# Legal Competency and Language Proficiency: Addressing the Lack of Intervention for Limited English Proficiency Consumers.

Vuong, Ky V.

A Clinical Research Project presented to the faculty of the Hawaii School of Professional Psychology at Chaminade University of Honolulu in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

Honolulu, Hawai'i

June, 2020

Legal Competency and Language Proficiency: Addressing the of Lack of Intervention for Limited English Proficiency Consumers.

This Clinical Research Project by Ky Van Vuong, directed and approved by the candidate's Clinical Research Project Committee, was approved by the faculty of the Hawai‘i School of Professional Psychology at Chaminade University of Honolulu in partial fulfillment of the requirements of the degree of Doctor of Psychology in Clinical Psychology.

SEan W. Scanlan, Ph.D.
SEan W. Scanlan, Ph.D. (Jun 20, 2020 11:29 HST)

Sean W. Scanlan, Ph.D., Program Director
Hawai‘i School of Professional Psychology

Clinical Research Project Committee

Lianne Philhower, PsyD, MPH

Lianne T. Philhower, Psy.D., M.P.H.
Chair

Ricky Trammel, PhD
Ricky Trammel, PhD (Jun 20, 2020 11:40 HST)

Ricky Trammel, Ph.D.
Committee Member

06/17/2020

By

Ky Van Vuong, MSCP

Abstract

In 2011, the Hawaii State Legislature revised state law, requiring the Hawaii Department of Health, Adult Mental Health Division (AMHD) to provide an outpatient competency restoration program to defendants who were found unfit to participate in their trial proceedings due to possible mental disease or defect and were released to the community on conditions determined by the court. Analysis of the outpatient competency restoration program and curriculum of teaching materials used by Hawaii and other states confirms that there is a scarcity of information addressing the needs of legally encumbered individuals with English proficiency issues. Utilizing a sample case vignette, the Cultural Broker model described by Mary Ann Jezewski (1995) shows potential to help address contextual and cultural issues that may often be overlooked in such a program. This model takes a three-stage approach to assessing problems and breakdowns in communication, helping individuals build connections to the OCRP and encouraging participation in the program.

*Keywords*: Competence restoration, limited English proficiency, recidivism, legally encumbered

## Table of Contents

## Chapter 1: Introduction

The United States Supreme Court case of Dusky v. United States, 362, U.S. 402 (1960) is credited for the creation of Outpatient Competency Restoration Programs. In this case, legally encumbered individual Milton Dusky, a 33-year-old man diagnosed with schizophrenia was charged with assistance in the rape and kidnapping of an underage girl. He was found competent to stand trial and was sentenced to 45 years in prison. This raised concerns about trying individuals that may not be able to appreciate the charges against them in court proceedings. This case led to the movement for an increase in competency evaluations (Wall, Krupp & Guilmette, 2003). The increase in competency evaluations meant an increase in the need for hospitalization of individuals found incompetent to stand trial. Instead of relying solely on state psychiatric facilities, outpatient competency programs were created to restore competency in individuals and to provide the least restrictive services to legally encumbered individuals that were found to be of low danger and low risk. The Report to the Twenty-Ninth Legislature, State of Hawaii, 2018 shows that discharges with legal status of unfit to proceed and released on conditions (§704-406(1)) increased significantly by 48% in FY 2017 after decreasing by 16% in FY 2016. The courts found that these individuals cannot understand the court proceedings and/or assist in their own defense. However, they were also found not to be a danger to self or others, or to be of substantial danger to the property of others, and therefore, were released on conditions. Hawaii's OCRP program is similar to others states with active OCRP programs, as it is a multimodal approach which addresses an individual's housing needs, psychiatric needs, case management and medication management. But there are differences regarding which entity in the competency evaluation decides whether an individual can be provided outpatient vs. inpatient services.

The consistent increase of individuals found unfit to stand trial and participate in their own defense has led to an increase in occupancy in state psychiatric hospitals (Gowensmith, Frost, Speelman, & Therson, 2016). To decrease the high occupancy rates in state psychiatric hospitals, outpatient competency restoration programs (OCRP) were developed, as community-based care is often important in reducing recidivism and potentially costly hospitalization (Heard, 2014). These programs targeted adults who had committed a crime, were unfit to stand trial, but were likely to regain competency (Johnson & Candilis, 2015). Currently, of 35 states that have revised laws allowing for outpatient competency restoration programs (OCRP), only 16 of these states have implemented such programs. Within 15 of them, the OCRPs implemented vary and require customization due to geographic diversity needs (Wik, 2018). There is limited information concerning the OCRP process and implementation in these programs. The research available only indicate that there is an implementation of these programs in these 16 states (Gowensmith et al., 2016). In the state of Hawaii, the OCRP reflect the state of Hawaii's statutes but further customization is noted in the Florida State Hospital's CompKit of OCRP manual noted (2009).

One of the diversities which appears to be overlooked is that of legally encumbered individuals who, due to English proficiency needs, require an interpreter to participate in the outpatient competency restoration programs. Trial proceedings are conducted in English; therefore, usage of an interpreter is crucial in communicating and understanding criminal proceedings for individuals who do not speak English well enough or are not confident in their English-speaking skills (Mossman et al., 2007). Individuals who rely on interpreter services to navigate the criminal proceedings system and are found unfit to stand trial but safe to release to the community would likely require interpreter services in their outpatient competency

restoration participation. Adjustments to these programs taught primarily in English are made to support individuals with English proficiency issues. The goal of these programs is to provide education for individuals to better understand the trial process and gain the knowledge necessary to actively participate in their own defense, to be given the given the same opportunity to succeed as their peers with better English proficiency.

