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The Impact of Misdemeanor Arrests on Forensic Mental Health Services: A State-Wide Review of Virginia Competence to Stand Trial Evaluations

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Across the United States, court orders for competence to stand trial evaluations and competence restoration services have been increasing much more rapidly than many states can provide these services, prompting what has been called a national "competency crisis." Though many factors contribute to this crisis, one that has received little attention is the potentially disproportionate role of misdemeanor arrests on competency services. Therefore, we reviewed a state-wide sample of court-ordered competence evaluation reports in Virginia (N = 1,126) to compare defendants facing only misdemeanor charges to defendants facing felony charges. Overall, defendants facing only misdemeanors were more often opined incompetent to stand trial than were defendants facing only felony charges (44.0% vs. 31.2%), perhaps due to the greater prevalence of psychotic symptoms among defendants facing only misdemeanor charges (34.5% vs. 15.9%). Indeed, hierarchical regression analyses suggested that incompetence opinions were primarily explained by the presence of psychotic symptoms. A simple fiscal analysis also revealed that defendants facing only misdemeanor charges are disproportionately costly to Virginia, due in part to a greater need for inpatient restoration services. These findings suggest the national competency crisis could be reduced, to at least some degree, by mental health diversion or treatment strategies specific to mentally ill defendants facing only misdemeanor charges.

Keywords: forensic assessment, competence to stand trial, competence restoration, misdemeanor, competency crisis

Defendants facing criminal charges—no matter how minor those charges—must have the basic capacities to meaningfully understand proceedings, assist counsel, and make decisions during their adjudication. That is, defendants must be competent to stand trial, a principle long recognized by many justice systems and formalized in the United States under the *Dusky v. United States* (1960) standard. Competence is crucial to fair criminal proceedings, preserving both the dignity and reliability of the court but also the dignity and autonomy of defendants. Thus, when there are concerns that symptoms of psychiatric illness or intellectual disability may leave a defendant without the capacities necessary to stand trial, counsel may request—and courts may order—a forensic mental health professional to evaluate that defendant's competence to stand trial. If the evaluator opines that the defendant is not competent to stand trial (incompetent, or IST), the court typically orders competence restoration. Historically, such competence restoration has involved inpatient psychiatric hospitalization and medication, sometimes supplemented by basic education on courtroom procedures, intended to improve the defendant's capacities enough to become "restored to competence" and meaningfully participate in adjudication.

Increasing Court Orders for Competence-Related Services

Evaluations of a defendant's competence to stand trial (CST) have always been the most common form of forensic mental health evaluation (Melton et al., 2007; Poythress et al., 2002), but courts are ordering competence evaluations even more frequently than in the past. Two decades ago, authorities estimated that approximately 60,000 competence evaluations of felony-charged defendants were conducted each year in the United States (Bonnie & Grisso, 2000), so that estimate has become ubiquitous, cited throughout the competency literature. However, the current number is almost certainly higher, even if the exact number of competence evaluations conducted annually in the United States is unknown (Mossman et al., 2007). The available jurisdiction-level data consistently reveal rapid increases in competence evaluations. As Gowensmith (2019, p. 2) observed,

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> CST evaluations in Wisconsin increased 32.5% from 2010 through 2015 (Wisconsin Department of Health Services, 2015), while evaluations in Washington increased 76.3% from 2001 through 2012 (Joint Legislative & Audit Review Committee, 2014). Colorado reported a 206% increase in the number of competence evaluations from 2005 to 2014 (Colorado Department of Human Services, 2015), and Los Angeles county reported a 273% increase from 2010 to 2015 (Sewall, 2016).

In Virginia, site of the present study, court orders for stand-alone competence evaluations of adults increased 218% from 690 in 2007 to 1,507 in 2018 (unpublished data from the Virginia Department of Behavioral Health and Developmental Services provided July 22, 2020).[1] Indeed, in a recent survey of forensic administrators and experts from nearly every state, 70% reported that they perceived referrals for competency evaluations of felony defendants were increasing, and 71% reported that they perceived referrals for competence evaluations of misdemeanor defendants were increasing (Warburton et al., 2020).

A natural consequence of increasing court orders for competence evaluations is an increase in the number of criminal defendants found IST and ordered to restoration services. Unless recent state increases in competence orders have been entirely spurious—that is, inappropriate referrals of defendants who are actually competent—increased orders for competence evaluations inevitably yield increased numbers of defendants found IST, even if the actual proportion of defendants found incompetent remains the same. Again, Gowensmith (2019, p. 2) summarized some of these trends:

> Wisconsin saw a 34.8% increase between 2011 and 2013 in defendants adjudicated IST and ordered to restoration (Wisconsin Department of Health Services, 2015), Hawaii saw a 35.8% increase from 2005 to 2009 (Gowensmith, 2019), [and] Washington had a 73% increase between 2010 and 2014 (Joint Legislative and Audit Review Committee, 2014).

A report from the County of Los Angeles in California (Katz, 2016, p. 2) is particularly illustrative:

> Over the past five years, there has been a sharp increase in the number of Incompetent to Stand Trial (IST) cases referred . . . In the year 2010 there were a total of 944 IST cases referred by the criminal trial courts. By the year 2015, the number of referrals had increased to 3,528. This represents a 350% increase in cases from 2010 to 2015. The increase in IST cases is notably sharp in the most recent statistics available. From 2014 to 2015, IST cases increased by 48%.

Similarly, in the recent survey of forensic administrators and experts from nearly every state, 65% reported that they perceived increased competence restoration orders for those defendants charged with felonies, and nearly 69% reported that they perceived increased restoration orders for defendants charged only with misdemeanors (Warburton et al., 2020).

More perplexing than the increased numbers of defendants found IST—which naturally follows the increase in court orders for evaluations—is the increased *proportion* of defendants opined IST. In a few jurisdictions that allow for examination over time, there has been an increase in the percentage (not just the raw numbers) of defendants who are opined IST once ordered to evaluation. In Virginia, IST rates in a large-scale sample of court-ordered evaluations averaged 17.6% during the years 1993 to 1998 and increased to 27.3% during the years 1998 to 2004 (Warren et al., 2006). More recently, these IST rates increased further to 38.8% during the years 2016 to 2018 (Murrie et al., 2020). In Washington state, internal data reveal a steady increase in the proportion of evaluations that ended in IST determinations during the 2013−2018 period, with IST rates reaching 42–46% during 2018 (Huber, 2019).

The recent, increasing IST rates from Virginia (39%) and Washington (42−46%) are striking for the degree to which they exceed historical observations and estimates about IST rates. For example, the modal estimate of IST rates in most jurisdictions has historically been around 20% (Roesch et al., 1999). Likewise, one comprehensive review of the competency literature concluded, "Most statewide samples appear to reveal IST rates around the 18−25% range" (Murrie & Zelle, 2015, p. 129). A rigorous meta-analysis of competency studies revealed a slightly higher average IST rate of 27.5% (95% CI [25.7, 33.4]; Pirelli et al., 2011). However, more recent point-in-time figures from other states (i.e., snapshot figures from a particular year or period, as opposed to the year-by-year figures just described for Virginia and Washington) also reveal higher rates of IST findings than the averages reported in this widely cited meta-analysis. For example, 56% of Alaska evaluations yielded an IST finding in 2018 (Agnew Beck Consulting, 2019), and Colorado reported IST rates around 53% during 2016–2019 (Colorado Department of Human Services, 2019). Of course, the widely cited meta-analytic average of 27.5% reflects a wide variety in underlying IST rates across individual samples (Pirelli et al., 2011). Yet in our review attempting to identify recent IST estimates across U.S. states, all figures we found were higher than the widely cited 27.5% meta-analytic average and the upper limit of its 95% confidence interval; no figures fell below this estimate. Put simply, recent state data suggest that the proportion of defendants found IST appears to be increasing, at least in jurisdictions that track these data.

