluator opinions in CST evaluations. We collected data from CST evaluations at two sites in Texas: a large, urban public defender's office (Study 1) and a rural community clinic serving several counties (Study 2). Data collected included time of court order and evaluation, evaluator opinion, evaluation characteristics, and defendant characteristics. Study 1 contained only defendants charged with misdemeanors; results indicated the rate of incompetency opinions was high (>60%) and the sample was primarily composed of defendants with SMI. We found that defendants diagnosed with a SMI, particularly if prescribed medication, were more likely be to be opined competent as time to evaluation increased. Study 2 results showed a more normative incompetency rate (approximately 25%). There was an effect for time on evaluation outcomes across the entire sample, with defendants being more likely be to be opined competent as time to evaluation increased. Defendants with bipolar and related disorders, substance-related disorders, and those

prescribed medications were more likely to be opined competent as time to evaluation increased. Both studies found several factors, irrespective of time, to be associated with competency opinions, such as schizophrenia spectrum disorder, substance-related disorders, and custody status. Implications for practice, policy, and directions for future research are discussed.

KEY WORDS: Competency to stand trial, Forensic evaluation

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CHAPTER I

Introduction

In 2015, a federal judge ruled that Washington state was violating the due process rights of some criminal defendants as the result of excessive wait times for competency to stand trial evaluations and restoration services (*Trueblood v. Washington State Department of Social and Health Services [DSHS]*, 2015). Defendants in Washington jails often waited over 60 days for competency to stand trial (CST) evaluations, in many cases leading to further deterioration and decompensation in their mental illness. In some cases, wait times exceeded any potential sentence length for the individual's charge. In three instances, incarcerated class members of the *Trueblood* lawsuit committed suicide or died while awaiting competency services (*Trueblood v. DSHS*, 2016).

Deinstitutionalization and a continued lack of adequate community care have led to the criminal justice system becoming the de facto first-line for the treatment of many persons with severe mental illness (Daniel, 2007; National Alliance on Mental Illness, 2015). In Washington's King County, individuals with mental illness remain in jail three times longer than those without mental illness (*Trueblood v. DSHS*, 2016). However, jails were not designed to be therapeutic (Daniel, 2007) and often struggle to protect defendants with mental illness from victimization by other inmates or from self-harm and suicidality. Defendants in the *Trueblood* case were often housed in solitary confinement, known to be detrimental to mental health (Grassian, 2006; Kaba et al., 2014), as the result of their impaired mental state, suicidality, or for protection from others.

The increase in the number of persons with mental illness in jails has paralleled an increase in the need for competence to stand trial (CST) evaluations. An individual's

ability to participate in and understand the proceedings against them has long been recognized as integral to the dignity, integrity, and reliability of the criminal justice system (Grisso, 2003). Assessing CST is a crucial part of the defendant's due process rights and failing to assess CST properly could lead to a violation of civil rights via unnecessary hospitalization. An individual's competence to stand trial is typically raised pre-trial to ensure the defendant is able to understand and participate in their case at the outset, and any agent of the court has a duty to raise the issue of competence any time there is a "good faith doubt" of competence (American Bar Association, 2015). An evaluation of CST is then conducted by a mental health professional, while the case against the defendant is typically stayed during all competency-related proceedings. The United States Supreme Court set the standard for competence to stand trial in *Dusky v. United States* (1960), holding that a competent defendant must have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding… [and]… a rational as well as factual understanding of the proceedings against him" (p. 402). All states abide by some variation of the *Dusky* standard for assessing CST, with most delineating specific functional or psycholegal abilities and requiring any deficits in these abilities be due to a mental illness or disability (Melton et al., 2007; Zapf & Roesch, 2009).

CST evaluations are the most common forensic mental health evaluations (Edens, Poythress, Nicholson, & Otto, 1999; Golding, 1992; Melton, Petrila, Poythress, & Slobogin, 2007), with court orders for CST evaluations increasing yearly (Johnson & Seaman, 2008). Generally, the goal of the justice system is to resolve the question of competency as quickly as possible in the least restrictive setting, preserving the due

process of the defendant (*Drope v. Missouri*, 1975, *Jackson v. Indiana*, 1972). In the interests of efficiency, states have increasingly shifted towards having CST evaluations performed in jails rather than state hospitals, to avoid unnecessary hospitalization of individuals who could be effectively treated in prison or who are competent to stand trial (Grisso, 2003; Zapf & Roesch, 2006; Zapf, Roesch, & Pirelli, 2013). For example, only 11.4% (336 of 2,939) of Washington's 2013 CST evaluations were completed in state hospitals (Joint Legislative and Audit Review Committee [JLARC], 2014). However, there are rising concerns over wait times for CST evaluations in jails due to the increasing demand for evaluations and services (Gowensmith, 2019).

Successful lawsuits and negative impacts on defendants, such as those in the class-action *Trueblood v. DSHS* (2015), have courts increasingly weighing the competing liberty and speedy trial interests of the defendants with the state's interest in the integrity and efficiency of the trial process. In 2006 and 2012, Colorado settled lawsuits over wait times for CST evaluations, which were alleged to have reached up to six months (Fender, 2012). Other states, such as Wyoming and South Dakota, are beginning to recognize the impact of increasing wait times on defendants and the integrity of the legal process and are enacting legislation in the wake of *Trueblood* (Schmelzer, 2017; Walker, 2015, 2016).

The proposed solution for long jail wait times in some states has been to impose deadlines for the completion of CST evaluations. Colorado settled with plaintiffs in 2012 regarding long CST evaluation and restoration wait-times and agreed to complete in-jail CST evaluations within 30 days of the court order and admit individuals for inpatient hospital evaluations within 28 days, deadlines the state is struggling to meet (Brown, 2017; Steffen, 2015). The suit against Colorado was reopened in 2016, when the state

was again accused of having a backlog of an estimated 100 inmates awaiting a CST evaluation or transfer to the hospital (Brown, 2017). Colorado attributed the backlog to a major increase in court orders for CST evaluations (up 44 percent from 2016 to 2017), as well as under-staffing at state hospitals (Brown, 2017). *Trueblood v. DSHS* (2015) required Washington evaluators to complete competency evaluations within seven days of a signed court order, later increased to fourteen days. Washington (pending further litigation) and Maryland now require most CST evaluations to be completed seven days after a signed court order, raising questions about the appropriate timing of CST evaluations (Gowensmith, 2019).

Possible Associations between CST Evaluation Timing and Evaluation Outcomes

The *Trueblood* solution of requiring a very brief wait-time for CST evaluations raises concerns about the possible consequences of conducting evaluations *too* quickly. Although excessive wait times for CST evaluations and restoration are problematic, especially when defendants go untreated, requiring CST evaluations too soon after a court order may increase opinions and findings of incompetency and the need for subsequent re-evaluations, reducing the efficiency of the CST evaluation system (Gowensmith, 2019).

There are several reasons why short CST evaluation timelines may be inefficient. First, defendants seen too quickly after a court order may still be under the influence of, or withdrawing from, a substance which may make them present with an impaired mental status. *Trueblood* court documents cite “waiting for intoxicants to clear out of an individual’s system” as one clinical barrier to timely in-jail CST evaluations (*Trueblood v. DSHS*, 2016, p. 18). Prior to the *Trueblood* (2015) ruling, evaluators in Washington

were purposefully delaying CST evaluations of intoxicated defendants. Second, CST evaluations conducted soon after a court order may see defendants at their most symptomatic, with symptoms exacerbated by the stress of the arrest and initial incarceration. Third, while defendants may receive psychiatric treatment in jail, there may not be enough time for a psychotropic medication to be prescribed or take effect if the evaluation is conducted within days of the court order. Finally, defendants may be less cooperative overall with legal demands early in their incarceration, potentially due to acute distress or anxiety (Gowensmith, Murrie, & Packer, 2015). As competency is a time-bound and therefore dynamic functional capacity, CST evaluations conducted too soon may result in many individuals appearing incompetent at the time of the evaluation. Many of these individuals may improve within days or weeks, due to medication effects, sobriety, or simply the passage of time from an acutely stressful event.

Preliminary data available from Washington and Maryland suggests that incompetency rates have increased significantly following the requirement for seven-day CST evaluation completion (Gowensmith et al., 2015; Gowensmith, 2019). Although "expert surveys" of Washington's CST evaluation system following the initial *Trueblood* (2015) decision have reportedly found "no signs of a widespread problem with inappropriate or excessive referrals," court documents also indicate approximately 50 percent of individuals are found to be incompetent to stand trial following evaluation (*Trueblood v. DSHS*, 2016, p. 8). This rate of incompetence findings is much higher than found in many other settings. Although base rates of incompetency vary by examiner, jurisdiction, and setting (Murrie, Boccaccini, Zapf, Warren, & Henderson, 2008), the modal estimate of incompetency is typically found to be around 20 percent of referred

defendants (Roesch, Zapf, Golding, & Skeem, 1999) with high estimates reaching at most approximately 30 percent rate of findings of incompetence (Nicholson & Kugler, 1991).

Further, initial data from Hawaii indicates that final CST reports submitted to the court within 15 days, versus 30 days, of a court order are more than twice as likely to opine defendants incompetent (Gowensmith et al., 2015). Additionally, because Hawaii defendants are all assessed for CST by three evaluators, it is possible to compare opinions from evaluators who conducted evaluations quickly (i.e., within 15 days of the order) to those from evaluators who took more time. When at least one CST evaluator opines the defendant incompetent within 15 days, the ultimate opinion of the court is competency approximately 50% of the time (Gowensmith et al., 2015). One possible interpretation of this finding is that half of defendants who initially presented as incompetent close to the time of their incarceration appeared competent after an additional few days or weeks (Gowensmith et al., 2015). When all evaluations are conducted within 30 days, rates of incompetence fall closer to national norms, which fluctuate around 20 to 30 percent of evaluated defendants (Gowensmith et al., 2015; Stafford & Sellbom, 2013). These data suggest CST opinions from evaluations conducted soon after court orders may be systematically different than those from evaluations conducted after a longer period of time.

Legal Recommendations and State Standards

Legal cases, criminal justice standards, and federal or state statutes vary widely in addressing time and competency proceedings; when deadlines are outlined, they often appear vague, arbitrary, and/or do little to empirically address the effect of time on CST opinions. A recent review of state statute deadlines for evaluation of CST indicated that

15 states specify no deadline for CST evaluation, while the remaining 35 states and the District of Columbia vary in their deadlines from 90 to five days, with many differences by setting or charge (Gowensmith et al., 2015). Despite CST being an integral part of the integrity of the legal system, the law appears to have not yet answered the question of what is the right amount of time in which to conduct a CST evaluation – preserving the due process of the defendant and efficiency of the criminal justice system.

Legal rulings in the Washington *Trueblood* case have little to say regarding the possible effects of timing on actual opinions of competency. Despite Washington's high incompetency rate of approximately 50 percent of evaluated defendants, the court cites "no credible evidence" that CST evaluations completed within seven days could result in "rushed or low-quality" evaluations (*Trueblood v. DSHS*, 2016, p. 7). While it is unclear what would constitute a low-quality CST evaluation, no empirical studies have been conducted regarding the effect of changing litigation and state statute deadlines on rates of incompetency.

Rather than considering the possible effect of time on competency opinions, the court in the *Trueblood* case focused on what length of time may be constitutionally justified. As the deadline continues to be litigated—increased from seven to fourteen days in August 2016—the decision mainly centers on "what constitutes a reasonable time in which to conduct evaluations" within constitutional due process requirements (*Trueblood v. DSHS*, 2016, p. 2). That is, the court is considering whether there exists a "rational relation between the nature and duration of confinement and its purpose" (*Trueblood v. DSHS,* 2015*,* p. 17; see *Jackson v. Indiana*, 1972). Just as *Jackson v. Indiana* (1972) set the time of commitment at "the reasonable period of time necessary"

(p. 738) to determine the probability of restoration after a finding of incompetency, *Trueblood* is seeking to define the reasonable time to wait in jail for such an evaluation and finding. Currently, Washington state statute, upheld by the August 2016 *Trueblood* injunction, requires evaluators receive all necessary CST evaluation documents (court order, charging documents, discovery) within 24 hours of the signing of the court order and complete the evaluation within fourteen days.

The American Bar Association (ABA) Criminal Justice Mental Health Standards provide some guidelines regarding best practices for the determination of trial competency (ABA, 2015). The issue of defendant competency may be raised at any stage of the proceedings, but typically is a pretrial motion and order close to the time of the individual's arrest and incarceration (ABA, 2015). The ABA guidelines state that each jurisdiction should determine their own time periods for CST evaluation and reports but suggest that this time period should "not exceed seven days in the case of a defendant in custody, nor fourteen days in the case of a defendant at liberty. For good cause, the time periods might be extended but should never exceed thirty days." The National Judicial College (NJC) has published *Mental Competency: A Best Practices Model*, created by a panel of judges, attorneys, psychologists, and experts in the CST field, recommending different time frames for misdemeanor versus felony CST evaluations (NJC, 2012). The NJC (2012) recommends performing CST evaluations within at least 15 days following a court order for misdemeanors, and within 21-30 days following a court order for felony offenses, with exceptions for defendants who are "acutely psychotic, or severely disturbed, or under the influence of substance use or abuse" (Gowensmith et al., 2015, p. 9). NJC experts caution against performing evaluations too close to the time of

incarceration (rather than court order), again citing concerns that CST evaluations conducted too close to incarceration make it difficult for evaluators to accurately distinguish the effects of acute substance intoxication from real functional impairment, as well as not allowing time for psychotropic medication stabilization (NJC, 2012). However, little empirical support or field testing of these guidelines exists in the current literature, with best practices largely based on clinical expertise and judgment.

Following the recommendation of the ABA, some states have imposed time frames for the completion of CST evaluations, although they are again based only on a best-practices, rather than empirically supported, model. As stated previously, Maryland and Washington have the two shortest time requirements, mandating no more than seven days from court order to CST evaluation. As Washington state continues to litigate an appropriate state deadline, a consultation report summarized information about deadlines and feasibility from evaluators in similar jurisdictions (Gowensmith et al., 2015). Maryland forensic administrators reported both clinical quality and structural feasibility problems with their seven day deadline. The report concluded that defendants with incomplete evaluations (whom are found incompetent by default), as well as individuals appearing temporarily incompetent (either due to substances, anxiety, or other factors), inappropriately strain hospital resources without an accurate or stable determination of incompetency (Gowensmith et al., 2015). Structurally, slight changes in personnel, referral number, or accessibility of defendants can lead to increased incomplete referrals, again leading to default findings of incompetency (Gowensmith et al., 2015). As a result, Maryland has seen an over 50% increase in opinions of incompetency (Gowensmith et al., 2015).

Five other jurisdictions – Rhode Island, Washington, D.C., North Carolina, Nevada, and Illinois – have deadlines for evaluations under 10 days. Rhode Island (five day deadline) and Washington, D.C. (three to five day deadline) both have more structural feasibility for a short CST evaluation deadline due to their small size, resulting in fewer court orders and less travel for evaluations (Gowensmith et al. 2015). While they both mandate evaluations within five days of a court order, Rhode Island allows ten addition days for report submission (effectively 15 day deadline), and Washington, D.C. only requires a screening of competency initially, with further evaluation if necessary within 30 days (Gowensmith et al., 2015). North Carolina imposes time frames by type of charge and location: ten days for misdemeanors if in jail, 20 days for those on bond, and 30 days for felonies, regardless of location (Gowensmith et al., 2015). While the effect of the shorter deadlines has not been investigated, administrator report indicates 30 days is both structurally and clinically feasible (Gowensmith et al. 2015). Washoe County in Nevada maintains a departmental policy for report completion within ten days, with several structural supports for this short deadline. All evaluators are privately contracted, provided with advance notice and records, and all defendants are transported to a central location, leading to a typical 30 day completion time with the ability to prepare in advance (Gowensmith et al., 2015). Finally, Illinois statute mandates seven days for an evaluation (with allowable 7 day extensions), but 30 days for a report.

Overall, for those states with the shortest deadlines various structural supports exist to increase the viability of meeting the requirement. These include small geographic area and number of referrals, centralized locations for evaluation, initial CST screening, triage by type of offense and location, or advance provision of records. However,

questions and concerns remain for the clinical challenges of short CST evaluation deadlines (Gowensmith, 2019). Can these 'quick' CST evaluations offer valid and effective opinions of competency? Maryland offers preliminary, but untested, field evidence that the factor of time (without structural support) will artificially inflate the number of incompetent defendants and strain the entire forensic mental health system.