This study will examine Hawaii's current outpatient competence restoration program (OCRP) and how it addresses the diversity needs of those with English proficiency deficits that require interpreter services to participate in the class. Outpatient competence restoration (OCR) can be an effective and cost-saving tool for providing a necessary service required by United States law, but it is taught and tailored to English speaking individuals. This analysis of Hawaii's current model of OCRP will utilize metanalysis of the OCR research along with competency restoration research articles to assess how language barriers are addressed in helping individuals gain competency. The result of this study will be a proposed model that would hopefully fill this gap for Hawaii's OCRP population of individuals with English proficiency issues.

## Case Vignette

The following case vignette was created using information from various cases integrated into a single case to protect the identify of those within the system. This is a hypothetical vignette based on an integration of training experiences in the field and does not represent any individual. Any similarity to a person is coincidental.

Ms. Thao Nguyễn a 57 year old a first generation Vietnamese immigrant female arrived on time to her interview with the court examiner, a psychiatrist who was to evaluate her for mental illness, dangerousness and competency to stand trial pursuant to her court order suspending proceedings for examination of defendant (HRS §, 704-406). Ms. Nguyễn attended

the examination with an interpreter who would translate for her, as her English proficiency was limited, and she had difficulty communicating without an interpreter. Ms. Nguyễn demonstrated limited understanding of the reason for her participation in the examination. Ms. Nguyễn was observed to be talking to herself prior to beginning the examination. She appeared agitated in her response to being examined. Ms. Nguyễn was adequately groomed, wearing a dress and slippers. Slight psychomotor agitation was evidenced. She continued to mumble her words, and it was often difficult for her interpreter to understand her. What could be understood was tangential and disorganized. Additionally, she presented with an angry affect. Unprovoked, she said, "I will cut you down with an axe…", and incomprehensible but something along the lines of, "…take my shirt off and show you my diddles." Ms. Nguyễn continued to ramble something about Native Americans and cutting people and then said, "They come back down from hell to the fire." At one point, Ms. Nguyễn abruptly hissed loudly like a snake.

According to a Police Report, on September 22, 2019 an officer responded to an argument on Karot Blvd., where a witness said that Ms. Nguyễn "was angry with a personal situation" and without provocation, began scratching her chest, face, and arms. The witness believed Ms. Nguyễn was angry, because her government subsidy check was late. The witness reported that Ms. Nguyen was off of her medications at the time. The Police Report goes on to describe that Ms. Nguyễn was taken to Strongman Medical Center to determine whether she required medication, but no current prescription could be verified. Upon arrest, the officer described the defendant as "uncooperative and verbally insulting." Ms. Nguyễn has a history of convictions in the State of Hawaii of the following offenses: Assault in the 3rd, degree, Theft in the 4th degree and Criminal Trespass in the 2nd degree.

Based on the clinical history, mental status examination and the collateral information presented in this document, Ms. Nguyễn 's DSM-5 diagnostic presentation can best be described as: Schizophrenia. The examiner found that Ms. Nguyễn did not appear able to participate meaningfully in her legal proceedings at the time. The examiner was not able to give a formal opinion at the time of examination regarding the extent to which Ms. Nguyễn's cognitive and/or volitional capacity was impaired at the time the conduct was alleged. Overall, Ms. Nguyễn currently presents a low to moderate probability of harm self and others or property over the next few months if she is released to the community.

The judge who was presiding over Ms. Nguyễn's case, upon reviewing the findings from the examiner's report, ruled that pursuant to HRS §, 704-406 Ms. Nguyễn was unfit to proceed and posed a low to moderate risk to self and others. She was ordered to participate in outpatient competency restoration administered by the Department of Health's Adult Mental Health Division. Ms. Nguyễn was scheduled to attend weekly hour-long sessions at the AMHD outpatient clinic.

Ms. Nguyễn attended her first session with her Vietnamese interpreter. She participated in the intake session by answering questions in short responses, but the facilitator noted that when Ms. Nguyễn was providing longer responses, the translation was short. When asked about her history with mental illness, she responded that she did not have a mental illness and she was not crazy. Further attempts to ask her questions were met with short responses and avoidance of eye contact.

When attempting to schedule the follow-up session with Ms. Nguyễn, she became agitated, yelling that she thought this would be it; she did not understand why she would have to keep coming back; and that the session was a waste of her time. Ms. Nguyễn stated she would

not return and did not care what would happen as a result. Ms. Nguyễn was at risk of hospitalization due to violation of her court order.

## Rationale for Study

Hawaii's state law attempted to address the needs of defendants who are found unfit to proceed due to concerns about mental illness potentially affecting their ability to work with their attorney and participate in their own legal defense (HRS §, 704-406). These defendants were typically committed to the custody of the Hawaii State Department of Health until they are able to be evaluated again for their fitness to participate in their legal proceedings. If the defendant's charge and risk for violence are low, there is a minimum risk of harming self or others, and the individual can safely be released in the community, they are court ordered to participate in OCRP (HRS §, 704-406 (1)).

The OCRP focuses on educating defendants on the criteria used to evaluate their legal competency. These criteria include the ability to understand the charges brought against the defendant, ability to understand the consequences of the charges against them, ability to work with their attorney regarding their legal defense, and courtroom-based behavior and decorum (HRS §, 704-406(1)). The OCRP manual utilized in Hawaii consist of 2 phases. The first phase consists of 13 lessons known as modules that focus on the factual knowledge component of competency restoration. The modules are in line with the competency assessment utilized by the court appointed psychologist and psychiatrist that evaluate individual on their understanding of severity of charges, pleas and plea outcomes, sentencing guidelines, courtroom personnel and their responsibilities, appropriate courtroom behavior, general trial process, how to work with one's defense attorney and rational decision making. The second phase of Hawaii's OCRP is the

application of phase I factual knowledge to the individual's specific case, this consists of 10 modules (Florida State Hospital, 2009).