The increasing orders for competence evaluation, apparent increase in proportions of defendants found IST, and increasing court orders for competence restoration services all lead to another consequence. Because competence restoration services still largely occur in inpatient psychiatric hospitals (Gowensmith & Murrie, in press), the proportion of forensic (vs. civil) patients in state psychiatric hospitals has increased dramatically in recent years. Indeed, the number of forensic patients in state hospitals from 1999 to 2016 has increased by 76%, with most of this increase attributable to individuals ordered for competence restoration services (Wik et al., 2017).

The "Competency Crisis"

The wide-scale substantial increase in orders for competence evaluation and competence restoration has created what many authorities are describing as a national "competency crisis" (e.g., Callahan & Pinals, 2020; Gowensmith, 2019; Warburton et al.,

[1] Despite the substantial increase in orders for stand-alone competence evaluations, the rate of orders for concurrent competence evaluations and sanity evaluations (i.e., when the court orders both evaluations at the same time) increased little over this period. When these combined (competence + sanity) evaluation orders are included, court-ordered competence evaluations increased 139% from 1,901 to 2,650 over the 2007−2018 period.

2020; Wortzel et al., 2007). In short, many state systems, particularly psychiatric hospitals, have been unable to accommodate the rapidly increasing orders for competence evaluation and restoration. This leaves many defendants with psychiatric illness waiting in jails, sometimes for many months, and often with clinical symptoms that worsen as they await restoration services. In many of these state systems, advocacy groups have initiated litigation to accelerate and improve mental health treatment for the criminal defendants found IST and lingering on waitlists for inpatient hospitalization. Thus, several states are now bound by Consent Decrees or Settlement Agreements to improve their competency-related services (e.g., *Center for Legal Advocacy dba Disability Law Colorado v. Barnes and Marshall,* 2018; *Oregon Advocacy Center v. Mink,* 2003; *Trueblood v. State of Washington Department of Human Services,* 2015).

Although this competency crisis has been well documented by scholars (e.g., Callahan & Pinals, 2020; Gowensmith, 2019; Wortzel et al., 2007) and even journalists (e.g., Tullis, 2019), the consequences of the crisis remain much clearer than the causes. Like most complex public health problems, the causes are likely multifaceted and interactive. Individual jurisdictions have noted the contributions of poor public psychiatric services, substance abuse, and homelessness (e.g., Katz, 2016). Most broadly, this crisis may be intertwined with what has been labeled the "criminalization of mental illness" (Wortzel et al., 2007), the well-recognized trend wherein public mental health treatment has become increasingly scarce and difficult to access such that criminal arrest (often followed by a competence evaluation) may seem the only remaining mechanism to link people with chronic mental illness to public mental health treatment (see Abramson, 1972; Dvoskin et al., 2020; Lamb & Weinberger, 1998).

What Role Do Misdemeanor Offenses Play in the Competency Crisis?

One contributor to the competency crisis, and perhaps the criminalization of mental illness more broadly, may involve the disproportionate role of misdemeanor charges. Misdemeanors are criminal offenses that are less serious than felonies, but states vary in the behaviors they label as misdemeanors (e.g., traffic violations) and their associated penalties.[2] Nevertheless, persons charged with misdemeanors, however defined, comprise the vast majority of individuals who come into contact with the criminal justice system (Chauhan & Travis, 2018). Indeed, a recent analysis estimated that 4,261 misdemeanors are filed per 100,000 people in the United States every year, totaling approximately 13.2 million yearly misdemeanor offenses (Stevenson & Mayson, 2018). Misdemeanors have comprised 74% to 83% of all criminal caseloads in the last 10 years, typically outnumbering felonies threefold (Stevenson & Mayson, 2018, 2020). To be clear, the prevalence of misdemeanor charges within the criminal justice system is not a recent development. Misdemeanor arrest rates have actually declined in recent decades, likely due to changes in policing practices, increased incarceration, and shifting age demographics (Stevenson & Mayson, 2018; Zimring, 2007). Nevertheless, it is clear that (a) the absolute number of misdemeanor arrests in the United States remains far higher than felony arrests, (b) the misdemeanor justice system is poorly understood and operates quite differently across jurisdictions, and (c) misdemeanor arrests disproportionately impact people in poverty and people of color (Stevenson & Mayson, 2020).

Some scholars have argued that many misdemeanor offenses criminalize behaviors that are directly or indirectly caused by mental illness and/or addiction (Hashimoto, 2007; Junginger et al., 2006; Natapoff, 2018; Stevenson & Mayson, 2018). However, we know little about mental illness rates among those charged only with misdemeanors. In one study of a single jurisdiction, 23% of individuals charged only with misdemeanor offenses appeared to have mental illness sufficient to require intervention (Pooler, 2015). Estimates of mental illness among the broader population of criminal defendants (i.e., those facing misdemeanor and/or felony charges) vary, but one influential study estimated that 14.5% of male jail inmates and 31.0% of female inmates have serious mental illness, defined as diagnoses of depressive disorders, bipolar disorders, schizophrenia, and schizophrenia-related disorders (e.g., Steadman et al., 2009).[3]

Might defendants facing misdemeanor (vs. felony) charges be disproportionately involved in the competence system or represented in the current competency crisis? No research has directly explored the question, but a few jurisdictions provide strongly suggestive data. Specifically, in the Los Angeles County example mentioned previously, authorities concluded, "The increase in IST cases is primarily due to a sharp increase in the number of misdemeanor referrals . . . the main driving factor in the sharp increase is not related to felony cases, but misdemeanor cases" (Katz, 2016, p. 2). Similarly, internal data from Washington state—site of the largest U.S. lawsuit addressing competency services—also reveal a disproportionate role of misdemeanor charges in the competence evaluation and restoration process. Whereas referrals for competence evaluations increased 84% from 2013 through 2018, "most of the increase is due to an increase in competency evaluations for misdemeanors" (Huber, 2019, p. 8).

Thus, internal data from Los Angeles County and Washington state are provocative examples that raise questions about the role of misdemeanor offenses in the current competency crisis. However, we are aware of no formal, peer-reviewed studies addressing the role of misdemeanor charges in the competency crisis. The formal research literature addressing evaluations of trial competence has rarely explored misdemeanor charges explicitly, but findings are suggestive in that they tend to reveal defendants facing less severe charges are more likely to be opined incompetent. For example, an early Virginia study (Warren et al., 1991) found that defendants charged with public order offenses (e.g., trespassing, disorderly conduct) were most likely to be opined incompetent to stand trial. Likewise, Rosenfeld and Ritchie (1998) found that defendants charged with misdemeanor offenses were more likely to be opined incompetent than other defendants. The largest studies of state (Warren et al., 2006) and federal (Cochrane et al., 2001) competence evaluations have also observed that

[2] The maximum penalty for misdemeanor offenses is typically 1 year of incarceration, but some states allow greater maximum penalties. Regarding the site of the present study, misdemeanors in Virginia are punishable by confinement in jail up to 12 months and/or a fine of up to $2,500.

[3] For comparison, recent estimates indicate that approximately 18.9% of adults within the United States have a mental illness, and 4.5% of adults within the United States have serious mental illness (Substance Abuse and Mental Health Services Administration, 2018).

defendants facing more serious charges are more often found competent, whereas those facing less serious (though not necessarily misdemeanor) charges are more often found incompetent.