The Present Study

The present study explores the association between the timing of competency to stand trial evaluations and evaluator opinions in two samples of CST reports from Texas. Study 1 sampled misdemeanor CST evaluation reports from the Harris County Public Defender's Office (HCPDO), a large, urban county containing the city of Houston. Study 2 used felony and/or misdemeanor case CST reports from the Psychological Services Center (PSC), a Sam Houston State University-affiliated community clinic in Huntsville, Texas, providing forensic evaluations for 16 surrounding suburban and rural counties. Texas requires CST evaluation reports be completed "not later than the 30th day after the date on which the expert was ordered to examine the defendant and prepare the report" (Texas Code of Criminal Procedure, Art. 46B.026 [a], 2004). Texas is a useful setting for studying the effect of CST evaluation timing because the 30 day deadline allows for a relatively wide time-frame for evaluations (1 to 30 days), while still being consistent with the national average deadline of 31 days (Gowensmith et al., 2015).

The primary study question is whether there is an association between CST evaluation outcomes and the amount of time elapsed between the CST evaluation court order and CST evaluation date. I expect a negative association between time and opinions of competence, such that shorter time from CST evaluation court order to evaluation will

be associated with higher rates of incompetency opinions (i.e., as time decreases, the likelihood of an opinion of incompetence increases). Such a finding would be consistent with preliminary findings from Washington, Maryland, and Hawaii suggesting that shorter time between a court order and a CST evaluation could inflate rates of incompetency opinions. Clinical judgment and anecdotal reports from these states also suggest that shorter times do not allow time for the potential effects of substances, acute symptoms, and/or distress to decrease, or the effects of psychotropic medications to increase.

There may also be an increase in opinions of incompetency after too much time between CST court order and evaluation, as illustrated in the *Trueblood* litigation where defendants with mental illness decompensated and became suicidal while waiting long periods in jail. If untreated, individuals with mental illness symptoms related to incompetency (e.g., psychotic symptoms) may become worse in the nontherapeutic environment of jail, particularly if the individual is isolated from others. In other words, the association between evaluation timing and incompetency to stand trial (IST) rates may be curvilinear, with higher IST rates for evaluations conducted very quickly or after a long delay.

If I do find an association between evaluation timing and evaluator opinions, it will be important to consider whether other factors known to be associated with CST evaluator opinions can explain the timing effect, or whether the timing effect is similar across all cases. Across CST evaluation studies, the strongest correlates of incompetency are psychotic diagnosis and psychiatric symptoms reflecting severe psychopathology (disorientation, delusions, hallucinations, impaired memory, and disturbed behavior;

Nicholson & Kugler, 1991). Meta-analytic findings from CST research have revealed the odds of being found incompetent are approximately eight times higher for defendants with a psychotic disorder than those without one (Pirelli, Gottdiener, & Zapf, 2011a). Although regularly included as a diagnostic category with a potential effect on competency, substance use disorders do typically not predict CST evaluation outcomes, even when analyzed by substance type (e.g., alcohol versus drug use; Nicholson & Kruger, 1991; Pirelli et al., 2011a; Hart & Hare, 1992; Warren et al., 2006). One study found a small effect of alcohol and drug use decreasing the likelihood of being opined incompetent (Cooper & Zapf, 2003). This general lack of an association between substance use and CST opinions could be due to the high rates of substance use among both competent and incompetent defendants, as well as the comorbidity and often 'secondary' diagnostic designation for substance use disorders comorbid with psychotic or mood disorders. If there is an effect for substance use, it may be especially dependent on time, potentially not emerging in CST research that does not include time as a predictor. Time may play a role in revealing as association between substance use and competency opinions that declines over time.

Other notable predictors of CST evaluation outcomes include employment status and previous psychiatric hospitalization history; the odds of being opined incompetent are over two times higher for defendants who are unemployed and have a psychiatric hospitalization history, versus employed defendants and those without a psychiatric hospitalization history (Pirelli et al., 2011a). Meta-analyses have also revealed small, but consistent associations for demographic variables (ethnicity, sex, marital status) and psycholegal/criminal variables (competency evaluation history, previous legal

involvement, current criminal charge; Pirelli et al., 2011a). Lastly, there is some evidence that other 'process' oriented factors are associated with CST evaluation outcomes, such as evaluator discipline (psychiatrist versus psychologist), setting (inpatient versus outpatient), referral source, use of records, as well as continued research on clinical factors of age, other diagnoses (intellectual disability, organic disorder, learning disorder, affective disorders), and compliance with medication (Fogel, Schiffman, Mumley, Tillbrook, & Grisso, 2013; Murrie et al., 2008; Warren et al., 2006; Warren, Chauhan, Kois, Dibble, & Knighton, 2013).

While all the above factors may be associated with CST evaluation outcomes, the present study focuses on the more dynamic variables or characteristics that may be most likely to interact with evaluation timing to help explain evaluator opinions. In particular, psychiatric diagnosis, medication status, and substance use disorder may play a salient role in explaining the relationship between time to CST evaluation and evaluation outcome. Time may be more strongly associated with opinions for defendants diagnosed with a psychotic or bipolar disorder because of psychotic and/or manic symptom's dynamic effect on a defendant's thought processes (e.g., disorganization, delusions, hallucinations), symptoms that are difficult to effectively treat and often take longer to stabilize on psychotropic medication. The effect of time on CST evaluation outcomes may also depend on whether the defendant has been prescribed and is compliant with psychotropic medication. Evaluating an acutely psychotic individual too close to the time of their arrest (and court order for CST evaluation) may not allow enough time for prescribed medications to take effect and symptoms to decrease. Too much time from court order for CST evaluation to evaluation without any prescribed medication could

lead to decompensation, increasing the severity of symptoms and potential incompetency of the defendant. Similarly with substance use disorders, individuals evaluated too close the initial CST court order may still be under the influence of drugs; short times to CST evaluations may matter more for defendants with substance use disorders than those without.

CHAPTER II

General Method

We collected data from archived CST reports available from two settings for two studies: (Study 1) the Harris County Public Defender's Office (HCPDO) a large, urban county containing the city of Houston, and (Study 2) a Sam Houston State University-affiliated community clinic in Huntsville, Texas, the Psychological Services Center (PSC), serving the surrounding suburban and rural counties. Reports from the HCPDO were part of a larger IRB-approved study regarding forensic evaluation report quality (Laxton, 2017). For Study 2, I obtained permission from the community clinic director to access the PSC archived reports, as well as IRB approval.

All reports were adult assessments of competency to stand trial, or joint competency and sanity evaluations, ordered by the court and performed by court-appointed evaluators working in state mental health agencies, community outpatient clinics, hospitals, or private practice. Study 1 reports were for defendants with misdemeanor changes, as these were the only type of reports available from the public defender's office; Study 2 reports were for defendants with misdemeanor or felony charges. Both studies used data from only initial evaluations of competency in order to most precisely track the time from a court order for competency to first competency evaluation. The number of days between the court order and first, or initial competency evaluation represents time that the defendant waited, either in jail or in the community, to proceed with their case following a question of their competence to stand trial. The amount of time that elapses between the initial court order and subsequent evaluations is

a separate issue, relating to fewer defendants (i.e., usually only those found incompetent), access to treatment, and treatment effectiveness.

For both studies, the same six clinical psychology doctoral students (including the author) completed the same training and coding protocol. Prior to the beginning of Study 1, all coders coded two reports, one as a group and one independently. The group discussed each report to identify any sources of error, disagreement, or misunderstanding. The coders then coded two sets of five reports independently and met to discuss coding discrepancies for these reports. Lastly, coders completed a final round of independent coding of seven randomly-selected reports to establish interrater reliability. In total, 19 reports were used for this reliability check. Overall, interrater reliability was excellent across all variables (*M* percent agreement = 92.31%; *M* multirater $\kappa_{free} = 0.87$). Following reliability testing, all reports were coded by a single rater.

CHAPTER III

Study 1 Method

Sample

Study 1 is based on information from competency reports for 244 misdemeanants represented by the Harris County Public Defender's Office (HCPDO). These defendants were part of a larger group of 352 misdemeanor defendants included in an earlier study (Laxton, 2017) who had been randomly selected from a pool of approximately 1,500 defendants. I excluded data for 102 defendants because their reports were for re-evaluations of competency, following a period of hospitalization for competency restoration or extended time. I also excluded data for six defendants because the court order was missing or undated. In the final sample, one report was a joint competency and sanity evaluation, all other evaluations were for competency only.

All competency reports from the public defender's office were for defendants charged in Harris County, Texas between 2010 and 2016. Twenty-eight different evaluators conducted the evaluations; they came from 10 different agencies/private practices and had varied credentials and training (n = 27 psychologists, n = 1 psychiatrist). All defendants were charged with one or more misdemeanor offenses and were represented by an appointed public defender.

Table 1 provides demographic and background characteristics for Study 1 defendants.

Table 1

Study 1 Defendant Characteristics

Variable	*n* (percent)
Defendant Age	*M* = 38.09 (*SD* = 13.37)
Defendant Race/Ethnicity	
White/Caucasian	67 (27.5%)
Black/African American	130 (53.3%)
Hispanic/Latino/a	34 (13.9%)
Asian/Asian American	9 (3.7%)
Other	4 (1.6%)
Not mentioned	0
Defendant Gender	
Male	198 (81.1%)
Female	46 (18.9%)
Level of Education	
Did not graduate high school	64 (26.2%)
High school graduate	45 (18.4%)
Some college	41(16.8%)

(continued)

Variable	*n* (percent)
Bachelor's degree	9 (3.7%)
Graduate degree	4 (1.6%)
Not mentioned	81 (33.2%)
Employment Status	
Unemployed	72 (29.5%)
Employed	29 (11.9%)
Not mentioned	143 (58.6%)

Measures

Coders recorded information about four general types of variables: time, evaluator opinion, evaluation characteristics, and defendant characteristics.

Time. Coders collected the following dates to establish a timeline of the defendants' incarceration: date(s) of current offense, date of arrest, date entered jail, date transferred to another location (if hospitalized or released on bond). Dates regarding competency proceedings included the date of the motion and order to examine competency, date of the CST evaluation, and date of the CST report. We used collateral documents in the defendant's file and county electronic records to confirm dates of arrest, incarceration, and dates of court motions and orders cited in reports. I measured time to

evaluation by calculating the number of days between the date of the court order and the date of the evaluation.

Evaluator opinion. There were three recording options for the evaluator's competency opinion: competent, incompetent, or no opinion.

Evaluation characteristics. The location of the evaluation was either jail or other correctional facility, inpatient secure facility, non-secure outpatient setting, or other (with specifier). Evaluators had conducted most of the evaluations in jail (n = 235, 96.3%), with fewer conducted in an outpatient setting (n = 7, 2.9%), and none in an inpatient setting. Two reports (0.8%) did not indicate the location of the evaluation.

Defendant characteristics. Coders collected information about defendant characteristics from the evaluators' reports. Even if the information was available from other sources (e.g., police or hospital records), information on defendant characteristics came from the report only.

Legal history. Coders recorded prior arrests, convictions, or any indication of involvement with the justice system in the CST report, as an adult or juvenile, as indication of legal history, for a dichotomous variable (no indication of prior legal history or indication of prior legal history). Evaluators reported that a majority of the defendants had a prior legal history (n = 150, 61.5%), while for more than a quarter there was no mention of the defendant's legal history (n = 67, 27.5%). Defendants without any history of legal involvement were uncommon (n = 27, 11.1%).

Offense. The current offense(s) was the name of each misdemeanor charge as stated in the report. I later categorized offenses categorized as either violent (e.g., assault, terroristic threat), property (e.g., theft, burglary), or miscellaneous (e.g., possession of

marijuana, trespassing). Violent offenses were operationalized as any offenses that included actual, potential, or threated physical harm, and included sex offenses (Nicholson & Kugler, 1991). If multiple offenses were present, I categorized by the most serious. These categories were based on past competency to stand trial evaluation research on variables associated with competency opinions (Cooper & Zapf, 2003; Hubbard & Zapf, 2003; Hubbard, Zapf, & Ronan, 2003; Schreiber, Green, Kunz, Belfi, & Pequeno, 2015; Viljoen & Zapf, 2002) and clinical utility.

Most defendants were charged with a miscellaneous offense (n = 158, 64.8%), followed by a quarter who were charged with a violent offense (n = 63, 25.8%). Property offenses were uncommon common charges for defendants (n = 23, 9.4%). Due to the small number of property offenses, I later collapsed the offense variable into non-violent (combining miscellaneous and property offenses, n = 181, 74.2%) and violent (n = 63, 25.8%) offenses.

Psychiatric diagnosis. Coders recorded all psychiatric diagnosis(es) given by the CST evaluator categorically according to the most common Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association [APA], 2013) diagnostic categories. Anxiety disorders and obsessive-compulsive and related disorders were one category. Coding used an 'other' category for less commonly assigned disorder categories, such as gender dysphoria or paraphilic disorders. Diagnoses were not mutually exclusive; defendants with multiple diagnoses were coded in multiple categories. Other areas for clinical consideration (e.g., V codes) and diagnostic specifiers (such as provision, rule-out, or by history) were not recorded. Psychiatric diagnoses of defendants can be seen in Table 2.

Psychiatric history. Psychiatric history assessed if and how often a defendant had been hospitalized for a psychiatric disorder (0 = no indication of any prior psychiatric hospitalizations, 1 = indication of prior psychiatric hospitalizations). If a defendant had been hospitalized, coders indicated the estimated number of past hospitalizations as a continuous variable. Defendants psychiatric history is detailed in Table 2.

Competency history. Similarly to psychiatric history, any history of prior CST evaluation (for a separate charge) at the time of the present CST evaluation was a dichotomous variable (0 = no indication of any prior CST evaluation, 1 = indication of prior CST evaluation). If a defendant had a history of prior CST evaluation, coders recorded the estimated total number of past CST evaluations. For these variables, it was possible for coders to use collateral information or electronic records to confirm defendant competency evaluation history. Table 2 displays defendant competency history.

Current medications. Coders recorded whether the defendant was prescribed any psychotropic medication at the time of the CST evaluation as a dichotomous variable (0 = not prescribed psychotropic medication, 1= prescribed psychotropic medication). Table 2 reports defendants medication status at the time of the evaluation.

Table 2

Study 1 Defendant Psychiatric Characteristics

Variable	*n* (percent)
Diagnosis	
No diagnosis	2 (0.8%)
Neurodevelopmental disorders	27 (11.1%)
Schizophrenia spectrum and other psychotic disorders	182 (74.6%)
Bipolar and related disorders	45 (18.4%)
Depressive disorders	19 (7.8%)
Anxiety and obsessive-compulsive and related disorders	5 (2%)
Trauma- and stressor-related disorders	10 (4.1%)
Disruptive, impulse-control, and conduct disorders	1 (0.4%)
Substance-related disorders	137 (56.1%)
Neurocognitive disorders	14 (5.7%)
Personality disorders	38 (15.6%)
Other	17 (7%)
Psychiatric History	
No prior psychiatric hospitalization	42 (17.2%)

(continued)

Variable	*n* (percent)
Prior psychiatric hospitalization(s)	157 (64.3%)
Not mentioned	45 (18.4%)
Competency History	
No prior CST evaluations	200 (82%)
Prior CST evaluations	42 (17.2%)
Unknown	3 (0.8%)
Medication	
Not prescribed medication	71 (29.1%)
Prescribed medication	169 (69.3%)
Not mentioned	4 (1.6%)

Procedure

The research team coded all CST reports at HCPDO. We included one CST report per defendant. If a defendant was evaluated multiple times for one charge (i.e., re-evaluated after transfer to a hospital for competency restoration), coders selected the oldest or initial CST evaluation. Coding the oldest CST evaluation allowed for more reports within the 30-day range from court order to evaluation and more accurate recording of these dates. Further, these evaluations were more likely to be performed in

jail and to identify more incompetent defendants (those who had not undergone competency restoration).

CHAPTER IV

Study 1 Results

Evaluators opined 160 (65.6%) of the defendants were incompetent to stand trial and 84 (34.4%) were competent. No reports contained a designation of 'no opinion' for a defendant's competence. Time from court order to competency evaluation ranged from zero days to 139 days, with a median of 29 days. The average length of time from court order to evaluation was 32.81 days (*SD* = 17.87). The mean number of days between order and evaluation was 32.03 days (*SD* = 16.66) for those opined incompetent, and 34.31 days (*SD* = 19.99) for those opined competent, t (241) = 0.97, p = .33, Cohen's d = .13.

Association Between Evaluation Timing and Evaluator Opinions

Figures 1 and 2 provide a depiction of incompetency rates over time, for both the entire sample and SMI defendants only respectively. Overall, the figures show a general trend of decreasing rates of incompetency opinions over time from evaluations completed within the initial two-week period after the court order to those completed within the seventh week after the court order. The rate of incompetency opinions then increases for evaluations conducted after the seventh week, although there were relatively few evaluations conducted this long after the court order (n = 20, 8.2%). This pattern is especially clear among those diagnosed with an SMI (see Figure 2).