There have been no studies evaluating the deficits in competency restoration for individuals with Limited English language proficiency (LEP) issues to date. Limited English proficiency is noted as a limited ability to read, write, speak or understand English (U.S. Department of Justice, 2002). There are no specific research data readily available on LEP individuals who have been court ordered to participate in OCRPs or Hawaii's OCRP. Issues that LEP individuals face as defendants have included poor understanding of legal proceedings and options due to language barrier, inability to communicate effectively with their defense council without access to an interpreter outside of court, emotional distress due to court proceedings, and complexity of legal language that diminishes the defendant's ability to understand English in the courtroom (Wong, 2011).

The United States Surgeon General on Mental Health (U.S. Department of Health and Human Services, 2001) noted that decreasing the ethnic and racial disparity in mental health treatment and access requires overcoming language barriers associated with limited English proficiency. This is a key issue that needs to be understood by governing parties and programs that aim to overcome the ethnic disparities in mental health service use. This would require promotion and implementation of required measures for language assistance and help in order to evaluate the implementation process and assistance effectiveness (U.S. Department of Health and Human Services, 2001).

Snowden, Masland, and Guerro, in 2007, evaluated the pitfalls and issues that come with Federally mandated requirement for interventions aimed at decreasing the ethnic disparity in the access of mental health care and mental health care programs. Title VI of the Civil Rights Act of

1964 requires that all state agencies receiving federal funding must ensure that individuals receive, free of charge, language assistance necessary to afford them equal access to services (Snowden et al., 2007). The barrier to this mandate is that there is no federal funding set aside for state and local authorities to implement the changes required to comply with the mandate. The responsibility of compliance falls onto the state and local authorities; failure to comply could result in mental health provider quality-of-care lawsuits. Research and implementation of intervention for those with LEP in the OCRPs could prevent potential Civil Rights violations.

## Purpose of Study

The purpose of this theoretical case study is to review the various OCRP programs in different states, focusing on Hawaii's OCRP, and identify the need for modification to better meet the diversity needs of legally encumbered individuals with English language proficiency issues. There does not appear to be any recent evaluation of the OCRP manual used in Hawaii, or an assessment of the diversity needs of individuals, and whether these needs are being met. The OCRP programs were developed to promote a reduction in recidivism in legally encumbered individuals, but their effectiveness in meeting this goal has not been determined. This research project is done in the hopes of evaluating what steps, if any, have been taken to help those with LEP and propose a model geared toward decreasing the gap in disparity for individuals with LEP's ability to benefit from a mandatory competency restoration program.

## Research Questions

1. Is Hawaii's OCRP inclusive of legally encumbered individuals with English language proficiency issues?
2. What are the needs of the legally encumbered individuals with LEP issues?

3. What revisions to the manuals used for the OCRP are needed for the culturally diverse population of Hawaii?
4. What would a model geared towards individuals with LEPs in mandatory OCRPs look like?
5. How might this model be evaluated for quality assurance?

**Significance of Study**.

Legally encumbered individuals found unfit to proceed in their legal proceedings due to mental illness or defect are a marginalized population; further marginalized are those individuals who, in addition to this encumbrance, do not speak English or who lack proficiency in English. As a result of addressing the need for a standardized competency restoration, HRS § 704-406 proposes to decrease lengthy hospitalization time at the Hawaii State Hospital and ensure the legally encumbered individuals' rights are honored.

The proposed model of Cultural Broker will incorporate the interpreter into the OCRP process. The interpreter will act as a bridge between OCRP facilitator and patient. The patient will be given an opportunity to express contextual and cultural issues that may not have been possible without this model.

This model may help the local health care system offer a feasible model for working with LEP individuals. In giving a voice along with maintaining translational accuracy from the model, health care providers can preemptively prepare for cultural issues that may come up during treatment of LEP individuals and work to address systematically.

This model will also help state legal stakeholders because it will better ensure that LEP individuals are accurately given the education they need through the OCRPs. Individuals will also have a better opportunity to understand and synthesize the OCRP material to their court

proceeding, this will hopefully decrease lengthy legal proceedings and ensure individual are aware of the legal proceedings.

The state of Hawaii may benefit from this proposed model because improvements to the OCRP program can help ensure the program is doing what it is expected to. OCRPs were found to be high in restoration rates and providing community-based care for those individuals that are evaluated as not a violent threat to themselves or others. Community-based care has been shown to be effective in reducing recidivism rates in the legally encumbered individuals that were found unfit. In examining how LEP individuals are supported, the program can improve and better serve Hawaii's population.

The field of psychology may benefit from this study as currently there do not appear to be any studies that look at legally encumbered individuals who have participated in Oahu's OCRP (Fitness Restoration), nor the effectiveness or lack of effectiveness in addressing the needs of individuals with English language proficiency deficits.

## Chapter 2: Review of Literature

Hawaii's OCRP program takes place in a group setting, once a week, for a one-hour session. There are 23 session in total. The initial session is the intake session, in which consumers are given an overview of the OCRP program and its purpose. During the intake session, individuals are asked survey questions based on the Florida State Hospital CompKit (Florida State Hospital, 2009). These questions are used broadly to assess the factual phase of the Dusky standard. The survey questions are the pre-test of the Florida State Hospital CompKit, it ascertains the defendants' ability to read and understand the curriculum's competency information and is an important adjunct to the initial competence evaluation.

The OCRP groups are facilitated by a Fitness Restoration Coordinator, this position is usually a master's level mental health therapist. Various teaching tools are utilized, depending on the needs of the group. In addition, the facilitator uses visual aids, such as pictures of a courtroom, to reach participants whose preferred learning modality is visual or who may be cognitively impaired. These materials are not publicly available, so that attorneys and defendants do not gain unfair advantage before the formal assessment and restoration efforts.