This pattern of findings (i.e., that those facing less serious charges are more often found incompetent) appears counterintuitive, at least if we assume that competence-impairing symptoms are distributed equally across defendants. After all, defendants facing more serious charges (and hence more complicated proceedings and decisions) generally require *greater* capacity to participate meaningfully in these proceedings (American Bar Association, 1989; Melton et al., 2007; Murrie & Zelle, 2015). Thus, scholars have offered multiple hypotheses for this counterintuitive phenomenon, observing that attorneys more often refer defendants who face more serious charges (Berman & Osborne, 1987; Hoge et al., 1992) or speculating that evaluators may be biased by severity of charges (Rosenfeld & Ritchie, 1998). However, the primary explanation for this consistent pattern of findings is likely that competence-impairing symptoms are not similarly distributed across defendants because those facing less serious charges tend to manifest more symptoms of serious mental illness. When researchers have examined clinical diagnoses alongside criminal charges and competence opinions, diagnosis appears to explain the relation between the other two (Cochrane et al., 2001; Warren et al., 2006). That is, serious psychiatric illnesses such as schizophrenia or other psychotic disorders were disproportionally common among defendants facing charges for minor, lower-level charges and much less common among defendants facing more serious charges such as murder or sexual offenses (Cochrane et al., 2001; Warren et al., 2006).

Taken together, the available research leads us to expect that a substantial portion of evaluations during the current competency crisis may address defendants facing only misdemeanor charges and that these defendants facing only misdemeanor (vs. felony) charges may be disproportionately likely to manifest the types of serious psychiatric symptoms that render them incompetent. Furthermore, if these expectations are correct, they raise questions about whether policies or approaches specific to misdemeanor-level defendants could play a significant role in reducing the fiscal and human toll of the competency crisis.

Current Study

To address these questions, we reviewed a state-wide sample of Virginia competence evaluation reports, with a focus on those addressing only misdemeanor charges. As of 2015, Virginia had the seventh-highest estimated rate of misdemeanor offenses per 100,000 people among all states at 6,930 filings (Natapoff, 2018). Virginia also has a well-developed Forensic Evaluation Oversight System that allows for examination of all court-ordered forensic evaluation reports addressing adjudicative competence or legal sanity (Gardner et al., 2018; Murrie et al., 2020). Thus, this study is the first to identify and review competence evaluation reports among defendants charged only with misdemeanors. Virginia's oversight system makes such a review possible and allows for comparison with other, earlier studies of competence evaluations that did not consider misdemeanor competence evaluations specifically (e.g., Warren et al., 1991, 2006).

For purposes of this study, we reviewed a state-wide sample of court-ordered competence evaluation reports (N = 1,126), including those that addressed only misdemeanor charges (n = 316), those that addressed only felony charges (n = 503), and those that addressed both (n = 248). We coded all reports for numerous variables describing the defendant, evaluation, and legal opinions. Further, we obtained fiscal data from Virginia's Department of Behavioral Health and Developmental Services regarding average costs associated with competence evaluation and restoration services. Through this review, we sought to answer

1. What proportion of competence evaluations address defendants facing only misdemeanor charges, and how do these evaluations differ from those addressing defendants with felony charges?

2. What are the typical competence findings for defendants facing only misdemeanor charges, particularly as compared to defendants facing felony charges?

3. What are the financial costs associated with competence evaluations and restoration for defendants facing only misdemeanor charges in Virginia?

Finally, because the overall goal of this study is to explore the impact of misdemeanor charges on competency services, our analyses consider one Virginia policy addressing defendants facing only certain misdemeanor charges. Specifically, in 2009, Virginia initiated a "45-day rule" that requires a new report on competence be submitted to the court within 45 (rather than the usual 90) days of restoration efforts for those defendants facing certain qualifying misdemeanor offenses (i.e., trespassing, disorderly conduct, or petit larceny). The goal of the legislation was to reduce the instances in which defendants charged with relatively minor offenses spent disproportionately long periods in restoration services (a scenario that could apply to other types of misdemeanor offenses, so it remains unclear why only these three charges were specified in the legislation). Generally speaking, this is a narrowly focused policy addressing competence services for those facing only certain misdemeanor charges, but we examined it in this study because it may have implications for broader policies addressing defendants in the competency system facing only misdemeanor charges.

Method

Context

We reviewed 1,126 court-ordered CST evaluation reports completed by 90 forensic evaluators practicing in Virginia. All evaluators were licensed psychologists or psychiatrists on the Virginia Commissioner of the Department of Behavioral Health and Developmental Services' (DBHDS) "List of Approved Evaluators" at the time of data collection (see Murrie et al., 2020 for further details on Virginia evaluators and competence evaluations). Generally speaking, defense counsel initiated the requests for competence evaluations (though in some cases, judges did so independently), and then the court formally ordered the evaluations, which were reimbursed by the Virginia court system.

Procedure

We reviewed all CST evaluation reports submitted to the Virginia DBHDS from February 1, 2018 to April 15, 2019 (a period of approximately 14.5 months).[4] However, due to occasional delays among evaluators in sending reports for review, the actual report dates spanned a 2-year period from April 5, 2017 to April 15, 2019. As part of the state-wide oversight process, Virginia Code § 19.2–169.1 states,

> In all cases, the evaluator shall send a redacted copy of the report removing references to the defendant's name, date of birth, case number, and court of jurisdiction to the Commissioner of Behavioral Health and Developmental Services for the purpose of peer review to establish and maintain the list of approved evaluators. (Virginia Code, 2020)

To comply with the Code of Virginia, all evaluators who submit a court-ordered report must therefore also submit a redacted copy of that report to the Virginia DBHDS. Although it is not possible to confirm that every evaluation for which the court system paid resulted in a report sent to the oversight system, the Forensic Evaluation Oversight Manager's informed estimation of evaluator compliance suggests that the vast majority of evaluators submitted reports. Thus, we cannot rule out the possibility that a few evaluators failed to submit reports, but the available evidence suggests our sample comprises the overwhelming majority of court-ordered CST evaluations submitted to Virginia courts during the study period.

Reports were coded by one of five independent coders. All coders were clinical psychology doctoral students who had completed two doctoral-level courses in forensic mental health assessment. Additionally, the Forensic Oversight Manager and second author provided a 6-hr, in-person training to all coders detailing competence evaluations, forensic report requirements, and relevant Virginia statutes. At the conclusion of the training, all coders reviewed several report exemplars to further increase coding consistency. To assess interrater reliability and ensure compliance with the coding protocol, the second author coded a random subsample of reports on two occasions. After 99 CST reports had been coded, the second author independently coded 20 reports (i.e., 20% of coded reports at that time). Variables with lower levels of agreement (e.g., criminal history: 70%) were reviewed with all coders, and the coding protocol was altered to increase reliability. Specifically, we made technical changes to the coding protocol (e.g., altered allowable inputs) and added a coding option for collateral sources (not reported in the current study). After 578 CST reports had been coded, the second author again independently double coded a random subsample of 20 reports. Interrater reliability statistics are depicted in the Appendix for all reported variables. As shown, all variables achieved at least good agreement, as traditionally defined (i.e., Cohen's $\kappa > 0.60$), with most variables achieving excellent agreement.

All evaluation reports were coded on multiple variables that described characteristics of the defendant, the CST evaluation process, the resulting report, and the forensic conclusions offered within the report. Regarding defendant characteristics, we coded multiple features of defendants' personal histories (e.g., sex, age, education) and current offenses (e.g., type of offenses). Additionally, we coded prominent psychiatric diagnoses and/or features when reports detailed this information. Regarding evaluation characteristics, we coded multiple aspects of the evaluation process such as interview length and setting. Regarding forensic conclusions, we coded variables describing the legal opinion offered in CST reports and the bases for such opinions. For instance, we coded the final legal opinion regarding CST and conclusions regarding each component or "prong" of the competency standard (i.e., factional understanding, rational understanding, and ability to assist counsel). We also coded the psychiatric features that evaluators identified as impeding the defendant's competency-relevant capacities.

