Journal of Forensic Social Work, 7:14-31, 2023
ISSN: 1936-928X print & 1936-9298 online

Introducing the BCAT: A Tool to Aid Treatment Providers in Assessing Adjudicative Competence

Mike Bartlett, LCSW
Bartlett Therapy of Provo

The most frequently requested forensic evaluations are to assess a defendant's adjudicative competence, yet inefficiencies in the competence review process often lead to wasted state resources and prolonged detainment. When a judge identifies a defendant as incompetent, criminal proceedings are postponed and the defendant is typically ordered to receive competency restoration treatment. The court also schedules a hearing to review the defendant's progress toward competence and orders a competency examiner to prepare a progress report for that hearing. If the court then determines the defendant is competent their case will proceed, otherwise the court will generally order that competency restoration treatment continue. These competency examinations and their associated court hearings typically occur in standard intervals, such as every three months. It is common for defendants to be restored to competence prior to their next scheduled court hearing, but competency examiners and courts are often not apprised of this development. This is partially due to dynamics associated with treatment providers. Though treatment providers such as psychiatrists and clinical social workers are trained in mental health issues, they are not typically trained to assess adjudicative competence. Consequently, they may inadvertently continue to provide daily competency restoration treatment to a defendant who has already been restored to competence. Such occurrences contribute to a waste of resources, unnecessarily long detainment for competency restoration treatment, and an unnecessarily long postponement of legal proceedings. This study examines whether the Bartlett Competency Assessment Tool (BCAT) could be utilized by treatment providers to assist them in predicting the recommendation of a competency examiner. If the BCAT predicts that the competency examiner will recommend to the court that a defendant is competent, a referral can be made for a competency examination to be completed ahead of schedule. In this study the BCAT accurately predicted the recommendation of the competency examiner in 25 of 27 cases. The relationship between the outcomes of the BCAT and the recommendations of the competency examiners was statistically significant, $\chi 2\ (1, N = 27) = 19.99, p < .001$. Limitations and implications of these findings are discussed, including the potential of the BCAT to help states better utilize resources and reduce unnecessary treatment and detainment.

Keywords: adjudicative competence; operational process improvement; competency assessment; competency restoration; forensic social work

INTRODUCTION

The issue of adjudicative competence in criminal proceedings remains relevant to both the criminal justice and mental health systems (Melton et al., 2018; Stone 1975). However, interactions between these systems often cause inefficiencies that strain them both (Callahan & Pinals, 2020). When a defendant is deemed incompetent they are referred for treatment from mental health professionals; however, many of those treatment providers lack formalized training in assessing adjudicative competence and thus may inadvertently delay a referral to a court-appointed competency examiner. This can lead to a waste of treatment resources, prolonged detainment, and unnecessarily long delays in legal proceedings (Fader-Towe & Kelly, 2020; Fuller et al., 2017; see also Jackson v. Indiana, 1972). If treatment providers could more accurately assess adjudicative competence then they could potentially make a referral for an early competency examination when such is warranted. This study investigates whether or not an assessment tool can assist treatment providers in predicting the recommendation of a competency examiner.

LITERATURE REVIEW

In Dusky v. United States, the Supreme Court ruled that defendants must have a "sufficient present ability to consult with [their] lawyer with a reasonable degree of rational understanding" and a "rational as well as factual understanding of the proceedings against [them]" (Dusky v. United States, 1960). If a "mental disease or defect" causes such a deficit then criminal proceedings cannot resume until the defendant is deemed competent, with many states developing further criteria in defining whether or not a defendant is competent (this is the language used in many states and the federal criminal justice system; other states use terms such as "mental disorder or intellectual or developmental disability," "mental illness, defect, or disability," or "a present mental condition"; 18 U.S.C, 1984; AK Stat., 2015; ARS, 2005; Grisso, 2014; Ohio Rev. Code Ann. 1997; Reisner & Piel, 2018; Utah Code Annotated, 2018; Wash. Rev. Code, 2019; Zapf & Roesch, 2009).

When a defendant is deemed incompetent they are typically referred for treatment and, after some amount of time, are again assessed to determine their progress toward competence (for example, see AK Stat, 2015 or Wash. Rev. Code, 2019). Most research regarding adjudicative competence has focused on whether or not a defendant is competent and factors associated with competence, with relatively little or no research conducted about the other facets of the competence determination and restoration process (Daniel et al., 1984; Gay et al., 2015; Hart & Hare, 1992; Mossman, 2007; Mueller & Wylie, 2007; Nicholson & Johnson, 1991; Reich & Wells, 1985; Zapf & Roesch, 1998). Many professionals from varying backgrounds become involved when an individual is deemed incompetent in criminal proceedings, including judges, lawyers, competency examiners, psychiatrists, psychotherapists, hospital nursing staff, and various clerical professionals (Fitch, 2014; Miller, 2003). The interactions between these professionals give rise to many potential barriers in restoring defendants to competence (Callahan & Pinals, 2020; Dressel & Burns, 2012).

Notable barriers arise between treatment providers and competency examiners, specifically with regard to their training and skill set in assessing adjudicative competence. Though some jurisdictions outline specific time periods for which competency examinations should occur, examinations are also often conducted upon referral from treatment providers (for example, as in Utah Code Annotated § 77-15-6 (17)(a)). However, due to a lack of expertise, treatment providers may not know when to refer a defendant for a competency examination.

Competency examiners are often forensic psychiatrists, psychologists, or other highly trained mental health clinicians. Examiners are generally required to obtain specific training and certification both in mental health and legal matters, specifically with regard to adjudicative competence. Treatment providers are generally psychiatrists and mental health therapists; these professionals usually lack specialized training in adjudicative competence, nor do they typically have even minimal training in the criminal justice system (Dressel & Burns, 2012; Gowensmith et al., 2016; Roesch, 2015).

The assessment process for adjudicative competence is not standardized. There are many potential assessment instruments that examiners utilize in assessing adjudicative competence, such as the Competence Assessment Instrument - Revised (CAI-R) and the Evaluation of Competency to Stand Trial - Revised (ECST-R; Lieb & Burley, 2011). These assessment tools have different means of determining competence and will sometimes produce different results. Accordingly, a trained examiner considers the outcome of these assessment instruments and also considers other sources of collateral information, including an interview with the defendant. The consideration of collateral information and the interview is also not standardized; examiners naturally consider different aspects of adjudicative competence as more or less important than others, and have their natural biases in interpreting Dusky v. United States (Gowensmith & McCallum, 2019; Reisner & Piel, 2018; Zapf & Dror, 2017). There is not complete inter-rater reliability among competency examiners (Mossman, 2013). Indeed, disagreement between examiners is so common that many state statutes outline procedures to navigate this situation (for example, Utah Code Annotated § 77-15-5 (10)(d)).