The OCRP also utilizes case vignettes for discussion. Roleplay is a useful strategy in this context as well, as participants act out the roles of courtroom members. Each defendant is consequently evaluated at the 13-week mark to determine their retention of the factual information prong of fitness restoration, and then again at the 23rd session to evaluate their ability to apply the factual information to their case specifically. Reports are made to provide insight on consumer's progress in retaining the factual component phase and their ability to apply the factual information in the last phase of the OCRP.

## The Nature of Crime

*In 2017, the Federal Bureau of Investigation (FBI) released a report as part of the Uniform Crime Reporting Program (UCRP) to provide information to law enforcement and the general public regarding trends in crime. The national average of crime incidents at that time was 1,283,220, with there being 394 crime offenses per 100,000 inhabitants. In Hawaii there were 3577 crimes reported in Hawaii in 2017, at 250 crime offenses per 100,000 inhabitants. The UCRP advises against using crime statistics as a ranking system due to local variabilities that may affect the crime statistics differently across the nation. The treatment advocacy reports Hawaii incarcerates more mentally ill individuals than it hospitalizes, as seen in Table Table 1: Reprinted from Treatment Advocacy Center's report patterns concerning treatment of individuals with mental Illness (MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A Survey of the States, Treatment Advocacy Center, 2010) Copyright (2010) by Treatment Advocacy Center. Reprinted with permission.*

(2010).

| Total Inmate population 2005 | Estimated Population of SMI inmates | Total Psychiatric inpatient population 2004 | Likelihood of Incarceration vs. hospitalization |
|---|---|---|---|
| 5,705 | 913 | 311 | 2.9 to 1 |

*Table 1: Reprinted from Treatment Advocacy Center's report patterns concerning treatment of individuals with mental Illness (MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A Survey of the States, Treatment Advocacy Center, 2010) Copyright (2010) by Treatment Advocacy Center. Reprinted with permission.*

Statistics on crime may give a picture of trends, but they do not look at the motivational aspects that contribute to criminal behavior. Research findings concerning motivation for criminal behavior and personality traits were also found in Sinha's 2016 study of personality correlates of criminal behavior. Thirty-seven male criminals were given the Cattel's 16 personality factors (PFs) scale for assessing their sociodemographic variables and different personality traits (Sinha, 2016). This research found that criminals differ from general population

or non-criminals in terms of personality traits. Personality trait differences included higher scores in intelligence, impulsiveness, suspicion, self-sufficient, spontaneity, self-concept control factors, and very low scores on Cattel's 16 PFs, indicating they were emotionally less stable compared to their non-criminal counterparts (Sinha, 2016).

Prins, Skeem, Mauro, and Link (2015) studied a sample of 183 people aged 18-63 with serious mental illness in intensive outpatient treatment by monitoring their progress for an average period of 34.5 months. The study tested whether criminogenic factors and psychotic symptoms were independently associated with arrest. Criminogenic factors and psychotic symptoms were helpful in predicting arrest rates. Arrest history was associated with increased arrest rate, while psychotic symptoms were associated with decreased arrest (Prins, Skeem, Mauro & Link 2015). Decreased arrest rates in legally encumbered individuals with mental illness was proposed to be due to their receiving mental health outpatient treatment services. Criminal history and variables such as risk factors, changeable behaviors, attitudes, and personality characteristics maintain recidivism (Prins, Skeem, Mauro & Link, 2015). Limitations of the study noted by the authors included the legal status of the sample not being under correctional supervision. Further, mental illness may be a protective factor in recidivism, but this was likely due to these individuals undergoing outpatient treatment.

## Paradigm and Theoretical Orientation

How we look at criminal behavior itself is an important factor in crime control, a set of strategies to reduce crime in a society. Effective long-term crime control strategies need to evolve in response to rapidly changing needs and new knowledge (Vila, 1994). This is why an evaluation of the interventions such as Hawaii’s OCRP in addressing recidivism is important; with new knowledge, the Department of Health would be better able to provide treatment in

accordance with the changing the needs of its consumers. Vila proposed that paradigms such as the extended evolutionary ecological theory approach give special consideration to the unique properties of cultural traits used extensively by humans to adapt to their environment (Vila, 1994). This paradigm treats crime as a cultural trait whose frequency and type can evolve over time in response to such phenomena as interactions between people's routine patterns of activity, the availability and distribution of resources, modes of production, childrearing practices, competition, and cooperation.

## Legal Competency

Individuals who were found not competent to stand trial due to their mental disorders are assigned the status of "unfit to proceed" (HRS § 704-406). The criteria for determining an individual's competency to stand trial or be deemed unfit to proceed were evaluated by state-employed clinicians and were found potentially lacking in areas such as being able to appreciate the charges, being able to understand the possible consequences of these charges, appropriate courtroom behavior and ability to work with their legal counsel in their own legal case (HRS § 704-406). These individuals, when identified as unfit, could be hospitalized at the Hawaii State Hospital (HSH) for treatment until they are either found competent or discharged into the community due to low risk of violence and low risk of danger to self and others. Legally encumbered individuals with this legal status may also be diverted to the community to receive treatment in an outpatient setting. HSH reported in 2018 that there was a decrease in admissions for the 2017 fiscal year, but it was still the second highest in the past decade. Those with the legal status of unfit to proceed consisted of 58% of its admissions in 2017 (HSH, 2018). Of the patients in HSH, 37% of the population had the unfit to proceed status (HSH, 2018).