Results

What Proportion of Competence Evaluations Address Defendants Facing Only Misdemeanor Charges, and How Do These Evaluations Differ From Those Addressing Defendants Facing Felony Charges?

Most CST reports identified the underlying charges (98.5%; 1,109 of 1,126). Of these, most reports addressed only felony charges (45.4%; 503 of 1,109), although more than 1 in 4 evaluations addressed only misdemeanor charges (28.5%; 316 of 1,109). Fewer reports (22.4%; 248 of 1,126) addressed a combination of misdemeanor and felony charges, whereas the remaining reports (3.8%; 42 of 1,126) solely addressed probation violations, failures to appear, or capiases. Two reports addressing felony charges included capital offenses.

Regarding the type of offenses addressed in CST reports, 53.2% of reports addressed person offenses (e.g., assault and battery), 43.2% addressed property offenses (e.g., petit larceny), 12.7% addressed firearm-involved offenses (e.g., unlawful possession of a firearm), 12.4% addressed drug/alcohol-related offenses, and 7.0% addressed sex offenses. Overall, approximately half of all CST reports (49.7%) addressed at least one offense that was violent in nature. Of course, evaluations regarding only felony charges were more likely to address violent charges (65.1%) than were misdemeanor evaluations (41.4%), $\chi^2(1, N = 817) = 43.29$, $p < .001$, Cramer's $V = .23$, 95% CI [.15, .29], though some misdemeanors were violent (the most common was misdemeanor assault).

Regarding the characteristics of CST evaluations, courts typically received a completed CST report 72.0 days (median = 52.0; $SD = 77.4$) after issuing a court order, but again, elapsed times varied widely. Some CST reports were completed 5 days after the court order, whereas others reportedly took up to 877 days (i.e., ≈ 2.4 years) to complete, though exact time is uncertain.[5] Evaluators typically submitted a completed report 8.6 days (median = 4; $SD = 17.9$) after completing the evaluation. Some evaluators submitted a completed report to the court on the day of the

[4] The CST reports coded in this sample are unique and do not overlap with Virginia CST reports described in earlier studies (e.g., Murrie et al., 2020).

[5] The very lengthy delays typically reflect orders for competence re-evaluation when the defendant spent lengthy periods in competency restoration services. It appeared that in some of these, evaluators erroneously cited an original order for competence evaluation rather than subsequent orders for re-evaluation during restoration efforts.

evaluation, and three reported taking over 100 days to submit a completed report (though closer inspection suggested these may have reflected errors by the evaluator).

Regarding defendant characteristics, most were male (75.5%), and their mean age was 38.1 years (SD = 14.2; 14 to 83). Of the CST reports that indicated race (586 of 1,126 reports did so), most defendants were African American (62.3%) or Caucasian (32.9%). Evaluators rarely described defendants as Hispanic/Latino (3.1%), Asian/Pacific Islander (1.2%), or another ethnicity (0.5%). Approximately one third of defendants (34.2%) had not graduated high school, whereas 41.3% either graduated high school or obtained a graduate equivalency degree. Approximately one quarter of defendants (24.5%) had attended or completed more advanced education or training beyond high school. In reports that addressed criminal history, most (82.3%) defendants had a prior criminal history noted.

Evaluators either diagnosed the defendant with a psychiatric disorder or documented significant psychiatric symptoms in almost two thirds of defendants (61.2%). Defendants most often exhibited psychotic symptoms (30.2% of defendants), followed by symptoms of mood disorders (14.1%), substance use disorders (5.4%), and intellectual disability (5.2%). Fewer defendants exhibited clinically significant features of an anxiety disorder (5.1%) or a personality disorder (4.0%). In 5.2% of reports, evaluators expressed the belief that the defendant was malingering psychiatric symptoms at the time of the evaluation.

Table 1 demonstrates how CST evaluations addressing only misdemeanor charges differ from evaluations addressing only felony charges or both misdemeanor and felony charges. We conducted a series of chi-square analyses and independent-sample t tests or independent-sample Mann-Whitney U tests (depending on whether the variable of interest was normally distributed and continuous or categorical) to directly compare evaluations addressing misdemeanor charges versus those addressing felony charges. Regarding the evaluation process and required resources, less time elapsed between the date of evaluation and the date the report was completed in misdemeanor cases than in felony cases. However, the amount of time elapsed between a court order directing a CST evaluation and the date a report was completed was the same, on average, whether the charges were misdemeanor or felony. Further, CST evaluations addressing only misdemeanor offenses (30%) were slightly more likely to be conducted on an inpatient basis as compared to CST evaluations addressing felonies (23.3%).

Defendants facing only misdemeanor charges differed from defendants facing only felony charges in several demographic categories. Specifically, those facing only misdemeanor charges were older (d = .21) and 1.42 times more likely to be female, whereas those facing only felony charges were 1.24 times more

Table 1
CST Evaluation Characteristics According to Offense Class

	Offense class					
	Misdemeanor	Felony	Combination	Test statistic	p value	Effect size [95% CI]
# of CST reports	316 (28.5%)	503 (45.4%)	248 (22.4%)			
# of current charges	2.0 (1 to 12)	2.6 (1 to 46)	4.0 (1 to 15)	—	—	—
Evaluation characteristics						
Elapsed time (days)						
Order to report date	79.6	64.5	72.7	U = 4,908	.48	r = 0.05 [−.02, .12]
Evaluation to report date*	6.1	10.7	8.0	U = 59,700.5	.001	r = 0.12 [.05, .19]
Interview length (minutes)	97.2	130.8	102.3	U = 1,071.5	.06	r = 0.18 [−.01, .35]
Inpatient setting	30.0%	23.3%	35.0%	$\chi^2(1, N = 750) = 4.12$	.04	V = 0.07 [.01, .14]
Defendant participated*	86.7%	96.8%	94.4%	$\chi^2(1, N = 819) = 30.15$	<.001	V = 0.19 [.12, .26]
Defendant characteristics						
Sex (female)*	31.3%	22.1%	22.2%	$\chi^2(1, N = 819) = 8.73$	.003	V = 0.10 [.04, .18]
Race						
Caucasian	39.1%	28.2%	34.1%	$\chi^2(1, N = 433) = 5.63$	.02	V = 0.11 [.02, .21]
African American*	54.6%	67.6%	61.4%	$\chi^2(1, N = 433) = 7.46$	.01	V = 0.13 [.04, .23]
Age*	40.4	37.3	36.5	$t(623) = 2.60$	.01	d = 0.21 [.05, .37]
Education level						
Incomplete high school*	26.0%	37.8%	33.8%	$\chi^2(1, N = 714) = 10.28$	.001	V = 0.12 [.05, .19]
High school diploma/GED	44.9%	40.0%	39.8%	$\chi^2(1, N = 714) = 1.60$	.21	V = 0.05 [.00, .13]
Some college	20.5%	16.1%	20.4%	$\chi^2(1, N = 714) = 2.17$	.14	V = 0.06 [.00, .13]
Advanced degree	8.7%	6.1%	6.0%	$\chi^2(1, N = 714) = 1.67$	.20	V = 0.05 [.00, .12]
Special education history	47.2%	57.9%	51.4%	$\chi^2(1, N = 408) = 4.28$	.04	V = 0.10 [.01, .20]
No criminal history	19.5%	18.1%	18.9%	$\chi^2(1, N = 479) = .13$	.72	V = 0.02 [.00, .11]
Psychiatric features						
Psychosis*	39.9%	24.7%	28.6%	$\chi^2(1, N = 819) = 21.20$	<.001	V = 0.16 [.09, .23]
Mood*	9.5%	17.1%	15.3%	$\chi^2(1, N = 819) = 9.23$	.002	V = 0.11 [.05, .17]
Anxiety	3.5%	6.0%	6.0%	$\chi^2(1, N = 819) = 2.52$	.11	V = 0.06 [.01, .12]
Substance use disorder	4.4%	5.6%	5.6%	$\chi^2(1, N = 819) = .52$	.47	V = 0.03 [.00, .09]
Personality disorder	2.2%	4.4%	6.0%	$\chi^2(1, N = 819) = 2.65$	.10	V = 0.06 [.00, .11]
Intellectual disability	5.4%	6.6%	2.8%	$\chi^2(1, N = 819) = .47$	.49	V = 0.02 [.00, .09]
Malingering/feigning	3.2%	6.8%	5.2%	$\chi^2(1, N = 819) = 4.93$	.03	V = 0.08 [.02, .14]