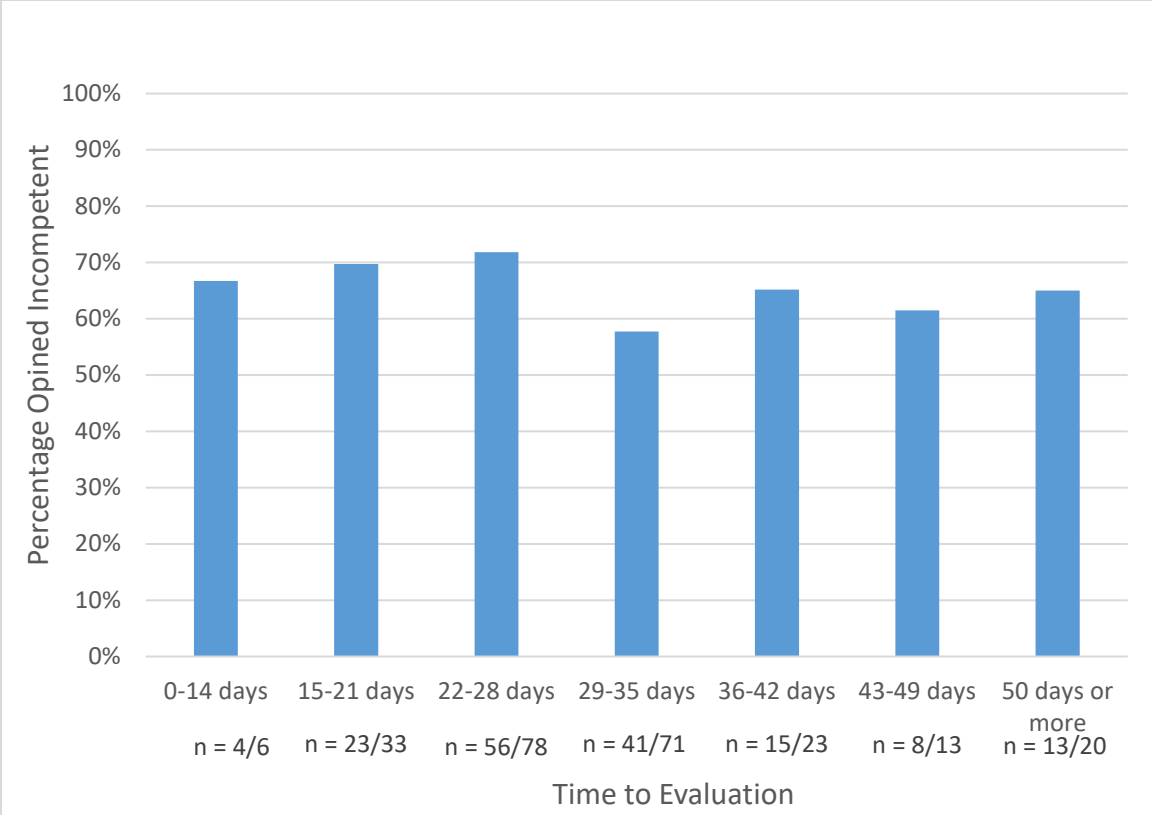

Figure 1. Study 1 Incompetency Opinion Rates by Time to Evaluation Group.

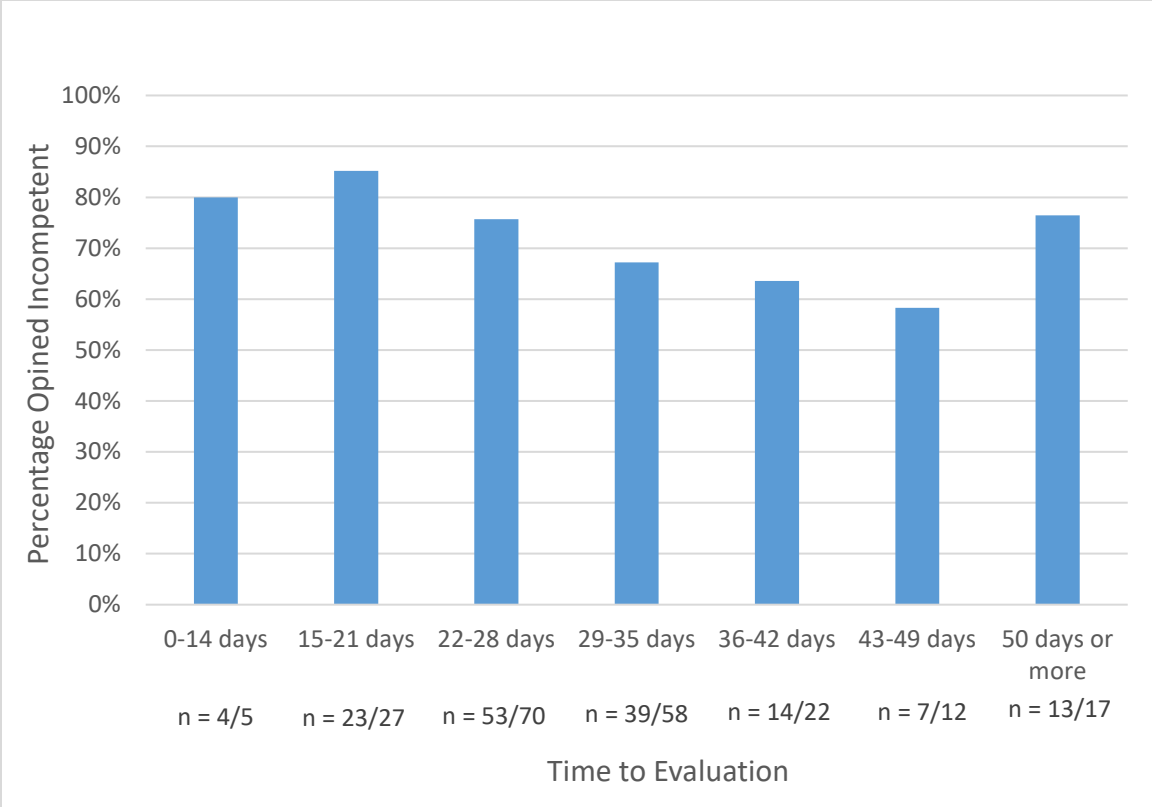

Figure 2. Study 1 SMI-Defendant Incompetency Opinion Rates by Time to Evaluation Group.

To examine the potential impact of evaluation date requirements on CST/IST rates, I sorted each case into one of two groups, based on values of less than or equal to 5 days, 7 days, 10 days, 15 days, 30 days, 60 days, or 90 days from court order to evaluation. These time deadlines correspond with meaningful evaluation deadlines in Texas and other states. I used all defendants in each analysis. For example, a defendant evaluated at 12 days would be included as being evaluated after the deadline for the 5, 7, and 10 day groupings, but as before the deadline for the 15, 30, 60, and 90 day deadlines. One evaluation was conducted within the 5, 7, and 10 day deadlines. Seven (2.9%) evaluations had been conducted within 15 days, 143 (58.6%) evaluations were conducted within 30 days, and 233 (100%) evaluations were conducted within 60 days. Most

evaluations were conducted within 90 days (n = 238, 97.5%), with only six evaluations being conducted after 91 days.

I used chi-square analyses and odds ratios to examine the association between evaluation timing and evaluator opinions for each of the common statute defined date grouping (see Table 3). An odds ratio greater than 1.00 would indicate that evaluations conducted *after* the defined date were more likely to result in an evaluator opinion of competent than those conducted before the defined date. Or, in terms of incompetence, an odds ratio greater than 1.00 would indicate that those evaluated *before* the defined date would be more likely to result in an evaluator opinion of incompetent compared to those conducted after the defined date.

The results from these odds ratio analyses indicated that there was no pattern of a statistically significant association between time to evaluation and competency opinions using any of these number of day groupings. That is, there was no evidence those defendants evaluated earlier were more likely to be deemed IST, or that those evaluated later were more likely to be opined competent. Within the entire sample, the rate of IST opinions fell between 100 to 50 percent for most time to evaluation groupings (e.g., the lowest IST rate was 50% of evaluations conducted in 91 or more days, the highest IST rate was 100% of evaluations conducted in 5, 7, or 10 days or less).

I also used a series of logistic regression analyses to provide a more fine-grained examination of the association between time and evaluator opinions. I screened the days variable for outliers prior to conducting the regression analyses. The distribution of days did not conform to a normal distribution, displaying a significant positive skew (Skewness = 3.48, SE = 0.16). An analysis examining the possibility of time to evaluation

outliers indicated 18 evaluations should be excluded from the sample as outliers. For these 18 cases, the distance from the boundary of a box plot based on the time to evaluation variable was more than 1.5 times the size of the interquartile range (i.e., distance from the 25th to the 75th percentile). These outlying evaluations included those completed in zero days (n = 1) and those completed in 52 or more days (n = 17). The rate of incompetency (n = 12, 66.7%) versus competency (n = 6, 33.3%) opinions in the outliers did not meaningfully differ from the overall sample. Exclusion of the 18 outliers resulted in a sample of 226 reports.

With the outliers excluded, evaluators opined 148 (65.5%) defendants incompetent to stand trial, and 78 (34.5%) defendants as competent. Time from court order to competency evaluation ranged from 11 to 51 days, with a median of 28 days. The distribution of days was still slightly positively skewed (Skewness = 0.47, *SE* = 0.16), but the skewness was notably reduced compared to the original sample (Skewness = 3.48). The average length of time from court order to evaluation was 29.19 days (*SD* = 7.98). The average length of time between order and evaluation was 28.82 days (*SD* = 8.08) for those opined incompetent, and 29.90 days (*SD* = 7.81) for those opined competent, t (224) = 0.97, p = .34, Cohen's d = .14.

I used logistic regression models to examine whether there was any evidence of an overall effect of time (number of days) on competency opinions (0 = incompetent, 1 = competent) and a possible curvilinear relationship. I centered the time to evaluation variable and created new variables that were the squared and cubed value of this centered variable to use in the regression models. The first model included the centered days variable as the predictor of evaluator opinions. The second model included both the

centered days variable and the squared value of the centered days variable to examine the possibility of a curve with one inflection point. The third model included the centered days variable, the squared days variable, and a cubed days variable to examine whether there was any evidence of a curve with two inflection points.

Findings from these regression models indicated that there was no overall association between time to evaluation and evaluator opinions. In model 1, time did not predict competency opinions (b = 0.02, SE = 0.02, p = .33, OR = 1.02 [0.98 – 1.05]). Model 2 found no evidence of a curvilinear effect of time on competency opinions (b = -0.001, SE = 0.002, p = .48, OR = 1.00 [1.00 – 1.002]). Finally, model 3 did not support a curvilinear relationship with two inflection points between time and competency opinions (b < .001, SE < .001, p = .55, OR = 1.00 [1.00 – 1.00])

Possible Moderators of the Association Between Evaluation Timing and Evaluator Opinions

I also used logistic regression analyses to examine whether the association between time and competency opinions might depend on defendant characteristics. These characteristics included a) serious mental illness, i.e., schizophrenia spectrum and other psychotic disorder diagnosis or bipolar related disorder, b) substance-related disorder diagnosis, and c) prescription of psychotropic medication. These variables were selected as being the most closely related to potential time of the evaluation, as they are often related to an individual's mental status.

I included three variables in each regression model: time (centered), the moderator variable of interest (diagnosis, medication status), and an interaction term (centered time multiplied by the moderator variable). In each of these models, I used the

subgroup that had the characteristic of interest (e.g., has diagnosis, is prescribed medication) as the reference group for the categorical defendant characteristic variable. The primary advantage of this coding approach for the categorical moderators is that the simple effect for time in the full model will represent the effect for time in the reference group (e.g., the effect for time among those with the diagnosis or prescribed medication), which is of particular interest in this study. One byproduct of this coding approach is that the simple effect for the categorical variable will represent the effect for not having the characteristic of interest (e.g., no diagnosis, not prescribed medication). A statistically significant interaction term would indicate that the association between time and evaluator opinion depends on the moderator variable.

Inspection of defendant characteristics indicated that few defendants had no SMI diagnosis (n = 31, 13.7%) and that these defendants were much more likely to be opined competent (77.4%) than defendants diagnosed with an SMI (n = 54 of 195, 27.7%), a very large (OR = 8.95, 95% CI [3.65, 21.99]) and statistically significant difference ($p <$ .001). I decided to remove these non-SMI defendants from the moderator analyses for two related reasons. First, these non-SMI defendants were uncommon in the sample and there were simply not enough of them to make clear comparisons with SMI defendants. Second, analyses with interactions for some characteristics would be difficult to interpret due to sparseness (e.g., too few defendants in some study cells), which would lead to unstable regression estimates and very large confidence intervals (Cohen, Cohen, West, & Aiken, 2003). Therefore, these logistic regression analyses reported below apply to defendants diagnosed with SMI.

Table 4 provides the logistic regression analyses results. Among defendants with SMI, the relationship between time and competency opinions approached significance (p = .07) in the hypothesized direction. For defendants with SMI, the odds of being opined competent increased as the number of days increased. Specifically, the odds of being opined competent increased by 1.04 for each additional day between order and evaluation, which translates to the odds of being opined competent increasing by 1.32 for each additional week between order and evaluation and 1.75 for each two week period between order and evaluation.

I conducted separate analyses of the association between time and evaluator opinions using only those diagnosed with a psychotic disorder (n = 172) and then only those diagnosed with bipolar disorder (n = 38). The goal of these analyses was to determine whether this effect for time applied to both of diagnostic categories used to define defendants as SMI. Although the effect for time was similar in size for both diagnosis subgroups (b = 0.04, OR = 1.02 to 1.04), sample size differences led to the effect approaching statistical significance among the larger subgroup of those diagnosed with a psychotic disorder (b = 0.04, SE = 0.02, p = .06, OR = 1.04 [1.00 – 1.09]) but not approaching significance for those diagnosed with bipolar affective disorder (b = 0.04, SE = 0.05, p = .43, OR = 1.02 [0.94 – 1.15]).

There was no evidence of an interaction effect for prescription of psychotropic medication. There was, however, a significance simple effect for time among SMI defendants who had been prescribed medication (p = .02). Among those prescribed psychotropic medication, the odds of being opined competent increased by 1.06 for each additional day between order and evaluation. This translates to the odds of being opined

competent increasing by 1.52 for each additional week between order and evaluation and 2.32 for each two week period between order and evaluation. To help put these findings in context, SMI defendants prescribed medication and evaluated in 16 to 30 days (n = 85) had a competency rate of 22.4%. SMI defendants prescribed medication and evaluated in 31 or more days (n = 56) had a competency rate of 35.7%.

There was also no evidence of an interaction effect for substance use diagnoses, but there was a simple effect of substance use diagnoses. Specifically, SMI defendants without a substance use diagnosis were less likely to be opined competent (17.4%) than SMI defendants with a substance use diagnosis (35.8%; OR = .39, p = .008).

Table 3

Study 1 Association between Time and Evaluator Opinions using Common Evaluation Deadlines

	Eval. completed within time period				Eval. completed after time period					
	Incompetent		Competent		Incompetent		Competent			
Time between order and eval.	*n*	%	*n*	%	*n*	%	*n*	%	Chi-square	OR
5 days	1	100%	0	0%	159	65.4%	84	34.6%	0.53	
7 days	1	100%	0	0%	159	65.4%	84	34.6%	0.53	
10 days	1	100%	0	0%	159	65.4%	84	34.6%	0.53	
15 days	5	71.4%	2	28.6%	155	65.4%	82	34.6%	0.11	1.32 [0.25, 6.97]
30 days	98	68.5%	45	31.5%	62	61.4%	39	38.6%	1.34	1.37 [0.80, 2.34]
60 days	153	65.7%	80	34.3%	7	63.6%	4	36.4%	0.02	1.09 [0.31, 3.85]
90 days	157	66%	81	34.0%	3	50.0%	3	50%	0.66	1.94 [0.38, 9.82]

Note. Percentages of incompetent and competent evaluations were calculated as percentages of evaluations within each time frame group, therefore, percent incompetent and competent should equal 100 percent of evaluations within that time group.

Table 4

Study 1 Summary of Logistic Regression Models Examining the Time by Defendant Characteristics Interaction for Predicting Competnecy to Stand Trial Opinions in Defendants with SMI

Predictors	*b*	*SE*	*Exp(b)*	*95% CI*	*p*
Severe Mental Illness					
Time	0.04^	0.02	1.04	1.00 – 1.08	.07
Substance-related disorder diagnosis					
Time	0.03	0.03	1.03	0.97 – 1.08	.33
No substance-related disorder	-0.93**	0.35	0.39	0.18 – 0.78	.008
Time*No substance-related disorder	0.01	0.04	1.02	0.93 – 1.10	.73
Prescription of psychotropic medication					
Time	0.06*	0.03	1.06	1.01 – 1.11	.02
Not prescribed medication	0.06	0.37	1.06	0.51 – 2.18	.88
Time*not prescribed medication	-0.07	0.05	0.94	0.86 – 1.02	.13

Note. This table presents the final model for each defendant characteristic variable, with each predictor and the interaction term in the model. $n = 195$. CI = Confidence Interval. *$p < 0.05$, **$p \leq 0.01$. ^$p < .10$ for effect in the hypothesized direction.