Individuals with this legal status are required by law to be provided with a fitness restoration program until they are either found fit to proceed in their legal proceedings or found unfit and unrestorable. The fitness restoration program is provided in an inpatient setting at HSH or in the community in an outpatient program. The Outpatient Competency Restoration Program (OCRP) is provided to individuals that were either discharged from the state hospital or diverted from the courtroom to the community instead of hospitalization. Those in the community given the status of Unfit to Proceed and Released on Conditions are referred to as 704-406(1)/406(1) (HRS § 704-406). Those who are 406(1) are court-ordered to participated in the State of Hawaii Department of Health, Mental Health Division's OCRP until they are either able to regain competency or are evaluated to be unfit and unlikely to have their competency restored.

**Competency Evaluations**

Bonnie and Grisso (2000) estimated that there are 60,000 competency evaluations conducted annually in the United States. Defendants who are found incompetent to stand trial make up the largest group of psychiatric patients committed to mental hospitals from the justice system. This demographic breakdown of mental hospital population has been an area reported in HSH's 2018 annual report, also reflected similar findings.

In a study examining the validity of competency evaluations of individuals found incompetent to stand trial, there were noted differences between individuals who are competent compared to those who lacked competency (Hubbard, Zapf, & Ronan, 2003). This research study comparing 487 individuals who were deemed not competent to stand trial, found that the noticeable difference between legally encumbered individuals who were not competent included age, employment status, ethnicity, criminal charges, and psychiatric diagnosis. In Alabama, the demographics of someone typically found not competent to stand trial were male, unmarried,

unemployed, and receiving income from various sources, such as disability pension. There is currently a lack of research on the commonalities of those found incompetent in Hawaii. Being able to ascertain the trend for someone being found not competent to stand trial is important as it can help address the differences between defendants predicted to be restorable and those predicted to be not restorable by mental health examiners. Those who were found to be unrestorable by court examiners were likely to be those with acute conditions related mainly to nonpsychiatric variables. The concerns raised by this study indicated that the accuracy of competency evaluations affected the likelihood of an individual being referred to treatment for competence restoration and an alternate disposition. The premise of an OCRP being offered to individuals is that there is a possibility of their competency being restored. A lack of accuracy can pose a potential barrier for someone who was found incompetent to access the services they need to gain competency through an OCRP.

Warren, Chauhan, Kois, Dibble and Knighton found that of the 2260 individuals that had undergone competency evaluation, psychiatric diagnosis was an influential variable in classifying opinions concerning the restorability of incompetent defendants. Defendants diagnosed with an affective or psychotic disorder were more likely to receive an opinion of likely/probable restoration than those defendants diagnosed with pervasive developmental, organic, substance-use, personality, or other disorders (2013). Their findings suggested that the clinical condition of the defendant was key in ascertaining the restorability of an individual. Ruth E. Masters published a counseling guide in 2003 that targeted counselors working with legally encumbered individuals. In the book, which addresses different modalities that can be utilized in the treatment of legally encumbered individuals, Masters proposed that change or rehabilitation requires motivation from the legally encumbered individuals. Rehabilitation is not a cure for

criminal behavior, but rather consists of interventions which help integrate legally encumbered individuals back into the community. Integration back into the community was an important factor in decreasing recidivism in legally encumbered individuals (Masters, 2003).

Castillo, Ijadi-Maghsoodi, Shadravan, Moore, Mensah, Docherty, and Wells (2019) also found that disparities between legally encumbered individuals with mental illness require community-based treatment. In reviewing recent community-based interventions in Monroe County, New York, adults with psychotic disorders charged with misdemeanors were conditionally released and randomized to usual treatment or Forensic Assertive Community Treatment (FACT). FACT provided services such as a 6-hour training in criminal justice collaboration for clinicians, screening for criminogenic risk factors among enrollees, weekly court appearances, and meetings to discuss barriers to success with the supervising judge, public defender, and district attorney. Over a year, FACT enrollees had significantly fewer convictions, fewer days in jail, and more days in outpatient mental health treatment compared to legally encumbered individuals that had received treatment as usual (Castillo, et al., 2019). Castillo, et al. (2019) proposed that while healthcare access is an important determinant for mental health, interventions and policies must intentionally address the larger ecosystem of social/structural determinants of criminal justice involvement. This finding was also reflected in Vila's 1994 article that pushed for a paradigm shift in viewing criminal behavior as not a static factor, but as dynamic and affected by the environment to which an individual is exposed. The needs of legally encumbered individuals require comprehensive treatment that addresses and adapts to the evolving needs of legally encumbered individuals with mental illnesses (Vila, 1994). ). D. A Andrews a psychology professor at Carleton University at Ottowa, James Bonta previous Director of Corrections Research for Public Safety and Emergency Preparedness Canada and J.

Stephen Wormith who was chair in forensic psychology at the University of Saskatchewan research stressed the importance of research in the assessment and adaptation of intervention geared towards recidivism (2006). The needs of the individual are dynamic, and treatment should address behaviors and attitudes referred to by Andrews et al. (2006) as criminogenic needs.

## Outpatient Competency Restoration Programs

The Treatment Advocacy Center's *Treat or Repeat* report on recidivism in the nation graded the various interventions by state. Table , from this report, shows that the 4 states having the highest rating in implementing programs that reduce recidivism are Hawaii, Maine, Missouri, and Oregon.

| | | | |
|---|---|---|---|
| **A** | State is making an excellent effort and has most components of a model program. | **A** | No state received an A grade. |
| **B** | State is making a commendable effort and has many components of a model program. | **B+** | Hawaii, Maine, Missouri, Oregon |
| | | **B** | California, Connecticut, Louisiana, Ohio, Tennessee, Washington, Wisconsin |
| | | **B–** | Colorado, Georgia, Minnesota, New York, Virginia |
| **C** | State is making a modest effort and has some components of a model program. | **C+** | Michigan, Oklahoma |
| | | **C** | Arizona, Arkansas, Illinois, Kentucky, Maryland, South Carolina |
| | | **C–** | Nevada, New Hampshire, Rhode Island, Utah, West Virginia |
| **D** | State is making a small effort and has few components of a model program. | **D+** | Delaware, Kansas, North Dakota |
| | | **D** | Alabama, Florida, Nebraska, New Jersey, Pennsylvania, South Dakota, Vermont |
| | | **D–** | Iowa, Montana, North Carolina |
| **F** | State is making almost no effort. | **F** | Alaska, Idaho, Indiana, Massachusetts, Mississippi, New Mexico, Texas, Wyoming |

**Note:** The grade refers specifically to the state's forensic services and corrections programs for individuals with serious mental illness. Other aspects of the state's mental health services program may be rated higher or lower than this grade.