Because adjudicative competence is not assessed in a standardized way it can be difficult for treatment providers to accurately predict the recommendation of competency examiners. Treatment providers are not typically trained to use the assessment instruments used by the examiners, nor are they necessarily trained in how to assess collateral information (Cervantes & Hanson, 2013; Noffsinger, 2001). There is no established standard for treatment providers to assess defendants' adjudicative competence.

These differences in expertise and skill sets lead to notable practical barriers in the competency restoration process. Treatment providers may believe a defendant is competent and thus refer them for a competency examination but the competency examiner does not believe the defendant is competent. The time spent conducting a competency examination and reviewing it during a court hearing can prolong the time a defendant remains incompetent (Levitt et al., 2010). Resources may also be wasted when a defendant is referred for an examination when such is not warranted. An incident at the Utah State Hospital is illustrative of this issue: treatment providers, including a forensic psychiatrist, believed eight defendants were likely competent and, in an effort to expedite court processes, requested that they immediately undergo competency examinations rather than wait until their next scheduled court hearing. During the following weeks they were all assessed, and in each case the competency examiner recommended to the court that the defendant was incompetent. The team of competency examiners reported this put significant strain on their workload for about six weeks as, prior to these eight referrals, they each had several other examinations scheduled.

A potentially more problematic situation arises when treatment providers do not realize a defendant is competent and thus a referral is not made to a competency examiner. In this case treatment providers may continue to provide treatment that does not address any competence-related deficits, which may in turn prolong the defendant's incarceration (Dressel & Burns, 2012). For example, it is not uncommon in Utah for a defendant to have their next competency review hearing scheduled three to six months away only for them to attain competence within just a month or two; in such cases a state will use resources to provide months of unneeded treatment, and this prolonged detainment may constitute a violation of the defendant's civil liberties. The length of time defendants are detained for competency treatment is increasingly scrutinized and has been of concern to various jurisdictions (Callahan & Pinals, 2020; Dressel & Burns, 2012; Miller, 2003; Morris & Parker, 2008; Zapf, 2013).

The solution to this problem appears to involve improving the treatment providers' ability to detect when a defendant is competent. However, training treatment providers to the same standard as examiners would likely be considered too costly and burdensome by states (Gowensmith, 2019).

A 20-question assessment tool was created to address the issues outlined above, called the Bartlett Competency Assessment Tool (BCAT). The BCAT is intended to be administered by treatment providers and contains questions related to dynamics of Dusky v. United States and Utah's competency statutes (such as in Utah Code Annotated 77-15-5 (5), 2018). The BCAT has a binary outcome - it indicates if the competency examiner will likely recommend a defendant as competent or incompetent.

Ultimately, the objective of the BCAT is to predict the recommendation of the competency examiner. Given that the recommendation of the competency examiner has only two outcomes (competent or incompetent), the null hypothesis (H_0) for this study is that the BCAT will not predict the recommendation of the competency examiner at a rate better than chance. The alternative hypothesis (H_1) is that the BCAT will predict the recommendation of the competency examiner at a rate better than chance.

METHODS

Sample

The inclusion criteria for the sample included all defendants assigned to a specific treatment team at the Utah State Hospital over a period of 17 months. There are five forensic units at the Utah State Hospital, and, with the exception of females being assigned to two specific units, all defendants are admitted simply to whichever unit has an opening; effectively, they are randomly distributed. Defendants were excluded from the sample if they posed an imminent risk of violence at the time the BCAT was to be administered. This criteria yielded an $N = 27$, with one defendant being excluded.

All in the sample were male. Their ages ranged from 22 to 64 ($M = 38.96$, $SD = 11.96$). Ethnicity of the sample included Caucasian ($N = 16$), non-white Hispanic ($N = 7$), Black ($N = 2$), Native American ($N = 1$), and Pacific Islander ($N = 1$). Those in the sample had varying amounts of alleged crimes, with crime severity that spanned the spectrum; some alleged crimes were Class C Misdemeanors (the least serious crime classification in Utah above an infraction) and some were First Degree Felonies (the most serious classification in Utah other than capital felonies). All but three of the defendants had a psychotic disorder as their primary diagnosis (such as schizophrenia), two had a Major Neurocognitive Disorder as their primary diagnosis (due to Vascular Disease and Epilepsy), and one had a substance use disorder as their primary diagnosis.

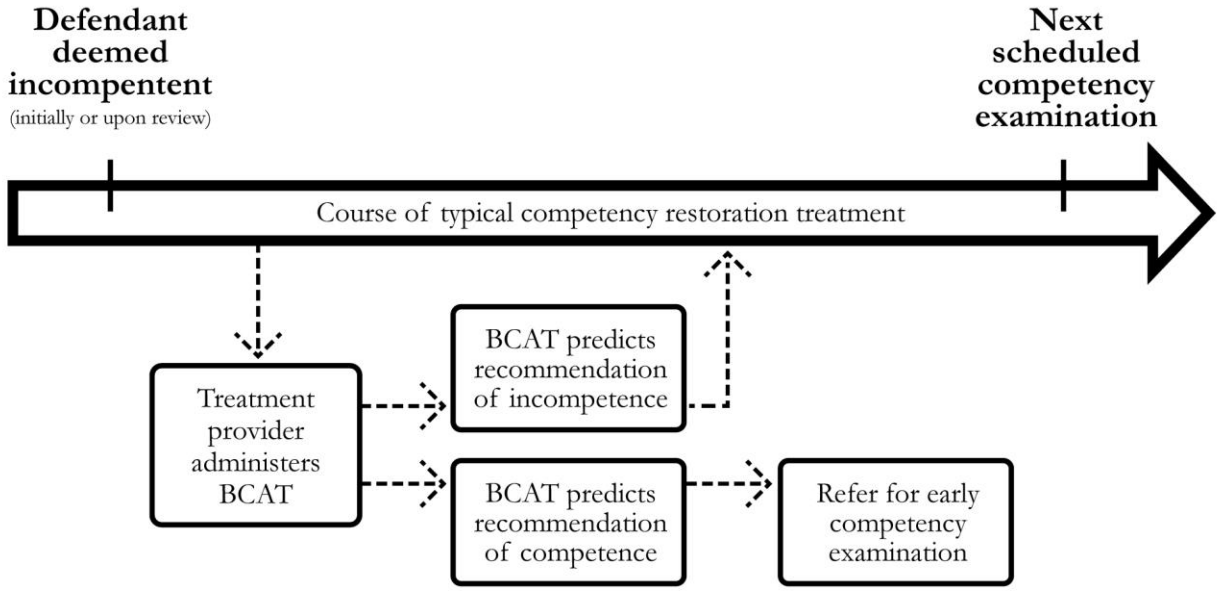
Procedures

Upon being deemed incompetent (either initially or upon review), a defendant was scheduled for a competency examination - usually three or six months in the future. However, a competency examination could occur sooner if treatment providers made a referral for an early examination. In the course of typical competency restoration treatment the BCAT was often used to gain an initial assessment of competence, to assess progress, and to inform treatment providers if the defendant should be referred for an early competency examination. If the BCAT indicated a competency examiner would likely recommend a defendant as competent then they were referred for an early competency examination. If the BCAT indicated a competency examiner would likely recommend a defendant as incompetent then a referral was not made. Regularly scheduled competency examinations continued as usual (see figure 1).