Note. ns range from 151 (interview length) to 1,067. Reports addressing solely violations, failures to appear, and capiases (n = 42; 3.8%) were not included in the table. CI = confidence interval; CST = competence to stand trial.
* Significant differences between misdemeanor and felony competency reports at $p \leq .01$.

likely to be African American and 1.45 times more likely to have withdrawn from high school before receiving a degree. Finally, defendants facing only misdemeanor charges were 1.62 times more likely to exhibit features of psychosis during the evaluation and were 0.56 times as likely to exhibit clinical mood symptoms.

A meaningful number of CST reports (93; 8.3% of all reports reviewed) addressed defendants charged with a single, nonviolent misdemeanor. It took an average of 58.2 days (median = 41.5; $SD = 51.8$) from the court order date to receipt of the completed report. Additionally, 50 reports (15.8% of all misdemeanor CST reports reviewed) addressed defendants charged only with qualifying misdemeanor offenses (i.e., trespassing, disorderly conduct, or petit larceny), for which a recent Virginia law requires evaluators to submit a report to the court within 45 days of restoration efforts.[6]

What Are the Typical Competence Findings for Defendants Facing Only Misdemeanor Charges, Particularly as Compared to Defendants Facing Felony Charges?

Across all reports, evaluators opined a defendant to be incompetent to stand trial in 35.3% (397 of 1,126) of reports. More specifically, because Virginia statute requires evaluators to offer impressions regarding an incompetent defendant's potential for restoration, evaluators opined a defendant to be competent in 62.4% (703 of 1,126) of reports, restorably incompetent in 27.7% (312 of 1,126) of reports, and unrestorably incompetent in only 7.5% (85 of 1,126) of reports. Evaluators rarely provided an inconclusive opinion (1.1%; 12 of 1,126) or failed to provide a clear opinion regarding adjudicative competence (1.2%; 14 of 1,126). Among defendants opined restorably incompetent to stand trial, evaluators recommended inpatient restoration services for more than half (58.3%; 182 of 312), even though Virginia statute essentially prioritizes outpatient restoration as the default option. Among those defendants opined unrestorably incompetent to stand trial, evaluators recommended civil commitment for approximately half of defendants (51.8%; 44 of 85) and case dismissal and/or discharge for approximately one third of defendants (32.9%; 28 of 85).

Regarding the specific competency criteria, approximately one quarter of defendants (25.2%; 284 of 1,126) were opined to lack sufficient factual understanding of court procedures. Approximately 1 in 4 defendants (27.4%; 309 of 1,126) were opined to lack sufficient rational understanding of the proceedings against them. Finally, approximately one third of defendants (33.3%; 375 of 1,126) were opined unable to adequately assist counsel.[7] The most commonly cited symptoms impeding a defendant's competence were psychosis (22.8%), followed by intellectual disabilities (6.1%) and disordered mood (4.0%).

Table 2 shows the rate of forensic conclusions regarding competency to stand trial according to misdemeanor versus felony charges. We conducted a series of chi-square analyses to compare CST evaluations addressing misdemeanor charges versus those addressing felony charges. Defendants facing only misdemeanor charges were 1.33 times more likely to be opined restorably incompetent than were felony defendants and marginally more likely to be opined unrestorably incompetent (1.68 times as likely), $\chi^2(1, N = 819) = 5.20$, $p = .02$.[8] Evaluators provided similar recommendations for defendants opined unrestorably incompetent (whether facing misdemeanor or felony charges), but those facing misdemeanor charges and opined restorably incompetent were 1.63 times more likely to be recommended for inpatient restoration services compared to restorably incompetent defendants facing felony charges. Those facing only misdemeanor charges were less likely to meet each competency criteria than were those facing felony charges, with the largest discrepancy occurring in their factual understanding of court procedures (those facing misdemeanor charges were 1.66 times more likely to fail this criteria). Finally, among all reports, evaluators were 2.17 times more likely to identify psychotic symptoms as the primary impediment to competency in those facing only misdemeanor charges versus those facing only felony charges.

Regarding the 93 CST reports addressing defendants charged with a single, nonviolent misdemeanor, 34.4% opined the defendant to be restorably incompetent, and an additional 10.8% opined the defendant unrestorably incompetent, for a total incompetency rate of 45.2%. Among those opined restorably incompetent, evaluators recommended that more than two thirds (68.8%; 22 of 32) of defendants undergo inpatient (as opposed to outpatient) restoration efforts. Of the 50 reports addressing defendants charged only with misdemeanor offenses that require evaluators to submit a report to the court within 45 days of restoration efforts (i.e., trespassing, disorderly conduct, or petit larceny), 44.0% opined the defendant to be restorably incompetent, and an additional 10.0% opined the defendant unrestorably incompetent, for an overall incompetency rate of 54.0%. Among those opined restorably incompetent, evaluators recommended inpatient restoration services for 81.8% (18 of 22) of defendants. Overall, defendants with the least severe offenses seemed to experience the most severe psychiatric symptoms in that they were more often opined incompetent and more often recommended for intensive inpatient (vs. outpatient) restoration services.

What Explains the Higher Rates of Incompetence Opinions for Those Facing Only Misdemeanor Charges?

To help explain why those facing only misdemeanor charges are opined IST more often than those facing felony charges, we used hierarchical logistic regression to examine the relative influence of offense class and psychiatric features. We entered offense class (i.e., misdemeanor or felony) into the initial model. We then entered psychotic features and disordered mood symptoms into the

[6] Despite the statutory language regarding certain misdemeanor charges, judges did not consistently request a 45-day turnaround for evaluations addressing qualifying charges in the current sample. Indeed, judges occasionally requested that evaluation reports be submitted within 45 days for charges not identified in statute and occasionally did not request a 45-day turnaround for evaluations addressing qualifying charges identified in statute. In any case, we only included reports of which the listed charges fulfill the statutory language.

[7] In some reports, evaluators failed to address (or provide a clear opinion regarding) the specific Dusky criteria. Specifically, they did not provide a conclusive opinion on factual understanding in 11.6% of reports, rational understanding in 13.2% of reports, and ability to assist counsel in 6.0% of reports.

[8] We used a conservative alpha level of $p < .01$ to account for the number of analyses conducted.