*Table 2: Reprinted from Grading of States on Efforts to create a system to decrease re-arrest by individuals with serious mental illness who have committed major crimes (Treatment Advocacy Center, 2017). Copyright (2017) by Treatment Advocacy Center. Reprinted with permission.*

In 2016, Gowensmith et al. studied the effects of OCRPs in the 16 out of 35 states with laws that allow for OCRP programs. Gowensmith et al. (2016) found that the overall benefit of OCRP was that it provided a helpful alternative to lengthy and costly psychiatric hospitalizations and have resulted in high competency restoration rates. The need for outpatient programs was echoed in the interviews of the forensic division heads of the respective states. The study reported that the increase in state hospitalization of legally encumbered individuals not only posed a financial concern for the state, but also decreased the bed space available for those without legal encumbrances (Gowensmith et al., 2016).

Integrating Gowensmith et al.'s 2016 article, Wik (2018) looked at the efficacy and potential consequences of OCRPs. The 16 available OCRPs lack standardization in their curriculum and programs. Wik proposed that the lack of standardization was not due to lack of effort from the programs but was necessary to serve the diverse population of legally encumbered individuals in different state programs.

Johnson and Candilis' 2015 study also tracked the progress of different state OCRPs. Johnson and Candilis (2015) emphasized the function of competency to stand trial in the judicial system to help assure that the defendants can participate in their own legal defense and understand the courtroom proceedings related to their criminal charges. OCRP programs were designed to promote client legal rights. Johnson and Candilis proposed that competency restoration typically occurred within a 45-day period from the beginning of the OCRP programs; longer durations did not appear to be significant in the competency for legally encumbered individuals. This study further supported the need for OCRP programs to ensure that those who were found unfit to stand trial were able to exercise their legal rights. Lengthy hospitalization is costly and does not indicate an increased rate of restoration in competency.

Wall, Krupp, and Guilmette's 2003 article further explored the usage of OCRP for treating legally encumbered individuals who were also found unfit. These individuals were diagnosed with cognitive difficulties, which the justice system continued to refer to as the mentally retarded (MR). The implication of this article is that without an OCRP in Rhode Island, legally encumbered individuals that also suffer from cognitive difficulties are overlooked by the justice system. They are not given the same opportunity as their counterparts without cognitive difficulties. Their OCRP utilized the "Slater Method," which is a multimedia approach in educating individuals that were not found competent to stand trial and suffering from cognitive difficulties. This is an example of a need for culturally sensitive modification to OCRP programs for a marginalized population that would have been committed to hospitalization for lengthy periods of time without being given the opportunity to participate in their own legal defense (Wall et al., 2003).

In 2017, a report published by the Treatment Advocacy Center, *Treat or Repeat, A State Survey of Serious Mental Illness, Major Crimes and Community Treatment,* rated Hawaii a grade of B+ for "superior forensic services compared to most states;" but according to the survey, Hawaii lacked data on recidivism and the effectiveness of forensic coordinators. To that end, the study recommended data collection on recidivism and rehospitalization to evaluate the effectiveness of programs used. In order to understand the effectiveness of what is currently being offered by Hawaii's OCRP, a review of its program components must be evaluated.

**Hawaii's OCRP Model**

The Adult Mental Health Division service delivery is based on a concept of recovery , the guiding principle with of AMHD is that a person with mental illness can recover(2017) and supports the use of innovative strategies to reduce involvement of individuals with mental illness

in the criminal justice system. Guiding principles of the forensic department include identifying and providing best practice mental health care to consumers. This includes best practice forensic services to integrate with and collaborate with the courts, corrections system, and law enforcement agencies to reduce a consumer's justice involvement.

As stated in the Hawaii Revised Statue, HRS 704-406(1), *"the department of health shall establish and monitor a fitness restoration program consistent with conditions set by the court order of release, and shall inform the prosecuting attorney of the county that charged the defendant of the program and report the defendant's compliance therewith."* The law does not define "program" but does state that the program be "consistent with the conditions set by the court," which allows the team flexibility in treatment modalities as well as restoration of fitness.

According to the literature reviewed, some states have recognized that case management services are critical for addressing restorability, as well as assessing the use of clinical and forensic services. The factors known to affect one's ability to become competent include employment, treatment adherence, and abstinence from substance use (Treatment Advocacy Center, 2019). Support in these areas can be health-affirming as well as cost-effective. Transportation assistance can be particularly useful in improving access to forensic and community services that assure the fairness of the judicial process.

Reviewing the components of the Hawaii Outpatient Competency Restoration Program shows that it provides an integrative approach, in addition to fitness restoration classes. Persons Released on Conditions (RoC) are linked to case management to assist with benefits and entitlements, a prescribing provider for medication consultation, a forensic coordinator to oversee the person's community tenure and monitor risk factors, engagement in substance abuse treatment as deemed appropriate, and participation in groups such as Illness Management and

Self-Recovery (IMSR), as well as psychosocial rehabilitation. In addition to these services, persons with criminal justice involvement are assisted with housing placements, depending on the level of care needed.