CHAPTER V

Study 1 Discussion

Overall, the Study 1 findings showed a high rate of incompetency opinions (> 60%) and no overall association between time and evaluator opinion. However, the association between time and evaluator opinion among defendants with SMI approached significance. Among SMI defendants, the odds of being opined competent increased by 1.32 for each additional week between order and evaluation and 1.75 for each two week period between order and evaluation. In other words, as expected, the odds of being opined competent increased as the time between the order and evaluation increased. Time was more clearly associated with opinions among those with SMI who had been prescribed psychotropic medication, with the odds of these defendants being opined competent increasing by 1.52 for each additional week between order and evaluation.

The association between increased time and increased likelihood of competency opinions among defendants with SMI who had been prescribed medication seems logical, as increased time from court order to evaluation allows more time medication to affect an individual's mental status, rational decision-making, and resulting competence-related abilities. As time from court order increases, defendants may also be increasingly adjusting to what was initially a distressing legal situation which may have increased their acuity (e.g., initial arrest, court hearing, learning of their charges, and meeting with their attorney).

I found that defendants with a substance abuse diagnosis were more likely to be opined competent than those without a substance abuse diagnosis, but there was no evidence of time to evaluation affecting this association. This substance use disorder

finding diverges from existing competency to stand trial research, which has found that substance use disorders are not associated with CST opinions (Nicholson & Kruger, 1991; Pirelli et al., 2011a; Hart & Hare, 1992; Warren et al., 2006). It is possible that the presence of a substance use disorder comorbid with severe mental illness, particularly if the individual was acutely intoxicated, clouds the picture of any competence-related deficits. Evaluators may be less likely to opine a defendant with SMI, but without a substance use diagnosis, competent as there is little question that any competence-related deficits are due to SMI symptoms rather than substance use.

A notable aspect of the Study 1 sample was that more than 60% of all defendants were opined incompetent to stand trial. This is nearly double the rate of incompetency opinions found in national samples, which is typically around 20 to 30 percent of defendants (Stafford & Sellbom, 2013). This high incompetency rate may be due to the sample including only defendants charged with misdemeanor offenses, who tend to have higher IST rates (Warren et al., 2006; Stafford and Sellbom, 2013). It is possible that only the most acutely ill defendants with a misdemeanor charge are referred for a competency evaluation, as most of these charges can be resolved or dismissed quickly and without a trial. That is, potentially the threshold for a CST evaluation referral is higher for a misdemeanor offense, with only the most impaired defendants being referred.

Study 1 was a sample with both strengths and limitations. The sample was diverse with respect to age, sex, and ethnicity, and represented defendants from a large, urban area. We used county electronic records to confirm dates of court motions and orders, verifying the accuracy of the time to evaluation variable. The sample was comprised almost entirely of defendants with severe mental illness charged with misdemeanor

offenses, and the sample allowed us to best examine the issue of timing among this particular subgroup of defendants (misdemeanants with SMI).

The absence of felony case defendants and the focus on cases from one geographical area raise questions about the generalizability of these results to other samples of CST evaluations. Often these misdemeanor offenses appeared related to the defendant's lack of housing and/or mental illness, such as trespassing, indecent exposure, or resisting arrest. Resources and policies specific to the area, such as treatment and housing availability may have led to this sample differing from other CST evaluation samples. Over 70 percent of individuals in this sample had a psychotic disorder diagnosis and over half had one or more prior psychiatric hospitalizations. It makes sense that this high rate of severe mental illness would be associated with a relatively high rate of incompetency. An arrest for a relatively minor misdemeanor and subsequent incompetency opinion and finding may have served as a mechanism for providing the individual with mental health services they would otherwise not receive.

Overall, Study 1 allowed me to most clearly examine the association between evaluation timing and evaluator opinions among misdemeanants with severe mental illness. Defendants charged with misdemeanors may be unique and valuable for their higher representation of severe mental illness and potential higher likelihood of being opined incompetent. In addition, most CST evaluations are ordered for defendants charged with misdemeanors (Gowensmith, Murrie, & Boccaccini, 2012). However, the extent to which our findings may generalize to a sample with more diversity in alleged offenses and psychopathology is unclear.

A larger and more diverse sample of CST evaluation reports is needed to further investigate the potential association between evaluation timing and evaluator opinion. A larger sample that includes felony case defendants would likely include more diversity in defendants and more reports conducted in short time frames (less than 15 days), allowing for more powerful analyses. Because of the unique characteristics of the Study 1 (e.g., all jail evaluations, all misdemeanants), I was not able to examine the possible effect of defendant custody status or offense type. The association between time and CST evaluation outcomes may be different among a larger sample of both felony and misdemeanor case defendants, with a lower base rate of severe mental illness and incompetency opinions.

CHAPTER VI

Study 2 Method

Sample

Study 2 is based on information from a sample of 959 competency reports archived and coded at the Psychological Services Center (PSC) clinic. Of these 959 reports, I excluded five reports due to not having a court order available in the file or having an undated court order. I excluded one report due to the court order being from civil court. In addition, I also excluded one report due to anachronous dates of evaluation and court order (i.e., evaluation date reported as before court order date) which could not be resolved with collateral information. I excluded CST reports indicating 'no opinion' on competency (n = 19). I excluded re-evaluations of competency for the same offense, following a period of hospitalization for competency restoration or extended time (n = 53). If a defendant had multiple CST reports for different charges, I included only the most recent, shortest time to evaluation (time for court order to evaluation) report and excluded the defendant's other CST reports (n = 63). This sample of competency reports, containing only initial evaluations of competency indicating an ultimate opinion of competency or incompetency, totaled 817 reports (for 817 defendants).

CST reports gathered from the PSC were from 16 different counties in Texas and conducted between 2000 and 2018. One clinical psychology doctoral student typically conducted the evaluation, supervised by one of four licensed clinical psychologists, one with a board certification in forensic psychology. The competency opinion is ultimately that of the supervisor. Defendants were charged with one or more misdemeanor and/or felony offenses and were represented by public or private defense attorneys. Evaluators

typically conducted CST evaluations in the outpatient community clinic (defendants transported from jail or defendants on bond) or in county jails (see below).

All reports contained the dates of evaluation and final report, description of the evaluation procedure, list of collateral information, current mental status of the defendant, psychosocial and psychiatric history, diagnoses, analysis of psycholegal abilities, competency opinion, and treatment recommendations. All reports had associated files containing copies of the court order for competency evaluation. However, reports differed in the amount and source of collateral information within the associated defendant file. Most defendant files contained at least the law enforcement offense report. Some contained past law enforcement records, psychiatric records, jail records, and/or referenced collateral interviews with relatives, jail staff, or mental health providers. The amount of psychosocial and psychiatric history in reports often depended not only on records or available collateral, but also on information provided by the defendant, particularly if no collateral was available. Table 5 provides demographic and background characteristics for Study 1 defendants.

Table 5

Study 2 Defendant Characteristics

Variable	*n* (percent)
Defendant Age	$M = 36.42$ ($SD = 13.89$)
Defendant Race/Ethnicity	
African American/Black	389 (47.6%)

(continued)

Variable	*n* (percent)
Caucasian/White	362 (44.3%)
Hispanic	57 (7%)
Biracial	5 (0.5%)
Native American	3 (0.4%)
Asian	2 (0.2%)
Defendant Gender	
Male	653 (79.9%)
Female	164 (20.1%)
Other	0
Level of Education	$M = 10.14$ ($SD = 2.69$)
Employment Status	
Unemployed	533 (65.2%)
Employed	129 (15.8%)
Unknown	155 (19%)
Marital Status	
Unmarried	593 (72.6%)

(continued)

Variable	*n* (percent)
Married	108 (13.2%)
Unknown	116 (14.2%)

Measures

Coders recorded information about four general types of variables: time, evaluator opinion, evaluation characteristics, and defendant characteristics.

Time. Coders collected the following dates to establish a timeline of the defendants' incarceration: date(s) of current offense, date of arrest, date entered jail, date transferred to another location (if hospitalized or released on bond). Dates regarding competency proceedings included the dates of the motion and order to examine competency, the date of the CST evaluation, and date of the final report. I measured time to evaluation by calculating the number of days between the date of the court order and the date of the evaluation.

Evaluator opinion. There were three recording options for the evaluator's competency opinion: competent, incompetent, or no opinion. I excluded CST reports indicating 'no opinion' on competency (n = 19).

Evaluation characteristics. Reports were either evaluations of competency alone (n = 642, 78.6%) or evaluations of competency and sanity (n = 175, 21.4%). Coders recorded the county where the defendant was charged (e.g., Brazos, Harris, Walker) and categorically coded the location of evaluation (jail, outpatient clinic, prison, inpatient

hospital, attorney office/court, other treatment center [e.g., nursing home, group home]). As defendants evaluated at the outpatient clinic were not necessarily in the community (they could be transported from jail to the outpatient clinic), I added a variable to distinguish defendants still in custody (held in jail, assessed there or at the outpatient clinic) or out on bond at the time of the evaluation. Table 6 summarizes offense county, location, and custody evaluation characteristics.

Table 6

Study 2 Evaluation Characteristics

Variable	*n* (percent)
County of offense	
Brazos	195 (23.9%)
Walker	136 (16.6%)
Waller	87 (10.6%)
Houston	75 (9.2%)
Anderson	67 (8.2%)
Grimes	64 (7.8%)
Polk	64 (7.8%)
Leon	29 (3.5%)
Madison	28 (3.4%)

(continued)

Variable	*n* (percent)
Montgomery	24 (2.9%)
San Jacinto	24 (2.9%)
Angelina	14 (1.7%)
Trinity	4 (0.5%)
Limestone	3 (0.4%)
Robertson	2 (0.2%)
Jefferson	1 (0.1%)
Location of Evaluation	
Jail	472 (57.8%)
Outpatient clinic	323 (39.5%)
Prison	8 (1.0%)
Inpatient hospital	2 (0.2%)
Attorney's office or court	10 (1.2%)
Other treatment center	2 (0.2%)
Custody Status	
In jail	592 (72.5%)

(continued)

Variable	*n* (percent)
Out on bond	224 (27.4%)
Unknown	1 (0.1%)

Defendant characteristics. We coded data on defendant characteristics to be consistent with the guidelines set out by Pirelli, Zapf, and Gottdiener (2011b). They recommend coding of defendant age, ethnicity, sex, level of education, employment status, marital status, psychiatric diagnosis, psychiatric history, competency history, and legal history. When possible, coders recorded data verbatim and I categorized data later for analysis (per recommendations of Pirelli, Zapf, & Gottdiener, 2011b). Table 7 provides information about defendant characteristics within the sample.

Legal history. Coders recorded prior arrests, convictions, or any indication of involvement with the justice system in the CST report, as an adult or juvenile, as indication of a legal history, for a dichotomous variable (no indication of prior legal history or indication of prior legal history). A majority of defendants had a prior legal history (n = 624, 76.4%). The remainder of defendants had no prior legal history (n = 64, 7.8%) or an unknown legal history (n = 129, 15.8%).

Offense. In coding for the current offense or offenses, coders recorded the name of each charge as stated in the report and record. I then categorized offenses into violent, property, and miscellaneous offenses based on past research and clinical utility. Approximately half of defendants were charged with a violent offense (n = 432, 52.9%),

followed by miscellaneous offenses (*n* = 271, 33.2%) and property offenses (*n* = 114, 14%).

Psychiatric diagnosis. Coders transcribed the psychiatric diagnosis(es) given by the CST evaluator exactly as delineated in the CST report. Designations such as 'by history,' 'rule-out,' or 'provisional' for any diagnosis were included as indicating the presence of the diagnosis. Other conditions that may be a focus of clinical attention (v-codes) were also recorded as written. I then combined defendants into diagnostic groups by their primary (i.e., most serious and first listed) diagnosis. Therefore, defendants were only coded in one diagnostic category; diagnoses were mutually exclusive. Diagnostic groups used in a past meta-analysis of CST research have included: psychotic disorder, personality disorder, substance use disorder, mood/affective disorder, or mental retardation (Pirelli et al., 2011a). Later studies on competency have also included designations for organic or neurocognitive disorders, combined mental retardation into a pervasive developmental disorder category with autism, and included an "other" category (Warren et al., 2013). Building on this research, I used diagnostic categories aligning with Pirelli and colleagues (2011a), separating mood/affective disorders into their DSM-5 (APA, 2013) categories of depressive disorders and bipolar and related disorders (including former DSM-IV mood disorder not otherwise specified). I also added categories corresponding with the DSM-5 diagnostic categories of neurodevelopment disorders (i.e., intellectual disability and attention-deficit hyperactivity disorder), anxiety and obsessive-compulsive disorders, trauma- and stressor-related disorders, disruptive, impulse-control, and conduct disorders, and neurocognitive disorders (APA, 2013). I categorized defendants identified as 'borderline intellectual functioning' (a V-code) with

neurodevelopmental disorders, as the V-code is often used when a careful assessment to differentiate it from intellectual disability is unable to be performed. For any primary diagnoses not falling into these categories, I created a classification of 'other diagnosis;' this category was composed generally of adjustment disorders and other mental disorders due to medical conditions.

To capture any substance involvement in the psychiatric diagnosis, I added a variable to identify defendants with a primary or comorbid substance use disorder. This included if the defendant had a "substance induced" primary disorder, such as substance-induced psychotic disorder. Table 7 summarizes defendant's psychiatric diagnoses.

Psychiatric history. Psychiatric history measured if and how often a defendant was hospitalized for a psychiatric condition (coded as either no indication of any prior psychiatric hospitalizations, or indication of any prior psychiatric hospitalizations). If a defendant had been hospitalized, coders recorded the number of past hospitalizations as a continuous variable, using the report and records to estimate as accurately as possible. Table 7 details defendant's psychiatric history.

Competency history. Similarl to psychiatric history, coders recorded any history of prior CST evaluation (for a separate charge) at the time of the present CST evaluation as a dichotomous variable (no indication of any prior CST evaluation, indication of prior CST evaluation). If a defendant had a history of prior CST evaluation, coders indicated the estimated total number of past CST evaluations, as well as the number of prior opinions of competency and incompetency. If the defendant had several CST evaluations within the community clinic file for separate charges, coders confirmed the number of

prior CST evaluations with the file; again, the number of prior CST evaluations is from the time of the present CST evaluation. Table 7 displays defendant competency history.

Current medications. First, coders recorded a dichotomous variable indicating whether the defendant was prescribed any psychotropic medication at the time of the evaluation (yes vs. no). If prescribed medication, the coder recorded all current medications as indicated in the CST evaluation. Coders also indicated the defendant's compliance with any prescribed medication (non-compliant with prescribed medication or compliant), based on information provided in the report (typically from the defendant's self-report) and/or records. Table 7 reports defendants medication status and compliance at the time of the evaluation.

Table 7

Study 2 Defendant Psychiatric Characteristics

Variable	*n* (percent)
Diagnosis	
No diagnosis or diagnosis deferred	37 (4.5%)
Neurodevelopmental disorders	47 (5.8%)
Schizophrenia spectrum and other psychotic disorders	235 (28.8%)
Bipolar and related disorder	110 (13.5%)
Depressive disorders	119 (14.6%)
Anxiety and/or obsessive-compulsive and related disorders	8 (1%)

(continued)

Variable	*n* (percent)
Trauma- and stressor-related disorders	9 (1.1%)
Disruptive, impulse-control, and conduct disorders	10 (1.2%)
Substance-related disorders	168 (20.6%)
Neurocognitive disorders	29 (3.5%)
Personality disorders	11 (1.3%)
Other	34 (4.2%)
Primary or Comorbid Substance Use Diagnosis	
No primary or comorbid substance use diagnosis	379 (46.4%)
Primary or comorbid substance use diagnosis	438 (53.6%)
Psychiatric History	
No prior psychiatric hospitalization	336 (41.1%)
Prior psychiatric hospitalization(s)	440 (53.9%)
Unknown	41 (5%)
Competency History	
No prior CST evaluations	224 (27.4%)
Prior CST evaluations	57 (7%)

(continued)

Variable	*n* (percent)
Unknown	536 (65.6%)
Legal History	
No prior legal history	64 (7.8%)
Prior legal history	624 (76.4%)
Unknown	129 (15.8%)
Medication	
Not prescribed medication	378 (46.3%)
Prescribed medication	420 (51.4%)
Unknown	19 (2.3%)
Medication Compliance	
Non-compliant with medications	73 (8.9%)
Compliant with medications	244 (29.9%)
Unknown compliance	103 (12.6%)

Procedure

The first author compiled a list of all defendant forensic evaluation files, years of evaluations, and number of reports from hardcopy files at the Psychological Services Center (PSC). As files are organized alphabetically by defendant last name, I randomly

selected letters of the alphabet to code in their entirety before moving on to the next letter. All defendants were deidentified using unique defendant identification letters and numbers. Coders recorded the identification of the evaluator and student evaluator (all de-identified) for each report. One of 125 clinical psychology doctoral students conducted the PSC reports. Each student was supervised primarily by one evaluator (the clinic director, n = 723, 88.5%), with the remaining reports supervised by three other evaluators (n = 94, 11.5%). Only CST or joint CST and sanity evaluations of adult defendants were coded for the present study.