Due to administrative constraints the exact date of the competency examination was unknown to treatment providers ahead of time, and the BCAT was administered with the assumption that the competency examination would occur within the next three weeks. The mean length of time between admission to the Hospital and the administration of the relevant BCAT was 83.42 days ($SD = 48.20$). The mean length of time between admission to the Hospital and the relevant competency examination was 104 days ($SD = 45.32$). The

Figure 1

Interposition of the Bartlett Competency Assessment Tool (BCAT) Into Typical Competency Restoration Treatment



mean length of time between administration of the BCAT and the competency examination was 20.58 days (*SD* = 15.26). There were two instances where, due to administrative issues, there was an unusually long length of time between administration of the BCAT and the competency examination; if these two instances are excluded from the data then the mean length of time between administration of the BCAT and the competency examination was 16.88 days (*SD* = 8.61).

With regard to the competency examinations, all defendants were randomly assigned one of eight competency examiners. One examiner completed eight examinations, another completed six examinations, two examiners each completed three examinations, three examiners each completed two examinations, and one examiner completed one examination.

Measures

The BCAT asks the defendant to identify their charges and the severity of those charges, a narrative of the alleged events, the possible punishments associated with the charges, their defense strategy, and assesses their awareness of the evidence involved in the case, the adversarial nature of the legal process, and the nature of their relationship with their attorney (dynamics from Dusky v. United States and Utah Code Annotated 77-15-5 (5), 2018). The full assessment and instructions to administrators are included in the Appendix; in order to better display the considerations enumerated below (and so others can more easily utilize them), they are presented as they were used in actual practice.

The BCAT has roughly three pages of instructions for administrators, with operationalized instructions for each question as to whether or not the defendant's response is "adequate" or "inadequate." These instructions were written with the same considerations as the BCAT itself, most notably that they needed to be understood by clinicians with minimal training in adjudicative competence (Bhattacherjee, 2012). The instructions to administrators also indicate the BCAT is an inadequate means of detecting a feigned presentation.

A "point system" was considered in scoring the BCAT but was rejected due to low validity. Specifically, a 20-point system was developed and a defendant was given either zero, one, or two points depending on their abilities in different domains (this system used different questions than the BCAT). However, discussions among treatment providers uncovered that a high score did not necessarily indicate competence nor did a low score necessarily indicate severe incompetence. This is because some competence-related deficits are more difficult to resolve than others and some are simply more problematic than others. To further illustrate, in one case the point system gave a score of 18 to a defendant who struggled to memorize the names of their many charges; in another case, the point system also gave a score of 18 to a defendant who correctly identified all of the factual components of their case but had an irrational legal strategy that was informed by delusions. The identical score of 18 implies that both defendants had similar levels of deficits, whereas in actual practice one issue is significantly more straightforward to rectify than another - it is usually simple to help a defendant learn the names of their charges, whereas it is often complicated to resolve delusional beliefs (Skelton et al. 2015).

Another point system was considered which could theoretically accommodate the relative importance of different aspects of adjudicative competence, but this was ultimately rejected due to the "pass/fail" nature of competency examinations. It was observed that competency examiners would recommend a defendant as incompetent if there was a single significant deficit regardless of their relative strengths in other domains of adjudicative competence. That is, examiners were not using a point system in their assessments - a single point of failure led to a recommendation of incompetence. Accordingly, for the purposes of this study the BCAT followed the "pass/fail" model employed by examiners - a defendant was identified as likely to be recommended as incompetent if a single domain was marked "inadequate."

Various other considerations were given in creating this tool, including the variety of possible examiners, the skill level of those administering the BCAT, the variety of possible defendants being assessed, assessing rationality rather than memorization, and other common considerations in assessments such as practicality, reliability, and validity (Goddard & Villanova, 2006; Mouton & Marais, 1998).

A problematic dynamic of competency examinations is that there is inter-rater variability. Specifically, there is variation in how competency examiners interpret Dusky v. United States - one examiner may recommend a defendant as competent while another will not (Reisner & Piel, 2018; Mossman, 2013). It can be difficult for treatment providers to predict the outcome of a competency examination when results vary among examiners. In an attempt to address this dynamic, hundreds of competency examinations conducted in Utah across several years were informally reviewed; questions on the BCAT were formulated to address issues that were central to findings of incompetence across examiners.

As noted previously, treatment providers have less expertise than examiners regarding adjudicative competence. To accommodate this, the BCAT has direct questions, minimal points requiring interpretation, and all assessment questions can only be coded as either "adequate" or "inadequate" (Punch, 2003). The BCAT also attempts to address this issue by focusing only on the primary components of adjudicative competence rather than fringe issues that are rarely the sole basis for a recommendation of incompetence.

Some defendants can understand and respond to complex questions while others cannot; defendants may have a variety of issues that contribute to their competence-related deficits, including intellectual disabilities, dementia, and mental health diagnoses such as schizophrenia (Cooper & Zapf, 2003; Nicholson & Kugler, 1991; Pirelli et al., 2011; Viljoen et al. 2002). The BCAT attempts to accommodate this issue by posing simple questions and using language that is easy to understand; though some questions could use more precise legal terminology or be phrased in a way that is more grammatically correct, they are instead phrased in a way that many defendants speak (Payne, 1951).

If defendants are routinely asked questions from assessment instruments used by examiners there is a risk they may simply memorize responses without possessing the rational abilities required by Dusky v.

United States (Mossman et al., 2007). Accordingly, the BCAT asks questions that are substantively similar to those commonly asked by examiners but that are phrased differently.