Table 2
Forensic Conclusions Among CST Evaluations According to Offense Class

	Offense class					
	Misdemeanor	Felony	Combination	Test statistic	*p* value	Effect size [95% CI]
# of CST reports	316 (28.5%)	503 (45.4%)	248 (22.4%)			
Legal opinion						
Restorably incompetent*	32.9%	24.7%	24.6%	$\chi^2(1, N = 819) = 6.59$	.01	$V = .09$ [.03, .16]
Unrestorably incompetent	11.1%	6.6%	5.6%	$\chi^2(1, N = 819) = 5.20$	.02	$V = .08$ [.01, .16]
Competent w/accommodation	9.8%	12.7%	9.7%	$\chi^2(1, N = 819) = 1.61$	.21	$V = .04$ [.00, .11]
Psychiatric features impeding CST						
Psychosis*	34.5%	15.9%	20.6%	$\chi^2(1, N = 819) = 37.78$	<.001	$V = .22$ [.14, .29]
Mood	3.2%	3.6%	5.6%	$\chi^2(1, N = 819) = .10$	.75	$V = .01$ [.00, .08]
Anxiety	0.3%	1.4%	0.4%	$\chi^2(1, N = 819) = 2.32$	.13	$V = .05$ [.01, .09]
Personality disorder	1.6%	0.4%	1.6%	$\chi^2(1, N = 819) = 3.21$	.07	$V = .06$ [.01, .13]
Intellectual disability	6.6%	7.6%	3.6%	$\chi^2(1, N = 819) = .24$	.62	$V = .02$ [.00, .09]
Insufficient factual understanding*	35.4%	21.3%	21.0%	$\chi^2(1, N = 819) = 19.89$	<.001	$V = .16$ [.09, .23]
Insufficient rational understanding*	36.1%	23.7%	23.0%	$\chi^2(1, N = 819) = 14.70$	<.001	$V = .13$ [.06, .21]
Inability to assist counsel*	43.0%	29.4%	28.2%	$\chi^2(1, N = 819) = 15.88$	<.001	$V = .14$ [.07, .22]
IST inpatient restoration*	68.3%	41.9%	63.9%	$\chi^2(1, N = 228) = 15.79$	<.001	$V = .26$ [.13, .38]
URIST recommendation						
Dismiss/discharge	37.1%	21.2%	50.0%	$\chi^2(1, N = 68) = 2.08$	.15	$V = .18$ [.01, .41]
Civil commitment	54.3%	54.5%	35.7%	$\chi^2(1, N = 68) = .00$	.98	$V = .00$ [.00, .27]
Malingering/feigning addressed	19.0%	25.6%	30.2%	$\chi^2(1, N = 819) = 4.85$	.03	$V = .08$ [.01, .14]

Note. CI = confidence interval; CST = competence to stand trial; IST = incompetence to stand trial; URIST = unrestorably incompetent to stand trial.
* Significant differences between misdemeanor and felony CST reports at $p \leq .01$.

model. We ran another similar hierarchical logistic regression in which we first entered psychiatric feature variables, then offense class, into the model. As Table 3 demonstrates, offense class predicts opinions of incompetence in isolation but is no longer significant when accounting for a defendant's psychotic features. Defendants with psychotic features were approximately 7.83 times as likely to be opined incompetent as those without such features after taking into account offense type and the presence of disordered mood symptoms.[9]

What Are the Financial Costs Associated With Competence Evaluations and Restoration for Defendants Facing Only Misdemeanor Charges in Virginia?

Although Virginia's $400 flat fee for court-ordered CST evaluations ranks among the lowest in the United States, there are other costs associated with competence evaluations and restoration efforts. Table 4 depicts some of the financial costs associated with CST evaluations, categorized according to the forensic conclusions. Specifically, the cost of any outpatient evaluation is the meager $400 flat fee paid by the court. However, the cost of restoration services varies greatly. Outpatient restoration is provided through community mental health centers, known in Virginia as Community Services Boards. At a minimum, the state forensic system reimburses the psycho-educational (i.e., court education) sessions, of which the average defendant receives 5.7 hr before achieving restoration. Beyond the education, the state forensic system reimburses an intake assessment (1.5 hr per defendant on average) and case management services (2.7 hr on average) specific to restoration. This totals almost 10 hr per defendant, reimbursed at $50/hr for a total of $500. These do not include the costs of any psychiatric medications necessary for restoration, which are not state reimbursed as a restoration service (they may be paid through other funds, such as Medicaid). Complicating matters, many indigent defendants would have been eligible for similar services through the community mental health centers regardless of competency status, though it is also likely that many would not have sought them. Thus, the costs of outpatient services in Table 4 represent a minimal estimate. Of course, even in the most expensive cases, these outpatient costs are well below the costs of inpatient restoration services. Those inpatient restoration services averaged approximately $805 per day during the 2019 fiscal year, totaling roughly $74,301.50 for defendants charged only with felonies and $75,670 for defendants charged only with misdemeanors over the course of a typical restoration stay.

Discussion

The current competency crisis in the United States—marked by steadily increasing orders for competence evaluations, incompetence findings, and waitlists for inpatient restoration services—is a complex public health challenge. Like any public health challenge with multiple causes, it will probably require multiple strategies to resolve. Based on anecdotal reports from a few jurisdictions (Huber, 2019; Katz, 2016) and suggestive findings in some older studies of competence evaluations (e.g., Cochrane et al., 2001; Warren et al., 2006), we hypothesized that defendants facing only misdemeanor charges may play a disproportionate role in the competency crisis. Results generally supported this hypothesis.

[9] Although we were primarily interested in the relative influence of offense class and psychiatric features, we repeated the above analyses after inserting all demographic variables that varied significantly among misdemeanor and felony cases (i.e., defendant sex [♀], race [African American], age, and education level [incomplete high school]) alongside defendant psychiatric features. Results did not change appreciably in that psychotic features again emerged as the only significant predictor in the presence of other variables (all other $|\beta s| < .38$; $ps \geq .27$; $n = 352$).

Table 3
Hierarchical Logistic Regression Analyses Predicting Incompetent Opinions

Predictor	β	Wald χ^2	Exp(*B*)	95% CI	*p*
Logistic regression 1					
Model 1, $\chi^2(1) = 13.62$, $p < .001$, Nagelkerke $R^2 = .02$					
Offense class	0.55	13.61	1.73	[1.29, 2.32]	<.001
Model 2, $\chi^2(3) = 172.14$, $p < .001$, Nagelkerke $R^2 = .26$; step change: $\chi^2(2) = 158.52$, $p < .001$					
Offense class	0.31	3.33	1.36	[0.98, 1.89]	.07
Psychotic diagnosis/features	2.06	142.49	7.83	[5.59,10.98]	<.001
Disordered mood symptoms	0.04	0.03	1.04	[0.65, 1.67]	.86
Logistic regression 2					
Model 1, $\chi^2(2) = 168.83$, $p < .001$, Nagelkerke $R^2 = .26$					
Psychotic diagnosis/features	2.10	149.96	8.15	[5.82,11.40]	<.001
Disordered mood symptoms	0.002	<.001	1.00	[0.63, 1.60]	.99
Model 2, $\chi^2(3) = 172.14$, $p < .001$, Nagelkerke $R^2 = .26$; step change: $\chi^2(1) = 3.31$, $p = .07$					
Psychotic diagnosis/features	2.06	142.49	7.83	[5.59,10.98]	<.001
Disordered mood symptoms	0.04	0.03	1.04	[0.65, 1.67]	.86
Offense class	0.31	3.33	1.36	[0.98, 1.89]	.07

Note. $n = 819$. Offense class coded 0 = felony, 1 = misdemeanor. Psychotic diagnosis/features coded 0 = no diagnosis/features, 1 = psychotic diagnosis/features. Disordered mood symptoms coded 0 = no diagnosis/features, 1 = disordered mood symptoms. CI = confidence interval.

In this Virginia sample, evaluations addressing only misdemeanor charges were not rare; they comprised more than one fourth of the sample (28.5%, or 316 out of 1,109 reports with identified charges). Indeed, 8.3% of all reports addressed defendants charged with a single, nonviolent misdemeanor.