If defendants had multiple CST evaluations (for different charges), coders recorded information from all evaluations. However, only the CST evaluation with the shortest time to evaluation and most recent report date was included in the data. If defendants had multiple evaluations for the same charge (i.e., re-evaluations following periods of hospitalization for competency restoration, or simply re-evaluation following an extended time) coders recorded each report, but the re-evaluation was noted for later exclusion in the data. I password protected raw, deidentified data files and stored files on a password protected computer.

CHAPTER VII

Study 2 Results

Considering the entire sample, evaluators opined 207 (25.3%) of the defendants were incompetent to stand trial and 610 (74.7%) were competent. Time from court order to competency evaluation ranged from zero days to 381 days, with a median of 18 days. The average length of time from court order to evaluation was 28.01 days (*SD* = 39.47). The distribution of days did not conform to a normal distribution, displaying a significant positive skew (5.21, *SE* = 0.09). The mean number of days between order and evaluation was 27.24 days (*SD* = 40.88) for those opined incompetent, and 28.27 days (*SD* = 39.01) for those opined competent, t (815) = 0.33, p = .94, Cohen's d = .03

Figures 3 and 4 provides a depiction of the incompetency rate over time, for both the entire sample and SMI defendants only, respectively. For the overall sample, there is a general—although not always consistent—trend of decreasing rates of incompetency from evaluations completed within the initial two-week period after the court order to those completed within the fifth week after the court order. The rate of incompetency opinions then increases for evaluations conducted after the fifth week. The general trend of decreasing rates of incompetency opinions is also present—and perhaps more apparent—among defendants with SMI, with rates beginning to increase after the seventh week from the court order. In both figures, it is clear that incompetency rates drop notably from the fourth (22-28 days) to the fifth (29-35 days) week, which was also true in Study 1.

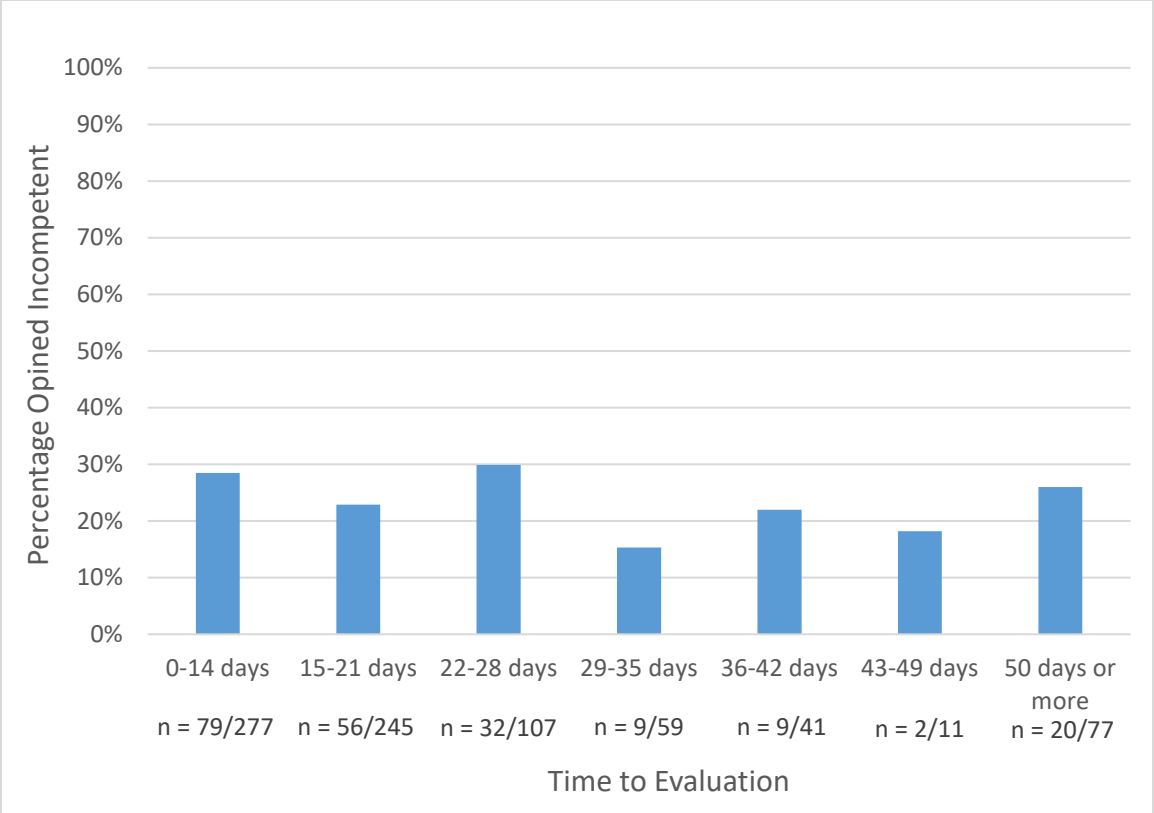

Figure 3. Study 2 Incompetency Opinion Rates by Time to Evaluation Group.

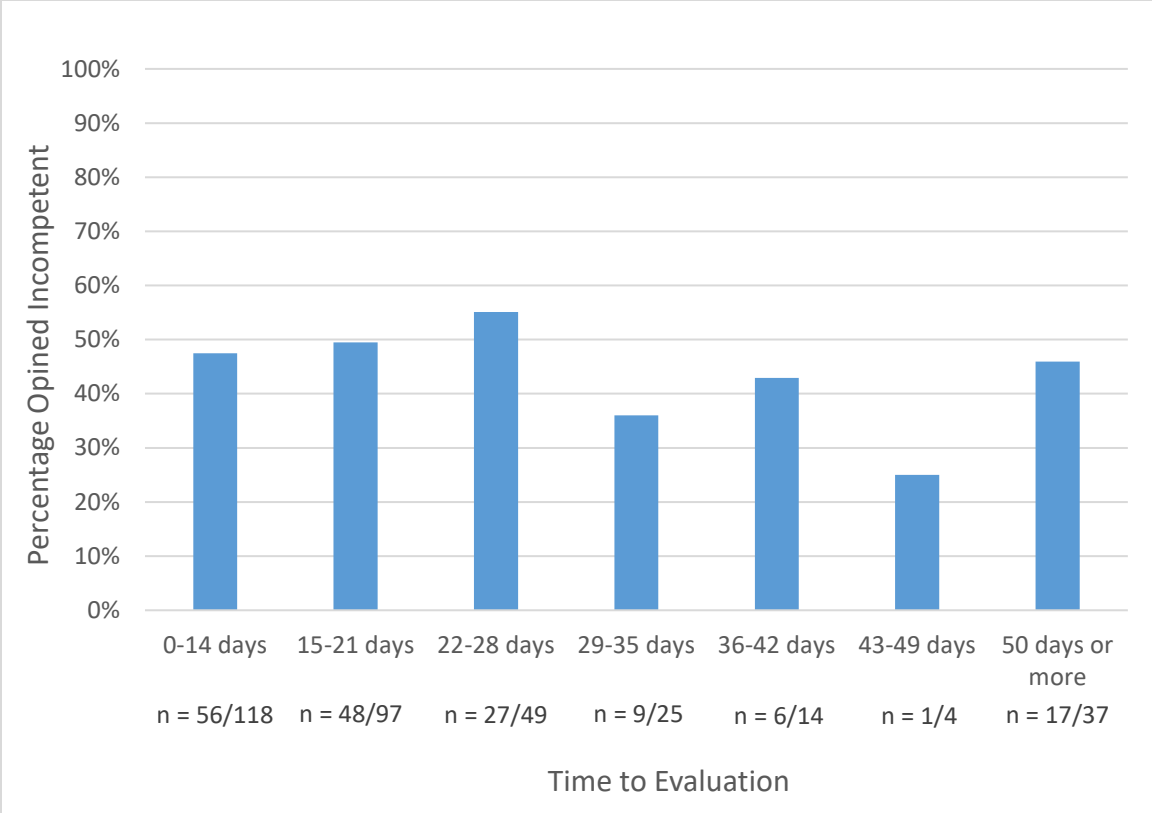

Figure 4. Study 2 SMI-Defendant Incompetency Opinion Rates by Time to Evaluation Group.

To examine the potential impact of evaluation date requirements on CST/IST rates, I sorted each case in to one of two groups, based on values of less than or equal to 5 days, 7 days, 10 days, 15 days, 30 days, 60 days, or 90 days from court order to evaluation. These time deadlines correspond with meaningful evaluation deadlines in Texas and other states. We used all defendants in each analysis.

Twenty evaluations were conducted within the 5 day deadline, 59 within the 7 day deadline, and 138 within the 10 day deadline. Within 15 days following the court order, 344 evaluations had been conducted. Finally, 655 evaluations were conducted within 30 days, 758 evaluations were conducted within 60 days, and 780 evaluations were

conducted within 90 days (i.e., only 37 evaluations were conducted 91 or more days following the court order).

Association Between Evaluation Timing and Evaluator Opinions

I used chi-square analyses and odds ratios to examine the association between evaluation timing and evaluator opinions for each of the common statute defined date grouping (see Table 8). An odds ratio greater than 1.00 would indicate that evaluations conducted *after* the defined date were more likely to result in an evaluator opinion of competent that those conducted before the defined date. Or, in terms of incompetence, an odds ratio greater than 1.00 would indicate that those evaluated *before* the defined date would be more likely to result in an evaluator opinion of incompetent compared to those conducted after the defined date.

The results from these odds ratio analyses indicated that there was no pattern of a statistically significant association between time to evaluation using any of these number of day groupings. That is, there was no evidence those defendants evaluated earlier were more likely to be deemed IST, or that those evaluated later were more likely to be opined competent. However, for both groups of defendants (i.e., evaluated before the cut date, evaluated after the cut date) opinions of incompetence became less common as the number of days increased. For example, among those evaluated before the cut date, rates of incompetence were 30.5% (7 days), 28.3% (10 days), 27.6% (15 days), 26.1% (30 days), and 25.5% (60 and 90 days). In other words, there was some evidence that opinions of incompetence became less common as the time between the court order and evaluation increased.

The distribution of days did not conform to a normal distribution, displaying a significant positive skew (Skewness = 5.21, *SE* = 0.09). An analysis examining the possibility of time to evaluation outliers indicated 75 evaluations should be excluded from the sample as outliers. For these 75 cases, the distance from the boundary of a box plot based on the time to evaluation variable was more than 1.5 times the size of the interquartile range (i.e., distance from the 25th to the 75th percentile). These outlying evaluations included only those completed in 52 or more days. The rate of incompetency (*n* = 187, 25.2%) versus competency (*n* = 555, 74.8%) opinions in the outliers did not meaningfully differ from the overall sample. Exclusion of the 75 outliers resulted in a sample of 742 reports.

With the outliers excluded, time from court order to competency evaluation ranged from 0 to 51 days, with a median of 16 days. The distribution of days was still slightly positively skewed (Skewness = 0.88, *SE* = 0.09), but the skewness was notably reduced compared to the original sample (Skewness = 5.21). The average length of time from court order to evaluation was 18.61 days (*SD* = 9.34) The average length of time between order and evaluation was 17.51 days (*SD* = 8.88) for those opined incompetent, and 18.97 days (*SD* = 9.48) for those opined competent, *t* (740) = 1.85, *p* = .29, Cohen's *d* = .16.

I used logistic regression models to examine whether there was any evidence of an overall effect of time (number of days) on competency opinions (0 = incompetent, 1 = competent) and a possible curvilinear relationship. I centered time variable and created new variables that were squared and cubed value of this centered variable to use in the regression models. The first model included the centered days variable as the predictor of

evaluator opinions. The second model included both the centered days variable and the squared value of the centered days variable to examine the possibility of a curve with one inflection point. The third model included the centered days variable, the squared days variable, and a cubed days variable to examine whether there was any evidence of a curve with two inflection points.

Findings from these regression models indicated that there was evidence of an overall association between time to evaluation and evaluator opinions. In model 1, time approached significance in predicting competency opinions (b = 0.02, SE = 0.01, p = .07, OR = 1.02 [1.00 –1.04]). This effect was in the hypothesized direction and suggests that as the amount of time between the court order and evaluation increased by one day, the odds of being opined competent increased by 1.02. The odds of being opined competent increased by 1.15 for each additional week between order and evaluation and 1.32 for each two week period between order and evaluation.

Model 2 found no evidence of a curvilinear effect of time on competency opinions (b = 0.02, SE = 0.01, p = .10, OR = 1.02 [1.00 – 1.04]). Finally, model 3 did not support a curvilinear relationship with two inflection points between time and competency opinions (b < .001, SE <0.001, p = .87, OR = 1.00 [1.00 – 1.00]).

Possible Moderators of the Association Between Evaluation Timing and Evaluator Opinions

I also used logistic regression analyses to examine whether the association between time and competency opinions might depend on certain defendant or evaluation characteristics. These defendant characteristics included a) serious mental illness, i.e., schizophrenia spectrum and other psychotic disorder diagnosis or bipolar related

disorder, b) depressive disorders, c) any primary or comorbid substance-related disorder diagnosis d) prescription of psychotropic medication, and e) violent offense. With the large Study 2 sample, I was able to analyze both the potential effect of a serious mental illness diagnosis overall (a combined variable of defendants diagnosed with a schizophrenia spectrum and other psychotic disorders or bipolar disorder), examine the effects for each diagnosis separately, and analyze any potential effect for depressive disorders. The evaluation characteristic included was the custody status of the defendant, looking at if being in-custody (i.e., in jail at the time of the evaluation) affected the relationship between time and evaluator opinion. These variables were selected as being the most closely related to potential time of the evaluation, as they are often related to an individual's mental status or the time to complete an evaluation.

I included three variables in each model: time (centered), the moderator variable of interest (schizophrenia spectrum and other psychotic disorders, bipolar disorders, any SMI, depressive disorders, substance use disorder, medication status, offense type, custody status), and an interaction term (centered time multiplied by the moderator variable). In each of these models, I used the subgroup coded 1 (e.g., has diagnosis, is prescribed medication, violent offense, in custody) as the reference group for the categorical defendant characteristic variables. Thus, the simple effect for time in a model with an interaction effect would represent the effect for time in the group coded 1. A statistically significant interaction term would indicate that the association between time and evaluator opinion depends on the moderator variable.

Table 9 displays the logistic regression analyses results. The findings show a somewhat different pattern of results for those with a bipolar disorder diagnosis and those

with a schizophrenia diagnosis. The results for bipolar disorder is consistent with my hypotheses and the serious mental illness finding from Study 1, with the simple effect for time approaching significance (p = .06) among defendants diagnosed with a bipolar disorder. For defendants with a bipolar disorder, the odds of being opined competent increased as the number of days increased. Specifically, the odds of being opined competent increase by 1.06 for each additional day between order and evaluation, which translates to the odds of being opined competent increasing by 1.52 for each additional week between order and evaluation and 2.32 for each two week period between order and evaluation. Defendants with a bipolar disorder diagnosis (n = 98) made up 13.2 percent of the overall sample (excluding outliers) and had an overall IST rate of 21.4 percent. Evaluations of these defendants within 15 days or less (n = 45) had a rate of incompetency opinions of 26.7% (n = 12). Defendants diagnosed with bipolar disorders evaluated in 16 to 30 days (n = 43) had an incompetency rate of 20.9% (n = 9). Finally, defendants with bipolar disorders evaluated in 31 or more days (n = 10) were all opined competent (incompetency rate of 0%, n = 0).

For schizophrenia, there was a statistically significant two-way interaction between time and diagnosis. Specifically, there was a significant association between time and evaluator opinions among those not diagnosed with schizophrenia (b = 0.04, SE = 0.02, p = .01, OR = 1.04 [1.01 – 1.08]). In other words, these findings indicate that time mattered, but only for those without a schizophrenia diagnosis. For those without a diagnosis of schizophrenia, the odds of being opined competent increased by 1.04 for each additional day between court order and evaluation. There was, however, no

association between time and competency opinions for those diagnosed with schizophrenia (b < -.01, OR = 1.00; see Table 9).

I conducted a follow-up analyses to explore this unexpected effect for those without schizophrenia. Specifically, because those with bipolar disorder were included in the non-schizophrenia group, and time was associated with opinions among those with bipolar disorder, I examined whether time was associated with CST opinions among those without schizophrenia and without bipolar disorder. The effect for time in this model still approached significance (b = 0.04, SE = 0.02, p = .08, OR = 1.04 [1.00 – 1.08]), suggesting that time mattered for those without SMI (i.e., no schizophrenia, no bipolar). There was also no evidence that the effect for time among those without schizophrenia could be explained by depressive disorder, as there was also no significant effect between time and evaluation opinion among defendants diagnosed with a depressive disorder (b = 0.13, OR = 1.14, see Table 9).