To encourage its use, considerations were given to lower the burden for treatment providers in administering the BCAT. Accordingly, the BCAT can fit on a single piece of paper (with questions printed on both sides) and has significant "negative space" (Ko & Liu, 2019; Moshagen & Thielsch, 2010). All questions have the same coded responses, which eases use and increases reliability (Dolnicar & Grün, 2007). The questions are phrased in a non-confrontational manner that allows the treatment provider to maintain rapport (Elliot 2002; Elliot et al. 2018). The BCAT is short enough that it can be administered and processed within a 50-minute psychotherapy session. The simplicity of the questions and the practicality of its administration should contribute to the reliability of the BCAT (Alwin & Beattie, 2016).

The competency examiners used the following standardized instruments as part of their competency examinations: Competence Assessment Instrument - Revised (CAI-R), Cognitive Capacity Screening Evaluation (CCSE), Evaluation of Competency to Stand Trial - Revised (ECST-R), The Interdisciplinary Fitness Interview - Revised (IFI-R), Inventory of Legal Knowledge (ILK), MacArthur Competence Assessment Tool - Criminal Adjudication (MacCAT-CA), Miller Forensic Assessment of Symptoms Test (M-FAST), Folstein Mini Mental State Exam (MMSE), Medical Symptom Validity Test (MSVT), The Montreal Cognitive Assessment (MoCA), Reynolds Intellectual Screening Test (RIST), Symptom Checklist - 90 - Revised (SCL-90-R), Test of Memory Malingering (TOMM), Vineland Adaptive Functioning Scale - 3rd Edition (VAFS), and the Wechsler Abbreviated Scale of Intelligence (WASI-II).

Analysis

The outcome of the BCAT had two possible outcomes (likely to be recommended as competent or likely to be recommended as incompetent), as did the recommendation rendered by the competency examiner (competent or incompetent). The extent of association between the BCAT and the recommendation of the competency examiner will be examined descriptively with raw counts. In addition, a Pearson chi-square (χ^2) test will be used to examine the statistical relationship between the outcome of the BCAT and recommendation of the competency examiner.

Since a referral for an early examination was not requested if the BCAT indicated the defendant was likely to be recommended as incompetent, there were some BCAT results with no corresponding competency examination result to which it could be compared. For the purposes of this study, the BCAT result obtained in closest proximity to the competency examination was used for analysis.

RESULTS

In the sample $N = 27$, the BCAT predicted the competency examiner would recommend the defendant as competent in 16 cases; of these 16 cases, the competency examiner recommended the defendant was competent in 14 cases and incompetent in two cases. The BCAT predicted the competency examiner would recommend the defendant as incompetent in 11 cases; of these 11 cases, the competency examiner recommended the defendant was competent in zero cases and incompetent in 11 cases (see Table 1).

The null hypothesis (H_0) is that the BCAT will not predict the recommendation of the competency examiners at a rate better than chance, or that $\chi^2 < 3.84$. The χ^2 for the contingency table shown in Table 1 is 19.99. Since the χ^2 is larger than the $p < .05$ significance threshold of 3.84, it is concluded that the statistical relationship between the outcome of the BCAT and the recommendation of the competency examiner is unlikely to be due to chance. Accordingly, hypothesis H_0 is rejected.

Table 1

Bartlett Competency Assessment Tool (BCAT) Prediction, by Competency Examiner Recommendation

		Examiner Recommendation	
		Competent	Incompetent
BCAT Prediction	Competent	14	2
	Incompetent	0	11

$\chi 2$ (1, N = 27) = 19.99, $p < .001$

The alternative hypothesis (H_1) is that the BCAT will predict the recommendation of the competency examiners at a rate better than chance, or that $\chi^2 > 3.84$. Since the χ^2 of 19.99 is larger than the $p < .05$ significance threshold of 3.84 (and the $p < .001$ threshold of 10.83), hypothesis H_1 is accepted.

DISCUSSION

Limitations

One limitation of this study is the relatively small sample size. Though there were enough data to get preliminary information about the predictive power of the BCAT, a larger sample size would enable the utilization of more robust analytical methods such as multiple logistic regression analysis (Cohen, 1992). This would provide more context as to the variables associated with stronger predictive power, such as whether or not crime severity or diagnosis play a statistically significant role. Additionally, a Pearson chi-square test of association is not ideal when more than 20% of the cells in a contingency table have frequencies fewer than five (Bewick et al., 2003); however, a Fisher's Exact Test of Independence, which is less sensitive to small cell sizes, also indicates $p < .001$.

Another limitation of this study is its generalizability. As noted previously, though the standards outlined in Dusky v. United States apply to all US states, many states have unique requirements which guide examiners in their assessment of adjudicative competence. This limitation, however, could be mitigated by making minor modifications to the BCAT; for example, by adjusting the operational definitions of an "adequate" response to include the possible penalties or plea options of the specific state. Despite being created with the statutes of Utah in mind, the BCAT does ultimately aim to address the standards established by Dusky v. United States and thus it may still have broad generalizability without any modification, though this could be examined in future studies. Additionally, this study included only male subjects; it is possible the results would differ if it included females, though studies suggest that demographic variables do not appear to be significant in other aspects of adjudicative competence such as restoration rates (Advokat et al, 2012; Harris & Weiss, 2018; Pirelli et al., 2011).

Another limitation of the BCAT is that it will be administered at a different time than the competency examination. Since adjudicative competence is measured at a specific point in time (Dusky v. United States says "present ability"), a defendant's competency status may change between the time they were assessed with the BCAT and the time they are examined for a formal recommendation to the court. Though ideally the BCAT would have concurrent validity with the competency examinations, this is not possible in practical application as there will inevitably be some amount of time between its administration and the competency examination. This limitation is highlighted by the two incidents where the BCAT incorrectly predicted the recommendation of competency examiners. In one case the treatment providers suspected the defendant of having an inauthentic response style. This defendant gave responses to the BCAT that indicated he was likely to be recommended as competent and then gave completely different responses to the competency examiner, who recommended he was incompetent; during a later court-appointed examination this defendant was opined to be malingering. The other incorrect BCAT prediction involved a situation where it predicted the defendant would likely be recommended as competent, but in the days between the

administration of the BCAT and the competency examination the defendant got into a fight with a peer; this fight was identified by the examiner as the sole reason the defendant was incompetent (stating the defendant may not be capable of manifesting "appropriate courtroom behavior"). In its current iteration, the BCAT will likely be less effective in instances of feigning and in instances where there are major events between its administration and the competency examination (of note, in these cases the time between administration of the BCAT and the competency examination was 13 days and 19 days, respectively - lengths of time within the standard deviation; they were also assessed by different examiners).