This subset of defendants facing only misdemeanor charges appeared to differ meaningfully from those facing only felony charges. Defendants facing only misdemeanor charges were 1.33 times more likely to be opined incompetent to stand trial and 1.68 times more likely to be found unrestorably incompetent. They were more often recommended for intensive inpatient (vs. outpatient) restoration services, even though outpatient restoration is prioritized in Virginia law and policy and is particularly suited (at least from a public safety perspective) for defendants facing misdemeanor charges. Those defendants charged with a single, nonviolent misdemeanor had even higher rates of IST findings (45.2%) and higher recommendations for inpatient restoration (68.8%) compared to other defendants charged only with misdemeanors.

Overall then, defendants with the least severe offenses seemed to experience the most severe psychiatric symptoms. For example, those facing only misdemeanor charges were 1.62 times more likely to manifest symptoms of psychosis during the evaluation and 2.17 times more likely to manifest symptoms of psychosis that directly interfered with adjudicative competence. These greater symptoms were likely what prompted higher rates of recommendations for inpatient treatment. Put simply, those facing only misdemeanor charges appeared to suffer greater psychiatric illness, and the defendants with the least serious charges (a single nonviolent, misdemeanor charge) appeared even more ill and more in need of more services. These findings were generally similar to a similar, recent study of insanity evaluations of misdemeanor defendants, who were more likely to suffer psychosis and more likely to be opined insane, compared to defendants facing felony charges (Gardner et al., 2020). Both studies suggest that among defendants referred for evaluation, those facing only misdemeanor (vs. felony) charges were more psychiatrically ill.

Though their charges were less serious, the amount of time elapsed between a court order directing a CST evaluation and the date a report was completed was the same, on average, whether the charges were misdemeanor or felony. When it came to restoration for those opined IST, outpatient restoration services are accessible in every Virginia jurisdiction, but evaluators recommended 68% of those facing only misdemeanor charges for inpatient restoration, compared to only 42% of those facing felonies.[10] Although we cannot access data on where the court actually ordered restoration (see "Limitations" section), this stark difference in recommendations from evaluators suggests that restoration services may be more intensive and expensive for defendants facing misdemeanors.

Implications

The higher rate of IST findings and greater recommendations for inpatient restoration among Virginia defendants facing only misdemeanor charges is consistent with anecdotal data from a few other jurisdictions (Huber, 2019; Katz, 2016) but also consistent with broader theories about the criminalization of mental illness (Abramson, 1972; Dvoskin et al., 2020; Lamb & Weinberger, 1998). Again, these theories posit that as public mental health services have become increasingly scarce, those with serious mental illness have become increasingly likely to face arrest, particularly on minor charges, as a result of behaviors related to their untreated illness and/or efforts to link them with treatment that

[10] Note that "outpatient" restoration services in Virginia include restoration services delivered in the jails, so evaluator recommendations for inpatient versus outpatient restoration are based on clinical treatment need, not on public safety considerations.

Table 4
Fiscal Costs Associated With Forensic Conclusions in Virginia Court-Ordered Competence Evaluations

	Average financial costs		Current sample	
Report conclusion	Inpatient evaluation	Outpatient evaluation	Misdemeanor (n = 316)	Felony (n = 503)
Competent				
Evaluation				
Evaluator fee	—	$400	$43,200 ($n$ = 108)	$95,600 ($n$ = 239)
State hospital stay	$24,472 ($805/day × M = 30.4 days)	—	$1,076,768 ($n$ = 44)	$1,761,984 ($n$ = 72)
Restorably IST				
Evaluation				
Evaluator fee	—	$400	$30,000 ($n$ = 75)	$42,000 ($n$ = 105)
State hospital stay	$24,472	—	$440,496 ($n$ = 18)	$293,664 ($n$ = 12)
Restoration services				
Outpatient	$500 ($50/hour × M = 10 hrs)	$500	$15,000 ($n$ = 30)	$33,500 ($n$ = 67)
or	or	or		
Inpatient	$74,301.50 or $75,670 ($805/day × M = 92.3 or 94.0 days)	$74,301.50 or $75,670	$5,372,570 ($n$ = 71)	$3,863,678 ($n$ = 52)
Unrestorably IST				
Evaluation				
Evaluator fee	—	$400	$3,200 ($n$ = 8)	$1,600 ($n$ = 4)
State hospital stay	$24,472	—	$538,384 ($n$ = 22)	$611,800 ($n$ = 25)
Total			**$7,519,618**	**$6,703,826**

Note. The average length of hospital stay for competence evaluations (M = 30.4; median = 25 days) and length of outpatient restoration services (M = 10 hours) represent the 2013 to 2019 fiscal years. The average length of hospital stay for inpatient restoration represents the 2019 fiscal year. We were able to obtain separate mean lengths of stay for inpatient restoration among misdemeanor and felony defendants (misdemeanor: M = 94.0; felony: M = 92.3). The average state hospital cost per day was obtained from the first 10 months of the 2019 fiscal year. IST = incompetent to stand trial.

appears accessible only through the criminal justice system. The high rate of recommendations for inpatient treatment strongly suggests that many of those facing only misdemeanor charges have severe psychiatric illness that warrants intensive treatment. However, it may be reasonable to ask whether the competency system is the best route to that needed treatment.

For defendants facing felony charges, competency evaluation and restoration is a crucial, constitutionally required protection to ensure a defendant can meaningfully understand and participate in proceedings. The same is true for defendants facing misdemeanor charges, of course, but the government interest in prosecuting misdemeanors tends to be less compelling. Indeed, government interest in prosecuting misdemeanors among mentally ill defendants might reasonably consider the costs of competence evaluation and treatment. These costs comprise not only the fiscal costs of evaluation and treatment—which total around $75,000 each for misdemeanor defendants referred to inpatient restoration—but also the human costs of delays awaiting this treatment, both for the defendant facing only misdemeanor charges and for all other defendants further down the waitlist for competency services in this era of competency crisis. Although there is probably no single or simple approach—at least one that will satisfy all stakeholders—that adequately addresses the disproportionate role of misdemeanor charges in the competency crisis, we suspect two broad categories of intervention hold the most promise: misdemeanor-specific competency policies and diversion to mental health treatment.

Misdemeanor-Specific Competency Policies

Some jurisdictions have already changed the policies around competency services to handle misdemeanor cases differently from felony cases. For example, Ohio limits restoration efforts to 30 or 60 days for misdemeanor offenses, depending on severity (Ohio Rev. Code Ann., 2020). The most extreme approach is the state of New York, where judges do not order restoration for defendants who are found incompetent to face misdemeanor charges and instead dismiss misdemeanor charges following a brief period of observation (N.Y. Crim. Proc. Law, 2020).

Virginia initiated small changes in 2009, mentioned earlier, by creating a 45-day rule that requires a new report on competence be submitted to the court within 45 days (rather than the usual 90 days) of restoration efforts for those defendants facing certain qualifying misdemeanor offenses. The goal was to reduce the instances in which defendants spent lengthy periods in restoration services for misdemeanor charges (sometimes longer than they would have served in jail had they been convicted of the misdemeanors). In our sample, there were 50 CST reports addressing defendants facing these qualifying misdemeanor charges; most (54%) of these were opined IST, with a higher percentage of unrestorably incompetent opinions (10%) and a higher rate of recommendation for inpatient treatment (81%) than any other subset of the sample. This suggests the legislation identified a population of CST examinees who are likely to be more psychiatrically ill and more likely to require intensive restoration treatment. However, these same factors suggest that a relatively small portion would be restored to competence within the 45-day period identified in statute and thus suggest many of these defendants will spend much more time in restoration treatment than they would have served in jail (if convicted of the misdemeanor with which they were charged). Perhaps the longer confinement is warranted if competence restoration is indeed the only route for treatment for these misdemeanor-level defendants. But might there be other routes to treatment for those misdemeanor-level defendants who need it? And might there be routes to treatment that cost less than a $75,000 period of inpatient restoration?