All models showed the expected pattern of results for the association between diagnoses of serious mental illness and competency opinions (independent of time). For example, defendants without a psychotic disorder diagnosis were more likely to be opined competent (88.6%) than defendants with a psychotic disorder diagnosis (39.7%; OR = 12.38, p <.001). Similarly, defendants without any SMI diagnosis were more likely to be opined competent (90.8%) than defendants with an SMI (39.7%; OR = 9.39, p <.001). Defendants without depressive disorder diagnoses were less likely to be opined competent (71.2%) than defendants with a depressive disorder diagnosis (96.3%; OR = 0.07, p <.001).

The simple effects for time among defendants with a substance-related disorder and defendants prescribed medication also approached significance in the hypothesized direction (p =.10, p = .08 respectively; see Table 9). For defendants with either a substance-related disorder diagnosis or prescribed medication, the odds of being opined competent increased as the number of days increased. For both subgroups, the odds of being opined competent increase by 1.03 for each additional day between order and evaluation, which translates to the odds of being opined competent increasing by 1.23 for each additional week between order and evaluation and 1.52 for each two week period between order and evaluation.

Defendants with any primary or comorbid substance-related disorder diagnosis (n = 400) made up 53.9 percent of the overall sample (excluding outliers) and had an overall IST rate of 16.5 percent. Evaluations of these defendants within 15 days or less (n = 190) had a rate of incompetency opinions of 20.5% (n = 39). Defendants diagnosed with substance-related disorders evaluated in 16 to 30 days (n = 162) had an incompetency rate of 13% (n = 21). Finally, defendants with substance-related disorders evaluated in 31 or more days (n = 48) had an incompetency rate of 12.5% (n = 6). Defendants prescribed medication (n = 380) made up 51.2 percent of the overall sample (excluding outliers) and had an overall IST rate of 22.4 percent. Evaluations of these defendants within 15 days or less (n = 160) had a rate of incompetency opinions of 25% (n = 40). Defendants prescribed medication and evaluated in 16 to 30 days (n = 173) had an incompetency rate of 21.4% (n = 37). Finally, defendants prescribed medication and evaluated in 31 or more days (n = 47) had an incompetency rate of 17% (n = 8).

There was also a simple effect for substance-related disorder diagnosis and prescription of medication in the same direction. Specifically, defendants without substance-related disorder diagnosis were less likely to be opined competent (64.6%) than defendants with a substance-related disorder diagnosis (83.5%; OR = 0.36, p <.001). Approaching significance, defendants not prescribed medication were also less likely to be opined competent (71.8%) than defendants prescribed medication (77.6%; OR = 0.74, p = .07).

A simple effect for the custody status of defendants approached significance. Defendants not in custody (i.e., out on bond) were more likely to be opined competent (79.9%) than defendants who remained in custody in jail (72.9%; OR = 1.45, p = .07)

Table 8

Study 2 Association between Time and Evaluator Opinions using Common Evaluation Deadlines

	Eval. completed within time period				Eval. completed after time period					
	Incompetent		Competent		Incompetent		Competent			
Time between order and eval.	*n*	%	*n*	%	*n*	%	*n*	%	Chi-square	OR
5 days	6	30%	14	70%	201	25.2%	596	74.8%	0.24	1.27 [0.48, 3.35]
7 days	18	30.5%	41	69.5%	189	24.9%	569	75.1%	0.90	1.32 [0.74, 2.36]
10 days	39	28.3%	99	71.7%	168	24.7%	511	75.3%	0.75	1.20 [0.80, 1.81]
15 days	95	27.6%	249	72.4%	112	23.7%	361	76.3%	1.63	1.23 [0.90 1.69]
30 days	171	26.1%	484	73.9%	36	22.2%	126	77.8%	1.04	1.24 [0.82, 1.86]
60 days	193	25.5%	565	74.5%	14	23.7%	45	74.7%	0.09	1.10 [0.59, 2.04]
90 days	199	25.5%	581	74.5%	8	21.6%	29	78.4%	0.28	1.24 [0.56, 2.76]

Note. Percentages of incompetent and competent evaluations were calculated as percentages of evaluations within each time frame group, therefore, percent incompetent and competent should equal 100 percent of evaluations within that time group.
* statistically significant

Table 9

Study 2 Summary of Logistic Regression Models Examining the Time by Defendant Characteristics Interaction for Predicting Competency to Stand Trial Opinions

Predictors	*b*	*SE*	*Exp(b)*	*95% CI*	*p*
Overall Sample					
Time	0.02^	0.01	1.02	1.00 – 1.04	.07
Schizophrenia spectrum and other psychotic disorder diagnosis					
Time	-0.005	0.02	1.00	0.96 – 1.03	.78
Not schizophrenia	2.52***	0.20	12.38	8.34 – 18.36	<.001
Time*Not schizophrenia	0.05^	0.02	1.05	1.00 – 1.10	.05
Bipolar and related disorder diagnosis					
Time	0.06^	0.03	1.06	1.00 – 1.13	.06
Not bipolar	-0.31	0.28	0.73	0.42 – 1.27	.26
Time*Not bipolar	-0.05	0.03	0.96	0.90 – 1.02	.16
Severe mental illness (SMI)					
Time	0.01	0.01	1.01	1.00 – 1.04	.32
Not SMI	2.24***	0.21	9.39	6.26 – 14.08	<.001
Time*Not SMI	0.02	0.02	1.02	0.98 – 1.07	.34
Depressive Disorder Diagnosis					
Time	0.13	0.09	1.14	0.95 – 1.36	.17
Not depressive	-2.64***	0.69	0.07	0.02 – 0.28	<.001
Time*Not depressive	-0.11	0.09	0.89	0.74 – 1.07	.22
Substance-related disorder diagnosis					
Time	0.03^	0.02	1.03	1.00 – 1.06	.10
No substance-related disorder	-1.03***	0.18	0.36	0.25 – 0.51	<.001
Time*No substance-related disorder	-0.01	0.02	0.99	0.95 – 1.03	.48
Prescription of psychotropic medication					
Time	0.03^	0.01	1.03	1.00 – 1.05	.08

(continued)

Not prescribed medication	-0.31^	0.17	0.74	0.53 – 1.03	.07
Time*Not prescribed medication	-0.02	0.02	0.99	0.95 – 1.02	.43
Violent offense type					
Time	0.01	0.01	1.01	0.99 – 1.04	.31
Non-violent offense	-0.08	0.17	0.82	0.66 – 1.29	.64
Time*Non-violent offense	0.01	0.02	1.01	0.97 – 1.05	.65
In custody status					
Time	0.01	0.01	1.01	0.99 – 1.03	.28
Not in custody	0.37^	0.21	1.45	0.97 – 2.17	.07
Time*Not in custody	0.02	0.02	1.02	0.98 – 1.07	.36

Note. This table presents the final model for each defendant characteristic variable, with each predictor and the interaction term in the model. $n = 803$. CI = Confidence Interval.

^$p \leq .10$, *$p < 0.05$, **$p \leq 0.01$. ^$p < .10$ for effect in the hypothesized direction.

CHAPTER VIII

Study 2 Discussion

Overall, the Study 2 findings showed a rate of incompetency opinions consistent with national norms (approximately 25%; Stafford & Sellbom, 2013). With outliers eliminated, time approached significance in predicting competency opinions. For each additional day from court order to evaluation, the odds of being opined competent increased by 1.02. Although this effect is small in magnitude, the suggestion that CST opinions may depend in the timing of the evaluation is noteworthy. For evaluations conducted within about 50 days of the court order, any increase in time from court order to evaluation appears to increase the likelihood that the defendant will be competent, rather than incompetent.

These findings suggest that concerns about rushing to conduct CST evaluations very soon after the court-order may be well-founded. Defendants may be evaluated "too quickly" or too close to the time of the CST court order, increasing the likelihood that they will be opined incompetent. Decreased time from court order to evaluation likely does not allow time for a defendant to adjust to their legal situation or access medication and therefore presents them to the evaluator in the most acute and symptomatic phase of their illness.

Unlike Study 1, we did not find an association between time and evaluator opinions for defendants with SMI overall, nor did we find that time mattered for defendants with a schizophrenia spectrum diagnosis. Instead, there was an association approaching significance between time and opinions among defendants diagnosed with bipolar disorders. As expected, for those with bipolar disorder, the odds of being opined

competent increased as the time between the order and evaluation increased. Lack of time to access treatment may be especially influential in cases of bipolar disorder. Manic symptoms of bipolar disorder, such as euphoria or irritability, grandiosity, pressured speech, flight of ideas, distractibility, and poor judgement, are the most likely to impair competence-related abilities, particularly if associated with psychotic features. By their nature, bipolar and related disorders are cyclical, and individuals with these diagnoses may have rapidly shifting moods and symptoms (APA, 2013). This cyclical nature of bipolar disorder may be what distinguishes it from schizophrenia disorders and SMI overall. There may be an increased risk in evaluating defendants with a suspected bipolar disorder 'too soon,' increasing the likelihood of coming to an incompetency opinion which may be unjustified several days or weeks later due a change in mood episode. Further, short time to evaluation may make it difficult for an evaluator to rule out any potential lingering effects of substance use in defendants with bipolar disorders. Substance use, in particular stimulant use, may exacerbate or mimic the symptoms of mania, and increased time to evaluation increases the likelihood of accuracy in distinguishing acute substance intoxication from acute symptoms.

As expected, the absence of a schizophrenia spectrum diagnosis and SMI diagnosis was associated with an increased likelihood of being opined competent. Psychotic symptoms and severe pathology have repeatedly been found to be the strongest predictors of incompetency opinions (Nicholson & Kugler, 1991; Pirelli, Gottdiener, & Zapf, 2011a). There was evidence of moderation in the association between evaluation timing and evaluator opinion based on the absence of a schizophrenia diagnosis. Unexpectedly, time mattered most for defendants without a diagnosis of schizophrenia.

Among these defendants, the odds of being opined competent increased by 1.04 for each additional day between court order and evaluation. It is unclear why time mattered more for those without schizophrenia than those with schizophrenia.

The reason for the effect of time among defendants without schizophrenia spectrum diagnoses is unclear, although it is at least partially attributable to those with bipolar disorder being included in the non-schizophrenia group. It is possible the separation of defendants into diagnostic categories did not adequately capture the variation in symptomatology among a large, diverse group, such as those without a schizophrenia spectrum diagnosis. Time may affect the individual symptoms and characteristics of these defendants in disparate ways, ultimately reflecting the overall sample finding that increased time leads to increased competency opinions.

Approaching significance, there was a similar effect for time with both defendants diagnosed with a comorbid substance-related disorder and defendants prescribed medications. While the effects were small, they were in the expected direction of increased time leading to increased likelihood of competency. Both of these effects support our hypotheses that increased time can have a clarifying effect for both evaluators and defendants. That is, increased time from court order to evaluation allows more time for the effects of any substance intoxication to decrease, and the effects of any prescribed medication to increase, both likely leading to amelioration of competency-related deficits.

Our finding that lacking a diagnosis with a substance-related disorder is associated with a decreased likelihood of being opined competent diverges from existing competency to stand trial research but is consistent with Study 1 results. In this sample,

all defendants without a substance-related disorder, whether SMI or not, were at decreased likelihood of being opined competent. Contrary to our hypotheses, the association between substance use and evaluator opinion was not affected by time. That is, evaluators did not appear to exercise more caution (opining more defendants with substance use disorders incompetent) during early evaluation periods when defendants could have still been experiencing the effects of a substance.

Lack of prescription of medication approached significance in its relationship to evaluator opinion. This association appears logical, such that defendants not prescribed medication are less likely to be opined competent, irrespective of time to evaluation. Importantly, this variable assessed if a defendant was or was not prescribed medication, not if the defendant was taking the medication or if it was effective. The association between prescription of medication and evaluator opinion still would suggest that any mental health treatment, irrespective of a defendant's compliance, may improve the likelihood they will be opined competent.

Approaching significance, the association between being released from custody (out on bond in the community) and an increased likelihood of a competency opinion is a novel finding. The relationship between a defendant being in or out of jail and the evaluators competency opinion may reflect the inadequate mental health resources in county jails. Compared with defendants in jail, defendants out on bond have access to their regular mental health care system and support network. Defendants in jail are subjected to the potential lack of treatment, stressors, and victimization that could take place in jail, likely worsening any mental health condition. Research has indicated that

while incarcerated, individuals in need of mental health interventions are at significantly higher risk for suicide, self-harm, and victimization (Hayes, 1995).

Overall, Study 2 addressed several of the limitations of Study 1, allowing for more nuanced and generalizable results. The larger sample created more range in the time to evaluation, including more reports completed in short (less than 15 day) time periods. Although we excluded re-evaluations of competency, multiple reports for the same defendant, and time outliers, we continued to have a relatively large and diverse sample. Access to the defendant file at the Psychological Services Center allowed us to verify information with available records, creating the ability to code an increased number of defendant variables and verify their accuracy. Defendant and evaluation characteristics in Study 2 were also more diverse than Study 1. There was more variability in the type and severity of diagnosis, evaluation location, and type of offense, allowing for further analysis of these variables' relationship evaluator opinion and time. Finally, Results for Study 2 showed our sample had a rate of incompetency opinions close to national norms.

Limitations to the generalizability of Study 2 findings include the small number of licensed evaluators conducting and supervising the evaluations and limited information about some defendant characteristics. Study 2 was limited to defendants charged in Texas, evaluated by both a licensed clinician and doctoral student in training, with most of these evaluations conducted by the same licensed clinician. Although 125 different doctoral students conducted interviews and co-authored reports for these evaluations, the competency opinion was ultimately that of the supervising evaluator. Although there is no reason to suspect that the evaluator opinions in this study were influenced by the amount of time between the court-order and evaluation date in some unique or

idiosyncratic way, the focus on cases from one clinic necessarily limits the generalizability of the study findings. Finally, limitations in the resources available for the study prevented us from attempting to code more nuanced measures of defendant psychopathology, such as details about current symptoms or level of acuity, which might have helped us better explore and explain the unexpected findings related to schizophrenia diagnoses.

CHAPTER IX

General Discussion

The present study represents the largest and most detailed empirical investigation into the relationship between time to CST evaluation and evaluator opinion. Although the effect of time on the CST evaluation process has been anecdotally field-tested in several changing state guidelines, CST evaluation timing is just emerging as a critical research and policy question (Gowensmith, 2019). In two archival samples of CST evaluation reports, we examined the concern that conducting CST evaluations too early leads to increases in incompetency opinions. In both studies, there was some evidence that increased time from court order to evaluation led to increased likelihood of a competency opinion. Although the findings were not always s consistent across studies, time appeared to matter most for defendants diagnosed with a severe mental illness (Schizophrenia in Study 1, Bipolar in Study 2), defendants prescribed medication, and defendants diagnosed with any substance-related disorder.

Consistent Results Across Studies

Both Study 1 and Study 2 found some evidence of an association between time and evaluator opinions. In Study 1, this effect for time applied to only those diagnoses with SMI, although most of the defendants in the study had been diagnosed with SMI. In Study 2, the effect applied to the entire sample, including non-SMI defendants. Although the effects were small, there was evidence that defendants were more likely to be found competent as time increases. Figures depicting rates of incompetency opinions over time suggested that they tended to decrease over time, with the lowest rates around the fifth to

sixth week, and then increase when the time between the court-order and evaluation was more than seven weeks.

Both studies also found that some defendants with a severe mental illness were more likely to be opined competent as time from court order to evaluation increases. In Study 1, this pattern applied to all defendants with SMI. In study 2, this pattern applied to only defendants with bipolar disorder.

Both Study 1 and Study 2 found evidence that being diagnosed with a substance use disorder increased the likelihood of being opined competent. Research has not typically found substance use to be a significant predictor of competency opinions (Nicholson & Kruger, 1991; Pirelli et al., 2011a; Hart & Hare, 1992; Warren et al., 2006) with the exception of one prior study finding substance use disorders were related to decreased incompetency opinions (Cooper & Zapf, 2003). Our results appear to replicate those of Cooper & Zapf (2003) study, both for SMI defendants charged with misdemeanors and a more diverse sample of defendants.

Prescription of medication was associated with increased likelihood of competence opinions in both Study 1 and Study 2. While Study 1 found an association between increased time and competency opinion in defendants with SMI and prescribed medication, Study 2 found no involvement of time in the relationship between medication and competency. Medication increasing the likelihood of competency, and conversely decreasing the likelihood of incompetency, suggests that medications may effectively address the mental health symptoms causing impairments in competency-related abilities. Evaluation timing's association with competency opinions in misdemeanant defendants with SMI prescribed medication is a unique finding. Perhaps for these defendants with

SMI and a high rate of incompetency opinions, mere prescription of medication takes time to resolve severe, potentially chronic, psychiatric symptoms. In addition, the Study 1 and 2 variable of medication prescription only measured an indication of any prescription of psychotropic medication in the CST report, not the defendant's compliance with that medication or its efficacy.