Another limitation is that the data for this study was obtained by the author, who also created the BCAT. Though the author was blind to the outcome of the competency examinations at the time the BCAT was administered, it is possible that administrators less familiar with this tool will obtain results less consistent than those obtained in this study (Fowler, 2013). Additionally, it is possible there was sampling bias and/or design bias (Larzelere et al., 2004; Nielsen et al., 2017). For example, though defendants were excluded from the sample if administering the BCAT was considered unsafe, there was not an operationalized definition of "unsafe" prior to the onset of data collection and thus there may have been bias in identifying defendants as unsafe.

Finally, a potential limitation arises if treatment providers use the BCAT as the sole basis of their assessment of adjudicative competence. Though it appears capable of predicting the recommendation of the competency examiner at a rate better than chance, if the BCAT provided the sole data point informing treatment providers it is possible a competent defendant may be considered incompetent (and thus spend too long receiving treatment), or an incompetent defendant may be considered competent (which will waste resources related to assessment). However, these potentially adverse outcomes exist whether or not the BCAT is used. Due to the limitations enumerated above it is recommended that scheduled competency examinations and court hearings occur as usual, and that the BCAT be used primarily to assist treatment providers in determining if a defendant should be referred for a competency examination ahead of schedule.

Implications

In this exploratory study the BCAT correctly predicted the recommendation of competency examiners in 25 of 27 instances; the relationship between the outcomes of the BCAT and the recommendations of the competency examiners was statistically significant. This suggests the BCAT may assist treatment providers in assessing adjudicative competence.

If treatment providers are apprised of a defendant's competence prior to scheduled court hearings they can make a referral for an early competency examination. This may, in turn, reduce the time defendants are detained for competency restoration treatment and decrease postponements in legal proceedings. For example, in this study some defendants were identified as competent as much as 10 weeks prior to their next regularly-scheduled competency examination, which saved months of unneeded and expensive treatment; inasmuch as the average cost of competency restoration treatment in state hospitals ranges from $300 to $1,000 per day for each defendant, the implications for resource utilization may be significant (Kirkorsky et al, 2020; Wik et al., 2020). The BCAT also correctly identified when defendants remained incompetent, and thus early examinations were not requested and resources were preserved. Such benefits could expand as the BCAT is used more broadly.

The administration of the BCAT could occur during the regular course of treatment at essentially no extra cost. Since it may speed up the competency restoration process and thus save resources, a greater number of defendants could receive competency restoration treatment with the same amount of financial resources currently available to treatment providers.

If the BCAT is administered to the same defendant on a regular basis it can provide treatment providers with information about the defendant's progress. Not only can this aid in restoration efforts and

increase efficiency, it can also aid in determining when a defendant may be unlikely to restore to competence within a reasonable amount of time (Noffsinger, 2001; also see Jackson v. Indiana).

Future research should utilize a larger data set with additional variables in order to better identify the variables associated with high predictive power, if any. Additionally, future studies should make use of at least several BCAT administrators and competency examiners to better assess its predictive power and reliability across a wide spectrum of professionals (Fowler, 2013).

Future studies could examine the extent to which the administration of the BCAT may expedite a typical competency-related case; this information could then be used to determine the extent to which the BCAT can help preserve financial resources and reduce unnecessary detainment. In order to examine these dynamics a control group would be necessary, as would a larger sample size (Weinfurt, 2000).

Of note, if future research of the BCAT reveals that it actually has weak predictive power this information also seems relevant. If such were the case it may indicate that there is disagreement between treatment providers and competency examiners with regard to adjudicative competence, which could produce a variety of systemic inefficiencies. If such were the case future research could examine the differences between treatment providers and examiners regarding what they consider to be the primary components of adjudicative competence.

More broadly, additional research should be conducted in other dynamics of the competency restoration process. As noted previously, most existing research regarding adjudicative competence addresses whether or not a defendant is competent, but there is relatively little research examining other dynamics of the restoration process - including best practices for restoration treatment (Pirelli et al., 2011; Zapf, 2013).

CONCLUSION

When a defendant is identified as incompetent a variety of professionals become involved in the competency restoration process. A significant strain on this process is that treatment providers lack formalized training in assessing adjudicative competence. This can lead to delays in referrals for competency examinations, which consequently contributes to a strain on resources and prolonged detainment. Though further research is needed to fully understand its efficacy, the BCAT appears to be a potentially beneficial tool for treatment providers in assessing adjudicative competence. In turn, it has the potential to help states better utilize resources, reduce unnecessary treatment and detainment, and reduce the length of postponements in legal proceedings.

NOTE

1. Analysis of the data used in this study was approved by the Utah Department of Health and Human Services Institutional Review Board.
2. The author declares no conflict of interest.
3. The author can be contacted at BCATcorrespondence@gmail.com

REFERENCES

18 U.S.C § 4241(d) (1984).

Advokat, C. D., Guidry, D., Burnett, D. M., Manguno-Mire, G., & Thompson, J. W. (2012). Competency restoration treatment: Differences between defendants declared competent or incompetent to stand trial. *Journal of the American Academy of Psychiatry and the Law*, *40*(1), 89-97.

AK Stat § 12.47.110 (2015).

Alwin, D. F., & Beattie, B. A. (2016). The KISS principle in survey design: question length and data quality. *Sociological methodology*, *46*(1), 121-152.

A. R. S. § 13-4501 (2005).

Bhattacherjee, A. (2012). *Social science research: Principles, methods, and practices*. University of South Florida.

Bewick, V., Cheek, L., & Ball, J. (2003). Statistics review 8: Qualitative data–tests of association. *Critical care*, *8*(1), 1-8.

Callahan, L., & Pinals, D. A. (2020). Challenges to reforming the competence to stand trial and competence restoration system. *Psychiatric Services*, *71*(7), 691-697.

Cervantes, A. N., & Hanson, A. (2013). Dual agency and ethics conflicts in correctional practice: sources and solutions. *Journal of the American Academy of Psychiatry and the Law Online*, *41*(1), 72-78.

Cohen, J. (1992). A power primer. *Psychological bulletin*, *112*(1), 155.

Cooper, V. G., & Zapf, P. A. (2003). Predictor variables in competency to stand trial decisions. *Law and Human Behavior*, *27*(4), 423-436.

Daniel, A. E., Beck, N. C., Herath, A., Schmitz, M., & Menninger, K. (1984). Factors correlated with psychiatric recommendations of incompetency and insanity. *The Journal of Psychiatry & Law*, *12*(4), 527-544.

Dolnicar, S., & Grün, B. (2007). How constrained a response: A comparison of binary, ordinal and metric answer formats. *Journal of Retailing and Consumer Services*, *14*(2), 108-122.

Dressel, W. F., & Burns, D. A. (2012). The National Judicial College and the Mental Competency Best Practices Model. *Judges J.*, *51*, 16.