**Other States' Outpatient Competency Restoration Programs**

The focus of this research study is the Outpatient Competency Restoration Program in Hawaii. Looking at other states with similar programs, the following is an overview of what constitutes OCRP in those states other than Hawaii. States such as Arkansas, California, Colorado, the District of Columbia, Georgia, Ohio and Oregon did not have information concerning their outpatient program available to the general public. While there are sections in their state law allowing outpatient status, there were no resources available describing what their OCRP entails.

Connecticut's OCRP begins when, during pre-trial, individuals are referred by the Judicial System for court ordered restoration to competency. An evaluation is conducted by the Office of Forensic Evaluation (OFE) to determine if the individual has a substantial probability of being restored to competency, in the least restrictive setting. Limited information was provided on their website, but brief case management services are offered to those with legal encumbrance and having a psychiatric disorder (Connecticut Department of Mental Health & Addiction Services, 2019).

Louisiana's Department of Health (2019) outpatient competency restoration programs are referred by courts for defendants who are non-dangerous and have been convicted or accused of one or more misdemeanor offenses or minor drug offenses. Defendants who are eligible to participate in competency restoration services on an outpatient basis may be released to the community, providing they adhere to certain conditions imposed by the court (Wik, 2018).

Minnesota's Department of Health stated in 2018 that they would cease their OCRP, due to changes in court judges, county attorneys and public defenders. Minnesota's program had been in operation from 2006 to 2018 but has since ceased providing outpatient services.

Nevada's Department of Health and Human Services, Nevada Division of Public and Behavioral Health (DPBH), offers outpatient and inpatient programs through their psychiatric state facility (2019) called Lake's Cross Center. DPBH's facility works with those who were found not competent and unrestorable along with those who were found Not Guilty By Reason of Insanity in court. They offer an outpatient program for those for whom treatment has been successful, but the criteria for evaluation of successful treatment was unclear. Outpatient services also include licensed social worker case management for these individuals (DPBH, 2019).

New York State Office of Mental Health (OMH) Division of Forensic Services (DFS, 2019) outlined the criteria and features of their OCRP. Criminal Procedure Law (CPL) §730.40(1) and CPL §730.50(1) were modified in 2012 to include the option of outpatient restoration for CPL 730.40 Temporary Orders and CPL 730.50 Commitment Orders. This modification to New York's law allowed for the court to commit individuals to the director of OMH for services but required the consent of the district attorney before providing outpatient treatment services. OMH DFS assists the provider, defense, prosecution and court in developing an outpatient treatment plan that takes into consideration the needs of the defendant and the resources available in the community (DFS, 2019). It utilizes an outpatient clinic to provide fitness restoration services contingent on availability. New York's law appears to be different from most, in that it allows for individuals to refuse outpatient treatment services.

Tennessee's Department of Mental Health and Substance Abuse Services (TDMHSAS, 2019) provides an OCRP, called mandatory outpatient treatment (MOT). Tennessee has 3 different MOTs pathways. Table , below, shows the criteria and timeline for their MOTS. The

program has clear guidelines and expectations of when legally encumbered individuals with legal encumbrance would be reevaluated for competency. While this is not uncommon among states that allow for OCRPs, it is unsure if the 15 states fully adhere to a timeline of competency to stand trial. The MOT program appears to provide psychotherapy, medication management, vocational and educational programs, substance abuse counseling, housing and case management (TDMHSAS, 2019). Tennessee's MOT program appears to be similar to that of Hawaii's OCRP. Tennessee was the first state to create a pilot outpatient competency restoration program (Wik, 2018).

| T.C.A. § 33-6-602 | T.C.A. § 33-7-303(b) | T.C.A. § 33-7-303(g) |
|---|---|---|
| Starts in the hospital for those committed under Title 33, Chapter 6, Part 5 | Starts in the community for NGRI acquittees after evaluation under T.C.A. § 33-7-303(a) | Is required for service recipients found not guilty by reason of insanity of murder or a class A felony under Title 39, Chapter 13 whether released after evaluation under 33-7-303(a) or after commitment under 33-7-303(c). |
| Expires six months after release or previous renewal unless renewed | Does not expire | Need for continued treatment reviewed by court after an initial six month mandatory period, thereafter the court reviews annually |
| Can be modified or terminated by provider | Can only be terminated by the court | Can only be terminated by the court |
| A court finding of non-compliance can result in re-hospitalization | Does not allow for hospitalization, may result in civil or criminal contempt | Allows for hospitalization for those judicially committed, or may result in civil or criminal contempt |

*Table 3:Reprinted from Tennessee Department of Mental Health and Substance Abuse Treatment, Mandatory Outpatient Services. (Tennessee Department of Mental Health and Substance Abuse Treatment, 2019). Copyright (2019) Treatment Advocacy Center. Reprinted with permission.*

Virginia's Department of Health of Behavioral Health and Developmental Services (HBHD), Forensic Services, offers an OCRP program through the Community Service Board (CSB). The CSB's services appear to be psychoeducation in nature, as well as linking clients with social and psychiatric services (HBHDS, 2018). Case management along with psychiatric services do not appear to be part of Virginia's OCRP, but are recommended as potential services

for clients with concerns of barriers to restoration. Virginia's OCRP is also different in that it also includes OCRP in jail as an outpatient service (HBHDS, 2018).

Wisconsin's Department of Health Services provides OCRP through contract with Behavioral Consultants, Inc. (WDHS, 2019). This private business provides OCRP throughout the state of Wisconsin. However, courts that have found individuals to be not competent and in need of competency restoration services cannot order outpatient competency restoration services. After evaluation of the individual, Wisconsin's Department of Health Services will decide if inpatient or outpatient services are required. Behavioral Specialists provide treatment-to-competency sessions, and Case Managers address community-based needs in the home environment.