Implications for Practice and Policy

Results from our study emphasize and support existing concerns about conducting CST evaluations too close to the time of court order. When evaluators conduct CST evaluations in short (less than 15 days) time frames, particularly for misdemeanants with SMI, any defendant with bipolar disorder, and defendants prescribed medication, they are more likely to opine these defendants incompetent than if they had waited to conduct the evaluation. While we found small increases in the odds that an evaluation will result in an incompetency opinion for these groups, during a "competency crisis" in the United States, any increase in incompetency opinions and subsequent findings has serious downstream effects (Gowensmith, 2019). Conducting evaluations too close to the time of the court order may artificially inflate the number of defendants opined and found incompetent, thus increasing defendants waiting in jails for transfers to already overburdened mental health settings.

In practice, prior to conducting a CST evaluation forensic evaluators are often unaware of the diagnosis or medication status of a defendant. Our results suggest that without knowing potential diagnoses or treatment of a defendant, waiting to conduct a competency evaluation would only increase the likelihood a defendant would be opined competent, not incompetent. The likelihood that a defendant (in certain groups) will be

opined competent almost doubles over a two week period between order and evaluation. Thus, a rush to evaluating a defendant in under two weeks may not be an efficient use of resources, particularly for severely mentally ill, intoxicated, and/or medicated defendants. Importantly, our studies had only small samples of CST evaluations conducted in under 15 or 7 days; our data is therefore based on a small representation of potentially problematic CST evaluations. However, our results indicate a general trend towards decreased time to evaluation leading to increased likelihood of incompetency opinions.

Regarding policy, more field and archival research is necessary before dictating a timeframe that balances the speed and accuracy necessary in CST evaluations. But our findings suggest that evaluations conducted between the fourth and fifth week after the court-order are associated with the lowest rates of incompetency, with evaluations conducted a few weeks earlier or a few weeks later being associated with higher rates of incompetency. A recent review of the field of competency-related services (Gowensmith, 2019) recommended that with exception for extreme cases, CST evaluations should not be completed within 15 days from the court order, and our findings are in line with this recommendation. Although our results should be interpreted with caution, due to the relatively small number of evaluations conducted especially soon (e.g., < 15 days) or long (e.g., > 50 days) after the court order, our study adds to the small, growing body of independent research raising concerns about states mandating short CST evaluation timeframes (e.g., seven or fourteen days) and artificially increasing incompetency rates (Gowensmith, 2019.

Future Directions

Several aspects of our data collection limited the conclusions that can be drawn from this archival study of CST evaluations, and create prime areas for future research. First, we collected data only on diagnoses, which may measure the nature and severity of a mental illness but does not provide information on type and acuity of symptoms. Future research should gather information on the diagnosis and symptom level. Data on defendant symptoms would give the opportunity to conduct more nuanced analyses, such as if time impacts evaluator opinion differently in defendants with positive versus negative symptoms of psychosis. Similarly, we had no information regarding the defendant's subjective distress or attitude towards their legal situation and the CST evaluation. Data on defendant distress and attitude may also be helpful to guide practice, providing information on when these tend to decrease in defendants referred for CST evaluation. Second, we had limited information on the effects of substance use that evaluators were using in forming their opinions.

Results from both studies suggested that a diagnosis of a substance use disorder increased the likelihood that a defendant would be opined competent, but it is unclear what actual presentation of these defendants led to the opinion of competence. Further research may look at substance use diagnosis in a similar way to other diagnoses, gathering information on type of substance and symptoms that evaluators attribute to substance use and those they do not. Different substances have different effects and length of effect, and may mimic particular symptoms (e.g., stimulants simulating manic symptoms). Third, both our studies had limited information regarding a defendant's acceptance of medication. Information typically came only from the defendant's self-

report of compliance, with no information about the length of compliance or perceived effects. Further information on medication type, compliance, and length of compliance, could be helpful in elucidating the impact of time on competency opinions for defendants prescribed medication.

Finally, further research into the timing of CST evaluations should also focus on gathering information on evaluations conducted in 'short' timeframes (i.e., less than 15 days). Even in a jurisdiction with a 30-day timeframe for evaluations, these quickly conducted evaluations were rare, in some cases limiting the analyses we were able to perform. More robust and stark results for the effect of time may require a larger sample of short timeframe evaluations to clearly answer the question of appropriate timing of CST evaluations.

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VITA

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Curriculum Vitae
Department of Psychology & Philosophy
Sam Houston State University

Education

In Progress — **Doctor of Philosophy (candidate)**
Clinical Psychology (Forensic Emphasis)
Sam Houston State University
Huntsville, Texas

Thesis: An Exploratory Study of the Need for Affect, Interpersonal Theory of Suicide, and Suicide Proneness (defended June 2015)

Dissertation: The Effect of Time on Competency to Stand Trial Evaluation Outcomes (proposed September 2017)

2013 — **Master of Arts**
Forensic Psychology
Marymount University
Arlington, Virginia

2011 — **Bachelor of Arts**
Psychology, French
University Honors Program, *Cum Laude*
Boston University
Boston, Massachusetts

Clinical Experience

August 2018 – Present — **Worcester Recovery Center and Hospital (WRCH) & University of Massachusetts Medical School**
Worcester, Massachusetts

Title: Pre-doctoral Intern, Forensic Track

- Forensic Evaluation Rotation
  - Conduct court-ordered forensic evaluations including competency to stand trial, criminal responsibility, need for care and treatment (civil commitment), and aid in sentencing

  - Conduct forensic consultation evaluations including updates of competency to stand trial, independent forensic risk assessments, and violence risk assessment
  - Co-facilitate a legal education psychoeducational group
  - Observe courtroom proceedings (such as commitment, involuntary medication, and competency) and expert testimony in hospital setting
  - Attend weekly forensic rounds to discuss legal and treatment status of legally-involved patients
  - Attend biweekly Law & Psychiatry Seminar series
  - Complete case law summaries (case briefs)
  - Participate in mock trial testimony experience

- Risk Assessment Rotation
  - Conduct internal risk assessments or risk assessment updates on suicide, violence, and fire-setting risk
  - Conduct psychodiagnostic and malingering assessments
  - Conduct admission assessments for assignment of appropriate risk evaluation and treatment needs
  - Provide individual therapy, update treatment plans, and meet with treatment team on risk mitigation specific treatments for suicide and fire-setting risk
  - Participate in hospital's Risk Policy Revision Subcommittee, researching how to implement the HCR-20 as a new model for violence risk assessment
  - Research, pilot, and analyze data from new measure for assessment of imminent risk for verbal and physical violence by patients

- Inpatient Neuropsychological Assessment Rotation
  - Conduct evidence-based neuropsychological and/or psychological assessments to inform treatment, discharge planning, and/or forensic evaluations
  - Multidisciplinary consultation addressing diagnosis, treatment, discharge planning, and community service

- Psychiatric Treatment and Recovery Center Rotation (PTRC)
  - Co-facilitate process and psychoeducational group therapy
  - Conduct evidence-based brief individual therapy
  - Conduct psychodiagnostic and malingering assessments
  - Attend weekly multidisciplinary treatment team and restraint meetings

Population: Adults committed to the WRCH for treatment of severe and persistent mental illness and/or forensic evaluation; adults committed to the PTRC for acute, inpatient stabilization and treatment of severe and persistent mental illness

Supervisors: Andrea Dinsmore, Psy.D., DFP, Peter LaCanfora, Psy.D., Jack Terry, Ph.D., Katie Trieber, Ph.D., William Warnken, Psy.D., ABPP

May 2018 – August 2018 **Psychological Services Center, Sam Houston State University**
Huntsville, Texas

Title: Practicum Student Clinician

- Completed comprehensive psychological evaluations for psychodiagnostic and psychoeducational disability assessments
- Authored integrated reports
- Provided clients with assessment feedback and recommendations
- Attended weekly clinic meetings to discuss cases and treatment needs

Population: Adults, children, and families in the community of Walker County, TX, seeking assessment

Supervisors: Jorge Varela, Ph.D.

May 2017 – May 2018 **Montgomery County Jail**
Conroe, Texas

Title: Practicum Student Clinician

- Conducted short- and long-term supportive and evidence-based individual therapy (DBT, CBT)
- Performed brief diagnostic assessments and risk assessments (suicide, homicide, security risk)
- Developed and lead psychoeducational groups (sleep hygiene, coping skills, distress tolerance)
- Attended bi-weekly interdisciplinary treatment team meetings addressing mental health treatment needs within the jail with mental health, medical, and jail/correctional staff
- Monitored mental health of individuals in segregated housing and assess for referrals to increased levels of mental health treatment

Population: Justice-involved adults incarcerated pre- and post-trial

Supervisor: Wendy Elliott, Ph.D., Darryl Johnson, Ph.D.

Sept 2015 – Aug 2018 **Psychological Services Center, Sam Houston State University**
Huntsville, Texas

Title: Assistant Forensic Evaluator

- Completed court-ordered evaluations of adults for competency to stand trial and criminal responsibility
- Co-authored reports documenting psycholegal opinions and treatment recommendations
- Completed ex parte evaluations for diagnostic clarification, treatment recommendations, and referral to specialty mental health court
- Observed expert testimony

Population: Justice-involved adults in several suburban and rural counties in Texas

Supervisors: Mary Alice Conroy, Ph.D., ABPP, Wendy Elliott, Ph.D., Darryl Johnson, Ph.D.

June 2016 – May 2017 **TIRR (The Institute for Rehabilitation and Research) Memorial Hermann Medical Center**
Houston, Texas

Title: Practicum Student Clinician

- Co-authored neuropsychological evaluation reports for diagnosis, rehabilitation progress, suitability for treatment, and worker's compensation
- Followed caseload of acute inpatients with weekly bedside evaluations and reports of mental status
- Completed semi-structured interviews of inpatients with spinal cord injuries to assess adjustment as part of a larger research project
- Attended weekly didactic seminars for postdoctoral interns, hospital-wide didactics, and grand rounds
- Collected data, coded protocols, and created database for research on a novel RBANS Story Recognition subtest

Population: Adults and children receiving inpatient or outpatient treatment and evaluation of stroke, traumatic brain injury, spinal cord injury, disorders of consciousness, amputation, neuromuscular disorders, brain tumor, dementia, and neurodegenerative diseases

Supervisors: Danielle Blinstrubas, Ph.D., ABPP, Corwin Boake, Ph.D., ABPP, Jerome Caroselli, Ph.D., ABPP, Kirstine Carter, Ph.D., Petya Demireva, Ph.D., Erin Holcomb, Ph.D., Ashley LeMaire, Ph.D.

Aug 2015 – June 2016 **Harris County Juvenile Probation Department**
Houston, Texas

Title: Practicum Student Clinician

- Completed semi-structured interviews with juvenile offenders, their legal guardians, and attorneys
- Co-authored court ordered mental health screening and integrated psychological assessments for treatment and placement recommendations
- Co-facilitated weekly psychoeducational groups with adjudicated females involved in human-trafficking
- Attended weekly group supervision with predoctoral psychology interns

Population: Justice-involved juveniles in detention center and community

Supervisors: Nicole Dorsey, Ph.D., Uche Chibueze, Psy.D., ABPP

Aug 2014 – Nov 2016 **Psychological Services Center, Sam Houston State University**
Huntsville, Texas

Title: Practicum Student Clinician

- Provided individual and family psychotherapy services with emphasis on empirically supported treatments
- Engaged in treatment planning and transfer/discharge planning
- Completed comprehensive psychological evaluations for psychodiagnostic and psychoeducational disability assessments
- Authored integrated reports
- Provided clients with assessment feedback and recommendations
- Attended weekly clinic meetings to discuss cases and treatment needs

Population: Adults, children, and families in the community of Walker County, TX, seeking treatment and/or assessment

Supervisors: Darryl Johnson, Ph.D., Craig Henderson, Ph.D., Adam Schmidt, Ph.D., David Nelson, Ph.D., ABPP

Sept 2014 – Nov 2014 **Family Assault Program, Montgomery County Juvenile Justice Center**
Conroe, Texas

Title: Student Clinician

- Co-facilitated group therapy for juveniles adjudicated on family violence and their families, focusing on anger management, emotion regulation, distress tolerance, problem solving, and communication

Population: Justice-involved juveniles in the community and their legal guardians

Supervisor: Darryl Johnson, Ph.D.

Teaching & Supervisory Experience

November 2018 – present

Worcester Recovery Center and Hospital (WRCH) & University of Massachusetts Medical School
Worcester, Massachusetts

Title: Pre-doctoral Intern Supervisor

- Supervise advanced doctoral student conducting individual psychotherapy and assessments (psychodiagnostic, risk, admission) with clients at an inpatient hospital
- Meet weekly to review cases and address clinical questions or concerns
- Review assessments and provide feedback

Supervisees: Doctoral students

Supervisor: Peter LaCanfora, Psy.D.

May 2018 – July 2018

Sam Houston State University
Huntsville, Texas

Title: Clinical Teaching Assistant

- Human Neuropsychology (PSYC 7374)
- Demonstrated commonly used neuropsychological instruments in class
- Conducted administration and scoring checks for several neuropsychology tests with doctoral level clinicians
- Provided written and in-person feedback on test administration
- Met with students as needed to answer questions, improve test administration, and provide feedback

Supervisees: Doctoral students

Supervisor: David Nelson, Ph.D., ABPP

Feb 2016 – May 2017

Psychological Services Center, Sam Houston State University
Huntsville, Texas

Title: Peer Supervisor

- Supervised second-year doctoral students conducting individual psychotherapy and psychodiagnostic assessments with clients at a community mental health clinic
- Co-facilitated supervisions sessions with a licensed supervisor
- Reviewed therapy progress notes and intake reports, assessment scoring, interpretation, and integration and provided oral feedback

Supervisees: Second-year doctoral students

Supervisor: Darryl Johnson, Ph.D.

Sept 2015 – May 2016 **Sam Houston State University**
Huntsville, Texas

Title: Clinical Teaching Assistant

- Assessment of Intelligence and Achievement (PSYC 5395)
- Conducted administration and scoring checks for several intelligence and achievement tests with doctoral and masters level clinicians
- Provided written and in-person feedback on test administration, including mock administrations reviewed via video
- Met with students as needed to answer questions, improve test administration, and provide feedback

Supervisees: First year doctoral students and school psychology master's students

Supervisor: Amanda Venta, Ph.D.

Jan 2016 – May 2016 **Psychological Services Center, Sam Houston State University**
Huntsville, Texas

Title: Peer Supervisor

- Supervised first year doctoral students implementing various treatment modalities in mock therapy during their Theory and Research in Psychotherapy course
- Provided oral feedback on implementation of foundational therapy techniques

Supervisees: First year doctoral students

Supervisor: Craig Henderson, Ph.D.

Sept 2013 – May 2014 **Sam Houston State University**
Huntsville, Texas

Title: Graduate Teaching Assistant/Instructor

- Introduction to Psychology (PSYC 1301)
- Created exams, presentations, and lectured for over 140 undergraduate students
- Held weekly office hours to support students and address concerns

Supervisor: Christopher Wilson, Ph.D.

Jan 2010 – May 2010 **Boston University**
Boston, Massachusetts

Title: Teaching Assistant

- Psychology and Criminal Justice (PSY 354)
- Addressed student questions in office hours, led review-sessions, and proctored exams
- Conducted research on current cases, research, and real-world applications of forensic psychology for class presentation

Supervisor: Margaret Hagen, Ph.D., J.D.

Additional Clinical & Professional Experience

Aug 2012 – May 2013 **Psychiatric Unit, George Washington University Hospital**
Washington, District of Columbia

Title: Volunteer

- Assisted medical and psychology staff with general inpatient care and well-being on an acute psychiatric treatment unit
- Assisted psychology staff with milieu, pet, and art therapy

Research Experience

Aug 2013 – Present **Forensic Assessment Ethics, Practice, and Policy Laboratory**
Sam Houston State University
Huntsville, Texas

Title: Research Assistant

- Manuscript preparation and review
- Research design, implementation, and data collection
- Data analysis using SPSS and MPlus
- Ongoing research areas:
  - The effect of time on competency to stand trial evaluation outcomes (dissertation)
  - Board complaints and forensic services
  - Content and quality of forensic reports of competency to stand trial evaluations
  - Evaluator empathy in psychopathy interviews
  - Sexually violent predator policy and risk assessment

Supervisors: Marcus Boccaccini, Ph.D., Jorge Varela, Ph.D.

Aug 2013 – Present

Suicide and Individual Differences Laboratory
Sam Houston State University & Old Dominion University
Huntsville, Texas & Norfolk, Virginia

Title: Research Assistant

- Grant and manuscript preparation, management of first-authored manuscript submission and review
- Research design, implementation, and data collection
- Planning and organization of a graduate-level suicide risk assessment course and training study
- Comprehensive literature reviews on perception of suicidality, individual difference effects on suicidality, suicide risk assessment in various settings
- Data analysis using SPSS and MPlus
- Supervision of other graduate students

Supervisor: Robert Cramer, Ph.D.