Dusky v. United States, 362 US 402 (1960).

Elliott, R. (2002). The effectiveness of humanistic therapies: A meta-analysis. In D. J. Cain (Ed.), *Humanistic psychotherapies: Handbook of research and practice* (57–81). American Psychological Association. https://doi.org/10.1037/10439-002

Elliott, R., Bohart, A. C., Watson, J. C., & Murphy, D. (2018). Therapist empathy and client outcome: An updated meta-analysis. *Psychotherapy*, *55*(4), 399. https://doi.org/10.1037/pst0000175

Fader-Towe H, & Kelly E. (2020). *Just and well: Rethinking how states approach competency to stand trial.* The Council of State Governments Justice Center.

Fitch, W.L. (2014). *Forensic mental health services in the United States*. National Association of State Mental Health Program Directors Publications.

Fowler Jr, F. J. (2013). *Survey research methods*. Sage publications.

Fuller, D. A., Sinclair, E., Lamb, H. R., Cayce, J. D., & Snook, J. (2017). Emptying the 'New Asylums' A beds capacity model to reduce mental illness behind bars. *Arlington, VA, Treatment Advocacy Center*.

Gay, J. G., Ragatz, L., & Vitacco, M. (2015). Mental health symptoms and their relationship to specific deficits in competency to proceed to trial evaluations. *Psychiatry, Psychology and Law*, *22*(5), 780-791.

Grisso T. (2014). *Competence to stand trial evaluations: Just the basics*. Sarasota: Professional Resource Press.

Ohio Rev. Code Ann. § 2945.37(G) (1997).

Goddard, R.D., & Villanova, P. (2006). Designing surveys and questionnaires for research. In F. T. L. Leong, & J. T. Austin (Eds.), *The psychology research handbook,* (114-123). Sage Publications.

Gowensmith, W. N. (2019). Resolution or resignation: The role of forensic mental health professionals amidst the competency services crisis. *Psychology, Public Policy, and Law*, *25*(1), 1.

Gowensmith, W. N., Frost, L. E., Speelman, D. W., & Therson, D. E. (2016). Lookin' for beds in all the wrong places: Outpatient competency restoration as a promising approach to modern challenges. *Psychology, Public Policy, and Law*, *22*(3), 293.

Gowensmith, W. N., & McCallum, K. E. (2019). Mirror, mirror on the wall, who's the least biased of them all? Dangers and potential solutions regarding bias in forensic psychological evaluations. *South African journal of psychology*, *49*(2), 165-176.

Harris, S., & Weiss, R. A. (2018). The impact of defendants' race in competency to stand trial referrals. *International Journal of Law and Psychiatry*, *57*, 85-90.

Hart, S. D., & Hare, R. D. (1992). Predicting fitness to stand trial: The relative power of demographic criminal and clinical variables. *Forensic Reports*, 5, 53–65.

Jackson v. Indiana, 406 US 715 (1972).

Kirkorsky, S. E., Gable, M., & Warburton, K. (2020). An overview of jail-based competency restoration. *CNS spectrums*, *25*(5), 624-629.

Ko, C. H., & Liu, Y. C. (2019). User preference of white space in news web pages. *8th International Congress on Advanced Applied Informatics,* 960-965.

Larzelere, R. E., Kuhn, B. R., & Johnson, B. (2004). The intervention selection bias: an underrecognized confound in intervention research. *Psychological bulletin*, *130*(2), 289.

Levitt, G. A., Vora, I., Tyler, K., Arenzon, L., Drachman, D., & Ramos, G. (2010). Civil commitment outcomes of v.incompetent defendants. *Journal of the American Academy of Psychiatry and the Law Online*, *38*(3), 349-358.

Lieb, R., & Burley, M. (2011). Competency to stand trial and conditional release evaluations: Current and potential role of forensic assessment instruments (Document Number 11-05-3401). *Olympia: Washington State Institute for Public Policy*.

Melton, G. B., Petrila, J., Poythress, N. G., Slobogin, C., Otto, R. K., Mossman, D., & Condie, L. O. (2017). *Psychological evaluations for the courts: A handbook for mental health professionals and lawyers*. Guilford Publications.

Miller, R. D. (2003). Hospitalization of criminal defendants for evaluation of competence to stand trial or for restoration of competence: Clinical and legal issues. *Behavioral sciences & the law*, *21*(3), 369-391.

Morris, D. R., & Parker, G. F. (2008). Jackson's Indiana: state hospital competence restoration in Indiana. *Journal of the American Academy of Psychiatry and the Law Online*, *36*(4), 522-534.

Moshagen, M., & Thielsch, M. T. (2010). Facets of visual aesthetics. *International journal of human-computer studies*, *68*(10), 689-709.

Mossman, D. (2007). Predicting restorability of incompetent criminal defendants. *Journal of the American Academy of Psychiatry and the Law*, *35*(1), 34-43.

Mossman, D. (2013). When forensic examiners disagree: Bias, or just inaccuracy?. *Psychology, Public Policy, and Law*, *19*(1), 40.

Mossman, D., Noffsinger, S. G., Ash, P., Frierson, R. L., Gerbasi, J., Hackett, M., Lewis, C. F., Pinals, D. A., Scott, C. L. Sieg, K. G., Wall, B. W., & Zonana, H. V. (2007). AAPL practice guideline for the forensic psychiatric evaluation of competence to stand trial. *Journal of the American Academy of Psychiatry and the Law Online*, *35*(Supplement 4), S3-S72.

Mouton, J., & Marais, H. C. (1988). *Basic concepts in the methodology of the social sciences*. Hsrc Press.

Mueller, C., & Wylie, A. M. (2007). Examining the effectiveness of an intervention designed for the restoration of competency to stand trial. *Behavioral sciences & the law*, *25*(6), 891-900.

Nicholson, R. A., & Kugler, K. E. (1991). Competent and incompetent criminal defendants: a quantitative review of comparative research. *Psychological bulletin*, *109*(3), 355.

Nicholson, R. A., & Johnson, W. G. (1991). Prediction of competency to stand trial: Contribution of demographics, type of offense, clinical characteristics and psycholegal ability. *International Journal of Law and Psychiatry, 144*, 287–297.

Nielsen, M., Haun, D., Kärtner, J., & Legare, C. H. (2017). The persistent sampling bias in developmental psychology: A call to action. *Journal of Experimental Child Psychology*, *162*, 31-38.

Noffsinger, S. G. (2001). Restoration to competency practice guidelines. *International Journal of Offender Therapy and Comparative Criminology*, *45*(3), 356-362.

Payne, S. L. (1951). *The art of asking questions*. Princeton University Press.