Diversion to Mental Health Treatment

Misdemeanor-specific changes to competence policy are likely to better steward resources in an era of lengthy waitlists and competency crisis. For example, dropping misdemeanor charges upon a finding of incompetence is certainly thrifty in the short term. However, these approaches do not always ensure adequate treatment for those who need it, which may constrain long-term effectiveness. Bypassing restoration efforts and dropping charges for a defendant with severe illness, for example, does little to prevent the defendant from returning to court with a new misdemeanor charge. Thus, a second strategy is diversion. Diversion reduces the overall number of people awaiting competency services, thus reducing wait times for those who do require the services. The competency process can be slow; evaluations averaged 58 days from court order until receipt of report in our Virginia sample. Thus, roughly 2 months pass, with a defendant sometimes waiting in jail, before treatment begins. Restoration services then typically span several months (Gowensmith & Murrie, in press). Thus, diversion efforts often provide a faster route to treatment, and that treatment may be completed more rapidly (perhaps without a lengthy—or any—inpatient stay in a psychiatric hospital).

According to the sequential intercept model (see Munetz & Griffin, 2006), diversion can occur at multiple points before courts or counsel would raise questions of competency. Examples at the early intercepts might include crisis intervention training, crisis centers, assessment ("drop off") centers, arraignment-based diversion, mental health courts/dockets, and court-based clinicians. These tend to divert many people into mental health care and other needed resources, including people who would otherwise progress to become defendants in the competency evaluation and restoration systems (DeMatteo et al., 2013). Some diversion strategies may maintain the possibility of pending charges as leverage to require the individual to participate in mental health treatment.

Even after a defendant begins competency services, diversion remains a possibility. For example, Los Angeles County initiated the Misdemeanor Incompetent to Stand Trial—Community Based Restoration program to divert mentally ill individuals awaiting competency restoration from jails. The program identifies incompetent defendants who could be eligible for one of several different levels of community care. They are released from jail to enter court-ordered, community-based treatment, usually with an involuntary medication order and a requirement to return to court for progress reports (Ochoa & Simpson, 2017). In the years following its 2015 inception, 2,242 patients have been diverted from jails to community treatment programs (Los Angeles County Health Services Office of Diversion & Re-Entry, 2020), at which point their charges are typically dropped.

Limitations

We reviewed competence evaluations but could not access the actual court decisions about the defendant's competence. Of course, several studies have revealed that judicial decisions about competence follow evaluator opinions in more than 90% of cases (Gowensmith et al., 2012; Zapf et al., 2004), so evaluator opinions are likely a very close proxy for judicial opinions about competence in this sample as

well. Similarly, we have no data on how consistently judges follow evaluator recommendations for inpatient versus outpatient restoration, although anecdotal evidence suggests Virginia judges often follow these recommendations as well, particularly because outpatient restoration can include jail-based restoration (so judges need not order inpatient restoration solely for public safety concerns). The greater problem is that we do not know what the court decided about restoration efforts, such as ordering restoration as recommended or dismissing charges entirely when a defendant facing only misdemeanor charges was opined incompetent or unrestorably incompetent.

More broadly, we do not know about those similar defendants who were not included in our sample. We suspect that defense counsel may not have raised questions about competence—even with some defendants for whom such questions were warranted—because they recognize the potential for the competency process to span much longer than a relatively brief adjudication and sentence; this concern would apply less to felony evaluations. We also have no way of knowing how many defendants with serious mental illness, facing only misdemeanor charges, might have been somehow diverted from the competency system. These may have occurred through formal diversion programs or simply dropped charges. Any such diversion would be far more likely among those facing misdemeanor charges than among those facing felony charges, so our findings certainly cannot be considered to reflect the "true" rates of incompetence among those facing misdemeanors versus felonies. However, the pattern in this sample—in which IST was more common among those facing only misdemeanors than those facing only felonies—likely holds true.

Conclusions

A national competency crisis poses substantial challenges to the public forensic mental health system and substantial risks for defendants with serious mental illness in jails awaiting competence evaluation or restoration. Though the crisis likely has many causes, this is the first study to systematically explore the role of misdemeanor charges. Findings reveal that defendants who are referred for competence evaluation and facing only misdemeanor charges are more likely than those facing felony charges to manifest symptoms of serious psychiatric illness, be opined incompetent, and referred for inpatient competence restoration. Though restoration services may indeed provide much-needed treatment, there may be better ways to provide appropriate treatment more promptly and more affordably. Likewise, there may be better ways to mitigate the broader competency crisis by exploring new restoration policies, or prioritizing diversion, for defendants facing only misdemeanor charges in the competency system.

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Appendix

Interrater Reliability Statistics for Double-Coded Reports

Variable	Percent agreement	Reliability statistic
Evaluation characteristics		
Evaluator	97.5%	$\kappa = 0.97$
Court order date	87.5%	—
Offense date	100%	—
Evaluation date	100%	—
Report date	95.0%	—
Interview length	97.5%	$ICC_{A,1} = .98$
Evaluation setting	90.0%	$\kappa = 0.82$
Defendant participation	97.5%	$\kappa = 0.87$
Defendant characteristics		
Sex	100%	$\kappa = 1.00$
Race/ethnicity	100%	$\kappa = 1.00$
Age	100%	$ICC_{A,1} = 1.00$
Education level	92.5%	$\kappa = 0.91$
Criminal history	80.0%	$\kappa = 0.71$
Psychiatric features	82.5%	—
Psychosis	92.5%	$\kappa = 0.84$
Mood	97.5%	$\kappa = 0.84$
Anxiety	97.5%	—
Substance use disorder	100%	$\kappa = 1.00$
Personality disorder	100%	$\kappa = 1.00$
Intellectual disability	97.5%	—
Malingering/feigning	97.5%	$\kappa = 0.90$
Legal charges	97.5%	—
Offense type	97.5%	$\kappa = 0.96$
Offense violence	100%	$\kappa = 1.00$
Forensic conclusions		
Restorably incompetent	100%	$\kappa = 1.00$
Unrestorably incompetent	100%	$\kappa = 1.00$
Competent with accommodations	95.0%	—
Impeding psychiatric features	87.5%	—
Psychosis	100%	$\kappa = 1.00$
Mood	97.5%	$\kappa = 0.66$
Anxiety	100%	$\kappa = 1.00$
Personality disorder	100%	$\kappa = 1.00$
Intellectual disability	97.5%	—
Insufficient factual understanding	100%	$\kappa = 1.00$
Insufficient rational understanding	100%	$\kappa = 1.00$
Inability to assist counsel	100%	$\kappa = 1.00$
IST inpatient restoration	97.5%	$\kappa = 0.94$
Dismiss/discharge recommendation	97.5%	$\kappa = 0.90$
Civil commitment recommendation	100%	—
Malingering/feigning addressed	95.0%	$\kappa = 0.89$

Note. The above statistics were calculated after double coding 40 reports. Cohen's kappa interpretations vary somewhat by author, but in general, values between 0.00 and 0.20 represent "poor" agreement, 0.21–0.40 represent "fair" agreement, 0.41–0.60 represent "moderate" agreement, 0.61–0.80 represent "good" agreement, and 0.81−1.00 represent "excellent" or "near perfect" agreement (e.g., Cicchetti & Sparrow, 1981; Fleiss, 1981; Landis & Koch, 1977). ICC = intraclass correlation; IST = incompetence to stand trial.

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