Jul 2016 – Jan 2017

LoneStar Study of Offender Trajectories, Associations, and Reentry
(National Institute of Justice funded)
Sam Houston State University
Huntsville, Texas

Title: Silver Tier Interviewer

- Conducted 20 baseline prison interviews with offenders waiting to be released within 30 days
- Certified as trained in Blaise computer assisted personal interviewing

Supervisors: David Pyrooz, Ph.D., Erin Orrick, Ph.D.

Jan 2013 – May 2013 **RAND Corporation & The Police Foundation**
Washington, District of Columbia

Title: Research Assistant

- Comprehensive literature reviews on the perception of DNA evidence in sexual assault cases
- Manuscript preparation and review for publication

Supervisor: Rob Davis, M.A., Chief Social Scientist

June 2012 – July 2013 **American Association of Suicidology**
Washington, District of Columbia

Title: Research Assistant

- Comprehensive literature reviews on geriatric suicide, suicide and comorbid mental illnesses, and opportunities for funding on these topics
- Assisted with project planning and organization in large-scale study of suicide within the US Marine Corps

Supervisor: Alan L. Berman, Ph.D.

Mar 2012 – July 2013 **Office of Nuclear Energy, United States Department of Energy**
Washington, District of Columbia

Title: Research Assistant

- Q (top secret) security clearance (not current)
- Researched psychological and sociological aspects of community consent to nuclear material repositories and the factors influencing perception of safety of nuclear repositories

Supervisor: Edward McGinnis, M.A., Deputy Assistant Secretary, International Nuclear Energy Policy and Cooperation

Feb 2012 – July 2013 **Jury Focus, Inc.**
Washington, District of Columbia

Title: Research Assistant

- Performed qualitative and quantitative data entry and analysis (Excel, SPSS) on mock trial and focus groups for civil cases

Supervisor: Matt Milano, Ph.D.

Sept 2010 – Dec 2010 **Centre Popincourt, Centre Thérapeutique Spécialisé**
Paris, France

Title: Research Assistant

- Observed and participated in psychological evaluations, art therapy sessions, and psychiatric consultations of chronically suicidal and mentally ill individuals at a specialized treatment center
- Researched and assisted in the development of a protocol for detection and prevention of suicide in the elderly (e.g., differential warning behavior, patient rationale, right-to-die legislation and philosophy)

Supervisor: Philippe Carette, Ph.D.

Sept 2008 – May 2009 **Endocrinology Department, Boston University Medical Center**
Boston, Massachusetts

Title: Research Assistant

- Assisted in applied medical research on the effects of testosterone replacement medication in the progression of atherosclerosis in men over sixty-five
- Administered mini-mental status exams (MMSE-2), took vitals for screening of participants, compiled and analyzed data

May 2008 – Aug 2008 **Glenn T. Seaborg Institute, Lawrence Livermore National Laboratory**
Livermore, California

Title: Laboratory Intern

- Assisted in basic medical research on dietary protein and osteoporosis
- Prepared data and presented research for student poster presentation

Publications

La Guardia, A. C., Cramer, R. J., **Bryson, C. N.**, & Emelianchik-Key, K. (In press). Analysis of personality, suicide, and self-injury in emerging adulthood. *Journal of College Counseling*.

Vera, L., Boccaccini, M., Laxton, K., **Bryson, C. N.**, Pennington, C., Ridge, B., & Murrie, D. C. (2019). How does evaluator empathy impact a forensic interview? *Law and Human Behavior, 43*, 56-68. doi:10.1037/lhb0000310

Bryson, C. N., Cramer, R. J., & Schmidt, A. T. (2019). Need for Affect, Interpersonal Theory of Suicide, and suicide proneness. *Archives of Suicide Research*. doi:10.1080/13811118.2018.1494650

McCallum, K. E., Boccaccini, M. T., & **Bryson, C. N.** (2017). The influence of risk assessment instrument scores on evaluators' risk opinions and sexual offender containment recommendations. *Criminal Justice and Behavior, 44*, 1213-1235. doi:10.1177/0093854817707232

Bryson, C. N., Cramer, R. J., & Schmidt, A. T. (2017). Traumatic brain injury and lifetime suicidality: Applying the Interpersonal-Psychological Theory perspective. *Death Studies, 41*, 399-405. doi:10.1080/07481187.2017.1320340

Cramer, R. J., La Guardia, A. C., **Bryson, C. N.**, & Morgan, K. (2017). The intersection of non-suicidal self-injury and suicide-related behavior: Patterns of elevated risk and implications for college mental health. *Journal of American College Health, 31*, 1-9. doi:10.1080/07448481.2017.1312416

Cramer, R. J., **Bryson, C. N.**, Eichorst, M. K., Keyes, L. N., & Ridge, B. E. (2017). Conceptualization and pilot testing of a core competency-based training workshop in suicide risk assessment and management. *Journal of Clinical Psychology, 73*, 233-238. doi:10.1002/jclp.22329

Cramer, R. J., Wevodau, A. L., Gardner, B. O., & **Bryson, C. N.** (2017). A validation study of the Need for Affect-Short Form in legal contexts. *Journal of Personality Assessment, 99*, 67-77. doi:10.1080/00223891.2016.1205076

Cramer, R. J., Moore, C. E., **Bryson, C. N.** (2016). A test of the Trait-Interpersonal Model of suicide proneness in emerging adults. *Personality and Individual Differences, 102*, 252-259. doi:10.1016/j.paid.2016.07.011

Cramer. R. J., **Bryson, C. N.**, Stroud, C. H., & Ridge, B. E. (2016). A pilot test of a graduate course in suicide theory, risk assessment and management. *Teaching of Psychology, 43*, 238-242. doi:10.1177/0098628316649483

Cramer, R. J., **Bryson, C. N.**, Gardner, B. O., & Webber, W. B. (2016). Can preferences in information processing aid in understanding suicide risk among emerging adults? *Death Studies, 40*, 383-391. doi:10.1080/07481187.2016.1166161.

Cramer, R. J., Burks, A. C., Stroud, C. H., **Bryson, C. N.** (2015). A moderated mediation analysis of suicide proneness among lesbian, gay, and bisexual community

members. *Journal of Social and Clinical Psychology, 34*, 622-641. doi:10.1521/jscp.2015.34.7.622

Manuscripts under Review

Cramer, R. J., Braitman, A., **Bryson, C. N.**, Long, M., & La Guardia, A. C. (Under Review). The Brief COPE: Factor structure and associations with self- and other-directed aggression among emerging adults.

Manuscripts in Preparation

Harris, P. B., **Bryson, C. N.**, Schrantz, K. N., Kan., L., & Henderson, C. E. (Manuscript in Preparation). Board complaints and forensic services: A full review of 21 states.

Harris, P. B., Schmidt, A. T., & **Bryson, C. N.** (Manuscript in Preparation). Letting the cat out of the bag: Informing participants about the nature of testing does not adversely impact their performance.

Conference Presentations

Bryson, C. N., Boccaccini, M. T., Gowensmith, L., Reinhard, E., & Holdren, S. (2019, March). *Does Time Matter in Competency to Stand Trial Evaluations?* Paper presented at the annual convention of the American Psychology-Law Society, Portland, OR.

Bryson, C. N., Boccaccini, M. T., Gowensmith, W. N., Laxton, K. L., Mattos, L., Reinhard, E., Holdren, S., & Lawrence, J. (2018, March). *Time Matters in Competency to Stand Trial Evaluations*. Poster presented at the annual convention of the American Psychology-Law Society, Memphis, TN.

Laxton, K. L., Varela, J. G., **Bryson, C. N.**, Mattos, L. A., Reinhard, E. E., Holdren, S. M., Lawrence, J., & Minor, B. R. (2018, March). *Content and Quality of Forensic Evaluation Reports of Competency to Stand Trial Evaluations*. Poster presented at the annual convention of the American Psychology-Law Society, Memphis, TN.

Pennington, C. R., Henderson, C. E., Ridge, B. E., **Bryson, C. N.**, McCallum, K. E., Marshall, K. K., & Schmidt, A. T. (2018, February). *Exploratory factor analysis of neuropsychological test data suggests a four factor model of executive functioning in an undergraduate sample*. Poster presented at the annual convention of the International Neuropsychological Society, Washington, D.C.

Bryson, C. N., Cramer, R. J., Braitman, A. L., & La Guardia, A. C. (2017, August). *The Brief COPE: Factor structure and associations with self- and other-directed aggression.* Poster presented at the annual convention of the American Psychological Association, Washington, DC.

Vera, L., Boccaccini, M., Laxton, K., **Bryson, C. N.**, Pennington, C., Ridge, B. (2017, August). *The influence of empathy on the accuracy of evaluator ratings of psychopathy*. Poster presented at the annual convention of the American Psychological Association, Washington, DC.

Vera, L., Boccaccini, M., Laxton, K., **Bryson, C. N.**, Pennington, C., Ridge, B. (2017, March). *Evaluator empathy in psychopathy interviews*. Poster presented at the annual convention of the American Psychology-Law Society, Seattle, WA.

Harris, P. B., **Bryson, C. N.**, Schrantz, K. N., Kan., L., & Henderson, C. E. (2017, March). *Board complaints and forensic services: A full review of 21 states.* Paper presented at the annual convention of the American Psychology-Law Society, Seattle, WA.

Bryson, C. N., Cramer, R. J., & Schmidt, A. T. (2016, March). *An integrated test of Need for Affect, the Interpersonal-Psychological Theory of Suicide, and suicide and aggression proneness.* Paper presented at the annual convention of the American Psychology-Law Society, Atlanta, GA.

Harris, P. B., Wechsler, H. J., Kan, L., Henderson, C. E., Schrantz, K. N., & **Bryson, C. N.** (2016, March). *Board complaints and forensic services: An examination of 22 states*. Poster presented at the annual convention of the American Psychology-Law Society, Atlanta, GA.

Bryson, C. N., Cramer, R. J., & Schmidt, A. T. (2016, February). *Applying the Interpersonal Theory of Suicide to a traumatic brain injury sample.* Poster presented at the annual convention of the International Neuropsychological Society, Boston, MA.

Pennington, C. R., Marshall, K. K., **Bryson, C. N.**, McCallum, K. E., Ridge, B. E., Cheiffetz, R. T., Stanford-Galloway, P., & Schmidt, A. T. (2016, February). *The role of executive functions in externally-valid decision-making processes*. Poster presented at the annual convention of the International Neuropsychological Society, Boston, MA.

Cramer, R. J., Gardner, B. O., **Bryson, C. N.**, Stroud, C. H., & Wevodau, A. L. (2015, March). *A validation study of the Need for Affect Scale-Short Form in legal contexts*. Paper presented at the annual convention of the American Psychology-Law Society, San Diego, CA.

Bryson, C. N. & Cramer, R. J. (2015, February). *An exploratory study of the Need for Affect, Interpersonal Theory of Suicide, and suicide proneness*. Proposal presented at the annual Sam Houston State University Graduate Studies Research Conference, Huntsville, TX.

Pennington, C. R., Schmidt, A. T., Ridge, B. E., McCallum, K. E., **Bryson, C. N.**, Marshall, K. K., & Cheiffetz, R. T. (2015, February). *Personality traits influence processing speed performance in a neurologically intact population*. Poster presented at the annual convention of the International Neuropsychological Society, Denver, CO.

Chevalier, C. S., McCallum, K. E., **Bryson, C. N.**, & Boccaccini, M. T. (2014, March). *Risk instrument use and integration in sexually violent predator evaluations.* Poster presented at the annual convention of the American Psychology-Law Society, New Orleans, LA.

McCallum, K. E., Boccaccini, M. T., & **Bryson, C. N.**, (2014, March). *When and how often are evaluator recommendations inconsistent with results of actuarial measures in risk assessments?* Poster presented at the annual convention of the American Psychology-Law Society, New Orleans, LA.

Professional Training Activities

2017	**Motivational Interviewing: Clinical Training Workshop** Joe Mignogna, Ph.D. Veterans Health Administration
2017	**Basic Life Support (BLS)** American Heart Association
2016	**Neurobehavioral Changes after Acquired Brain Injury: A Team Approach to Understanding Diagnosis and Interventions** David Arciniegas, M.D., Christopher Falco, M.D., Margaret Struchen, Ph.D., Kelley Shaw, M.S., CCC-SLP, Jessica Bielamowicz, PT, MPT, Kerry Davis, MSN, RN, CRRN, CBIS TIRR Memorial Herman
2015	**Blaise Computer Assisted Interviewing (CAI) Training** David Pyrooz, Ph.D. LoneSTAR Project - Study of Offender Trajectories, Associations, and Re-entry
2012	**Psychological Autopsy Training** Alan L. Berman, Ph.D. American Association of Suicidology

Didactics & Seminars

Apr 2018	**Controversies and Critical Thinking in Forensic Psychological Evaluations** Terry Kukor, Ph.D., ABPP Netcare Access & Drexel University
Apr 2018	**Clinical Work with Transgender Clients & LGBTQ+ Legislative Updates** Megan A. Mooney, Ph.D. Trauma and Grief Center, Texas Children's Hospital & Baylor College of Medicine
Apr 2017	**"Indispensable Forensic Psychology" in the Age of Neuroscience** Stephen J. Morse, Ph.D., J.D. University of Pennsylvania
Jan 2017	**LGBTQ Issues in Psychology and Clinical Work** Drew Miller, Ph.D. Sam Houston State University Counseling Center
Nov 2016	**Getting it Wrong About Miranda Rights: Research on our Myths and Misconceptions** Richard Rogers, Ph.D. University of North Texas
Oct 2016 – May 2017	**TIRR Memorial Herman Postdoctoral Didactic Seminars** Topics including: • Low Effort and Feigned Cognitive Testing • Motivational Interviewing in a Rehabilitation Setting • Religion and Spirituality in Treatment • Disorders of Consciousness and Severe Traumatic Brain Injury • Management of Chronic Pain • Adjustment to Disability • ABPP Practice Fact-Finding, Oral Exam, Ethical Case TIRR Neuropsychology Faculty TIRR Memorial Herman
Sept 2016	**Overview of Psychiatric Medications, Indications, and Potential Side Effects** Barry Gritz, M.D. Private Practice

Apr 2016	**Caring for our Veterans' Mental Health and the VA** Joe Mignogna, Ph.D. Veterans Health Administration
Apr 2016	**Risk-Need-Responsivity (RNR): A Simulation Tool** Faye Taxman, Ph.D. George Mason University
Oct 2015	**Title IX and Campus Sexual Misconduct** Jeanine Bias, M.A. Sam Houston State University Title IX Coordinator
Sept 2015	**APA Hoffman Report: Implications for the Profession** Craig Henderson, Ph.D., Lisa Kan, Ph.D. Sam Houston State University
Apr 2015	**WJ-IV and WISC-V: Updates in Administration and Interpretation** Ramona Noland, Ph.D., LSSP Sam Houston State University
Apr 2015	**Callous Unemotional Traits in Children and the Treatment of Conduct Disorder in Juvenile Settings** Paul Frick, Ph.D. Louisiana State University
Nov 2014	**The Innocence Project of Texas** Nick Vilbas, J.D. The Innocence Project of Texas
Oct 2014	**The Role of Forensic Psychologists in Family Law Matters** Michael Gottlieb, Ph.D., ABPP Private Practice
Aug 2014 – May 2015	**Supervision Seminar** Mary Alice Conroy, Ph.D., ABBP, Jorge Varela, Ph.D. Sam Houston State University
Jan 2014	**Clinical Conceptual Problems in the Attribution of Malingering in Forensic Evaluations** Richard Frederick, Ph.D., ABPP Private Practice

Awards

Mar 2019	**Travel Award for Outstanding Graduate Student Research Proposal** American Psychology-Law Society
Mar 2016	**Travel Award for Outstanding Graduate Student Research Proposal** American Psychology-Law Society
2015 – 2016	**Outstanding Teaching Assistant Award (Nominee)** Sam Houston State University
2014 – 2015	**Outstanding Thesis Award (Nominee)** Sam Houston State University
2007 – 2011	**Academic Competitiveness Grant** Boston University

Professional Memberships

2014 – Present	American Psychology-Law Society (APA Division 41)
2010 – Present	Psi Chi – National Psychology Honor Society

Professional Service Activities

Spring 2015	SHSU Undergraduate Psi Chi Graduate School Prep Committee Advisor
Nov 2014	Ad-Hoc Reviewer, *Journal of Aggression, Conflict and Peace Research* (special issue on "Contemporary Perspectives on Suicide and Self-injury")
Fall 2014	SHSU Undergraduate Psi Chi Research Committee Advisor
2014 – 2016	American Psychology-Law Society Conference Student Volunteer

Languages

French: fluent, written and verbal