Pirelli, G., Gottdiener, W. H., & Zapf, P. A. (2011). A meta-analytic review of competency to stand trial research. *Psychology, Public Policy, and Law*, *17*(1), 1-53.

Punch, K. F. (2003). *Survey research: The basics*. Sage.

Reich, J., & Wells, J. (1985). Psychiatric diagnosis and competency to stand trial. *Comprehensive Psychiatry*, *26*(5), 421-432.

Reisner, A. D., & Piel, J. L. (2018). Mental Condition Requirement in Competency to Stand Trial Assessments. *The Journal of the American Academy of Psychiatry and the Law*, *46*(1), 86-92.

Roesch, R. (2015). Social worker assessments of competency to stand trial. *Journal of Forensic Social Work*, *5*(1-3), 186-200.

Skelton, M., Khokhar, W. A., & Thacker, S. P. (2015). Treatments for delusional disorder. *Cochrane Database of Systematic Reviews*, (5).

Stone, A. A., & Stromberg, C. D. (1975). *Mental health and law: A system in transition* (Vol. 75). National Institute of Mental Health, Center for Studies of Crime and Delinquency.

Utah Code Annotated § 77-15-5. (2018).

Utah Code Annotated § 77-15-6. (2018).

Viljoen, J. L., Roesch, R., & Zapf, P. A. (2002). An examination of the relationship between competency to stand trial, competency to waive interrogation rights, and psychopathology. *Law and Human Behavior*, *26*(5), 481-506.

Wash. Rev. Code § 10.77.079 (2019).

Wik, A., Hollen, V., & Fisher, W. H. (2020). Forensic patients in state psychiatric hospitals: 1999–2016. *CNS spectrums*, *25*(2), 196-206.

Weinfurt, K. P. (2000). Multivariate analysis of variance. In L. G. Grimm, & P. R. Yarnold (Eds.), *Reading and understanding multivariate statistics,* (245-276). American Psychological Association.

Zapf, P. A., & Roesch, R. (1998). Fitness to stand trial: Characteristics of remands since the 1992 Criminal Code amendments. *The Canadian Journal of Psychiatry*, *43*(3), 287-293.

Zapf, P., & Roesch, R.(2008). *Best practices in forensic mental health assessment: Evaluating competency to stand trial*. Oxford University Press.

Zapf, P. (2013). *Standardizing protocols for treatment to restore competency to stand trial: Interventions and clinically appropriate time periods.* (Document No. 13-01-1901). Washington State Institute for Public Policy. https://www.wsipp.wa.gov/Publications?reportId=338

Zapf, P. A., & Dror, I. E. (2017). Understanding and mitigating bias in forensic evaluation: Lessons from forensic science. *International Journal of Forensic Mental Health*, *16*(3), 227-238.

BARTLETT COMPETENCY ASSESSMENT TOOL (BCAT)

Name of defendant:_____ **Date:**_____

1. What are the names of your charges?

Adequate___ Inadequate___

2. *(For each charge)* **How serious is it? (Is it a felony/misdemeanor? What degree/class?)**

Adequate___ Inadequate___

3. What are the police saying you did? What's the short version of the story?

Adequate___ Inadequate___

4. If you were found guilty of the charges, could you go to prison?

Adequate___ Inadequate___

5. If you were found guilty of the charges, how long could you be locked up?

Adequate___ Inadequate___

6. Other than being locked up, what else could a judge sentence you with?

Adequate___ Inadequate___

7. What are your plea options, and how do they work?

Adequate___ Inadequate___

8. How would you describe a plea bargain?

Adequate___ Inadequate___

9. What are you thinking of pleading?

Adequate___ Inadequate___

10. Why?

Adequate___ Inadequate___

 Bartlett, M. (2023). Introducing the BCAT: A tool to aid treatment providers in assessing adjudicative competence. *Journal of Forensic Social Work, 7(1), 14-31.*

11. *(If they say they plan to plead not guilty)* **At a trial, what are the main pieces of evidence that a prosecutor will bring up?**

Adequate___ Inadequate___

12. *(If they say they plan to plead not guilty)* **At a trial, what are the main pieces of evidence that you could use in your defense?**

Adequate___ Inadequate___

13. *(If they say they plan to plead not guilty)* **What are the potential benefits of testifying? What are the potential risks?**

Adequate___ Inadequate___

14. What do you hope happens with your case?

Adequate___ Inadequate___

15. The next few questions are about the people in the courtroom. What is the job of the prosecutor?

Adequate___ Inadequate___

16. What is the job of the defense attorney?

Adequate___ Inadequate___

17. What is the job of the judge?

Adequate___ Inadequate___

18. What is a jury and what do they do?

Adequate___ Inadequate___

19. Do you feel comfortable working with your lawyer? Do you think they could help you with your case?

Adequate___ Inadequate___

20. DO NOT ASK: **Did the defendant behave in a manner that would be appropriate for court?**

Adequate___ Inadequate___

 Bartlett, M. (2023). Introducing the BCAT: A tool to aid treatment providers in assessing adjudicative competence. *Journal of Forensic Social Work, 7(1), 14-31.*

BARTLETT COMPETENCY ASSESSMENT TOOL INSTRUCTIONS

You do not need to ask all of the questions word for word, but please try to maintain the essence of each question. All questions are asked as if there are multiple charges in a single case, but you can adjust the phrasing depending on the defendant's situation. The questions are deliberately phrased in a casual manner rather than using technical legal terms; using the technical terms may be either beneficial or confusing to defendants, so use them at your discretion. This tool is inadequate to detect or assess malingering. The intent of the BCAT is simply to provide information to treatment providers.

Use the following guidelines to determine if a response is adequate:

1. They should be able to name their charges. This does not need to be completely exact - for example, it is okay if they say "trespassing" rather than "criminal trespass" - but it should be substantively accurate. If a defendant has a large number of charges/cases (for example, 20 charges), they need to know the names of all of the most serious ones - especially felonies. If they can answer questions 2-6 adequately, then it is okay if they do not remember the exact names of all of their misdemeanor charges so long as they can name the felonies.

2. They should know if each charge is a 1st, 2nd, or 3rd Degree Felony or a Class A, B, or C Misdemeanor.

3. They should be able to explain the main narrative of the events surrounding their arrest. It is okay if they disagree with the police/prosecutor, but they need to know the basics of why the police arrested them and what the police/prosecutor are claiming they did. You can also ask them for their version of events but this is not required. Asking for the "short" story prompts them that you are not currently interested in all of the details but just the main events. During this answer, they cannot go off on a tangent for a prolonged period or otherwise present in a manner that is not conducive to reciprocal conversation. Ask yourself: would a lawyer be able to consult with this defendant if they presented this way?

4. If they have a felony charge they should answer "yes." If they do not have a felony charge they should answer "no."

5. They should be able to accurately describe their possible sentence (for example, 1-15 years for a 2nd degree felony). It is okay if they answer as if they are sentenced either concurrently or consecutively. If they answer with a time frame that indicates they would be sentenced concurrently, consider asking them how much time they could serve if everything was added up. Realistically, though, they will likely be sentenced concurrently, with their most severe charge being the realistic time frame for a sentence.

6. Other possible sentences include a fine, community service, probation, and treatment. They should be able to describe the basics of what these terms entail. They may use other terms such as "diversion program" instead of "treatment." For capital cases they should know they could receive the death penalty.

7. They should know the pleas guilty, not guilty, no contest, guilty and mentally ill, and not guilty by reason of insanity. They should be able to describe the basics of what these pleas mean and what would happen if they entered the plea; for example, they should know that if they plead not guilty then they will proceed to trial. If the NGI plea obviously does not apply or if it would make little sense for them to plead that way (for example, if they have misdemeanors), then it is okay if they are unable to identify all of the facets of that plea.

 Bartlett, M. (2023). Introducing the BCAT: A tool to aid treatment providers in assessing adjudicative competence. *Journal of Forensic Social Work, 7(1), 14-31.*

8. They should be able to describe a plea bargain. It is okay if the description is basic, such as “they’ll reduce my charges if I plead guilty.” They should also be aware that if they engage in a plea bargain that they will be sentenced and that they cannot then deny the charges and/or go to trial. They should be aware that if they engage in a plea bargain they give up certain rights, like their right to go to trial. They should be aware that they can engage in a plea bargain by pleading guilty, no contest, or guilty and mentally ill; however, if they know the above information and say they are planning on pleading guilty, it is okay if they are educated about this and still marked “adequate.”

9. They should respond with either guilty, not guilty, no contest, guilty and mentally ill, not guilty by reason of insanity, or by saying they intend to engage in a plea bargain. If they say they want to engage in a plea bargain then they should clarify which plea they are considering. It is okay if they do not have a specific legal strategy in mind so long as their thought process about this is rational (“I want to talk to my lawyer first,” etc.).

10. Their response to this question should make logical and rational sense and cannot be influenced by a mental illness. For example, if they say they want to engage in a plea bargain because a) it is faster, b) they think they will lose at trial, c) there is too much evidence against them, or something similar, then this can be considered a logical reason to enter that plea. If, for example, they say they want to plead guilty because a) it’s impossible to get a fair trial, b) their lawyer wants them to be convicted, c) they are Jesus and need to visit the prison, or something similar, then this is not a rational reason. You should also consider if their illogical/irrational thought process is due to a personality disorder as opposed to another mental illness. If their lawyer says there are no issues with this domain then their response is adequate.

11. This question is further examining if their defense strategy is logical and rational. They should be able to identify the main pieces of incriminating evidence in their case. It is okay if they disagree with what the evidence suggests, but they cannot claim the evidence does not exist or will not be used. If their lawyer says there are no issues with this domain then their response is adequate.

12. This question is further examining if their defense strategy is logical and rational. They should be able to identify the evidence that could be used in their defense. If they are unable to identify evidence that could be used in their defense or are otherwise unable to explain why the prosecution’s evidence would be insufficient, their rationale for pleading not guilty is inadequate. If their lawyer says there are no issues with this domain then their response is adequate.

13. If the defendant plans on proceeding to trial, they need to know that they do not need to testify, that there are risks and benefits to testifying, and they need to be able to testify relevantly. Potential benefits include that they will be able to provide evidence in the form of explaining their side of the story. Potential risks include that they will need to answer questions from a prosecutor and that the prosecutor will try to cause them to appear guilty; they may be asked questions that cause them to accidentally incriminate themselves or that could otherwise harm their case.

14. This is another question assessing their rational appreciation of their situation and their legal strategy, and is mainly asked to see if they have any extremely unrealistic predictions or if delusions are interfering with their defense strategy. For example, a person convicted of murder will not be sentenced to probation. A person is very unlikely to simply have all of their charges dropped for no reason. If the defendant gives an answer that seems too optimistic, you can modify the question and ask something like, “What do you think might actually happen with your case?” If their lawyer says there are no issues with this domain then their response is adequate.

15. They should be able to identify that the prosecutor is working against them. It is helpful if they can identify that the prosecutor is the person accusing them, that they coordinate with the police, or any other important function of the prosecutor.

16. They should be able to identify that the defense attorney is their lawyer and that they are trying to help them fight the charges. It is okay if they call the defense attorney an "LDA" or "public defender."

17. They should know that the judge is in charge of the courtroom, ensures the law is obeyed in the courtroom, and is in charge of sentencing. It is helpful if they know that if they go to trial that they can ask for a bench trial, in which case the judge will listen to the evidence and decide if they are guilty or not guilty.

18. They should know that a jury is a group of randomly selected people that listen to evidence presented during a trial and then decide if the defendant is guilty or not guilty. Ideally they are aware that they can ask for a jury trial instead of a bench trial, but if not they can be educated about this and marked "adequate."

19. They need to be able to work with their lawyer and not have any irrational beliefs about their lawyer. Sometimes defendants will complain about their lawyer and it is unclear if this could be an issue that renders them incompetent. Consider asking a clarifying question such as the following: “I’m going to describe two situations and you tell me which one is closest to what’s going on for you: Your lawyer is actively working against you, working with the prosecution to get you convicted, or something else like that; OR your lawyer isn’t a very good lawyer, doesn’t do enough for you, and you wish they were more involved in your case.” If they indicate they believe their lawyer is working against them, this question should be marked “Inadequate.” If they are simply dissatisfied with their lawyer, consider asking another clarifying question such as “If you talked with your lawyer and they said they would help you with that defense strategy you just mentioned, would you be able to work with them?” If it appears that there are no significant barriers to working with their attorney then they should be marked “adequate.” If their lawyer says there are no issues with this domain then their response is adequate.

20. The defendant should be able to present in a manner that would not cause any issues in a courtroom setting. There are myriad ways that this could be a problem, such as yelling, swearing, constant interruptions, and the like. It may also be problematic if the defendant is so distracted by internal stimuli that they are unable to attend to the assessment. If the defendant was essentially able to engage in the assessment without any marked behavioral issues then this question can be marked “adequate.” If a defendant presents with behavioral issues, it should be determined if the behavioral issues are volitional - if they have the capacity to behave appropriately then they should be marked “adequate.”