The Texas Department of State and Health Services provides OCRP to individuals that were found not competent to stand trial (TDSHS, 2019). Texas' Department of State and Health Services (2019) states that in addition to competency restoration treatment, they also provide psychiatric care and Managed Care Organizations under the Texas Resilience and Recovery Management Guidelines. The goal of Texas' OCRP program is to integrate individuals with mental illness and who have committed a crime back into the community to participate in an appropriate degree of treatment that will keep them stable over their lifetime.

When designed according to the responsivity principle of RNR, OCRP programs may not fully address the learning style portion. But the responsivity of the tailoring of cognitive learning interventions to take into consideration particular client characteristics, such as motivation, gender, and ethnicity as each state's OCRP differs to a certain extent to match their diverse populations.

**OCRP Summary**

In the state of Hawaii, 250 crimes were committed per 100,000 inhabitants in 2017 (UCR, 2017). There is a lack of research regarding how many of these crimes were committed by individuals with serious mental illness and lack competency to stand trial. The available information concerning the statistics for those with mental illness and incarceration indicates that of the total inmate population in 2005, 913 out of 5,705 inmates also suffered from serious mental illnesses (FBI, 2017). Individuals with mental illnesses were more likely to be incarcerated versus hospitalized by a factor of 2.9 to 1. Thirty-seven percent of Hawaii State Hospital's population were individuals who were found unfit and not competent to stand trial (HSH, 2017). HSH's annual report also raised concerns of an increase in individuals who were found unfit to proceed (704-406). In addressing the needs of Hawaii, HRS 704-406 provided guidance for the State of Hawaii's Department of Health's Mental Health Division to provide an outpatient competency restoration program (OCRP) for individuals found unfit to proceed in their legal proceedings but were low risk and could be released into the community on conditions. The program is also intended to decrease the rate of re-offense by individuals who could be restored.

When addressing the motivation for criminal behavior, Evolution Ecological Theory provide a paradigm shift of viewing criminal behavior as a static variable (Vila, 1994). In the way criminal behavior is viewed, the modality of treatment to reduce recidivism also changes. Evolution Ecological Theory proposes that for crime control interventions to be effective, the interventions need to address the multifaceted aspects of an individual (Vila,1994). The interventions need to be aware of cultural needs and continuously improve, as people are not static creatures. With this theory in mind, it is important to evaluate the OCRP programs

currently implemented to address the efficient usage of resources and ensure that the program is doing what it is intended to accomplish.

While researching the effects of OCRP on reducing recidivism, there is found to be a scarcity in available data. Evaluations of OCRP throughout the various states that are purported to have active OCRP programs is difficult to locate or does not exist. There is a need for further research because there is limited information about the effects of OCRPs.

## Language Proficiency

The OCRPs are essentially teaching legally encumbered individuals factual information concerning the trial process in the first phase of OCRP and the application of that factual knowledge to their case specific information. The topics that are covered not fully extensive are: severity of charges, sentencing guidelines, pleas and plea outcomes, courtroom personnel and their roles and responsibilities, appropriate courtroom behavior and the trial process. This court ordered program requires legally encumbered individuals to learn these topics. But for their LEP counterparts, there are other barriers to their learning besides motivation.

In evaluating the effects of barriers in mental health for Pacific Islanders, Kwan, Soniega-Sherwood, Esmundo, Watts, Pike, and Sabado-Liwag Palmer (2019) found that there were 5 key themes. The barriers they found were mental health stigma, culture and language barrier, concerns concerning care and cost of healthcare, family and friend support and the need for outreach and education concerning education to raise awareness concerning mental health. These factors could pose as barriers in participation for individuals participating in OCRPs. The programs which these individuals are court ordered to participate are due to concerns that they have a mental illness, the culture and language barriers will be apparent during their participating in the program, the cost of the program is court ordered and will not require payment from the

individuals and friends and family are often those who can help in supporting these individuals get to their programs along with their assigned social workers. Education and awareness of mental health issues are crucial, as these individuals are being found unfit due to concerns of mental health illnesses. If they are not able to understand the framework for why they were found unfit, how can they truly appreciate the nature of their legal status?

Snowden et al. (2007) proposes that effective measures for overcoming language barriers to treatment access require acknowledgement that language barriers have negative effects for individuals with LEP. In acknowledging that there is a negative effect, then administrators and providers will be compelled to act. Bauer, Chen and Alegría (2010) through researching the difference between individuals with LEP versus their EP counterparts were significantly less likely to identify a need for mental health care, experience longer duration of untreated mental disorders, use fewer healthcare services for mental disorders. Among Latino and Asian Americans, the disparity in access to care for these two population with LEP. One of the components of competency restoration is individuals being able to identify symptoms of their mental illness and how it may have contributed to their arrest and charge. If an individual with LEP is unable to have a talk about their mental illness, this can pose as a roadblock to their competency restoration.

Ramos-González, Weiss, Schweizer and Rosinski (2016) researched the fitness to stand trial process from the evaluator's viewpoint. The authors found that while evaluators that would have the language proficiency to evaluate legally encumbered individuals in their primary language was preferred, it was usually not feasible. Legally encumbered individuals often required interpreters to participate in their court proceedings and evaluations. The authors

stressed the importance of utilizing trained interpreters that translate the verbatim and ensure that translation loss did not occur.

## Interpreter Services in Mental Health

The use of interpreters in mental health is required for providers that are not bilingual. While the usage of a bilingual mental health provider is ideal, it is not always feasible due to limited access of time sensitive nature of treatment (Ramos-González et al., 2016). The usage of interpreter in court and in mental health programs can be a great help for those with LEP. LEP pose a serious barrier for individuals such as barriers in communicating effectively in the health care setting, providing high-quality care, access to medical care, more invasive management and hospitalization, medical errors and drug complications, poor satisfaction with care (Bauer & Alegría, 2010). The disparity in mental health care are worsened by the usage of untrained interpreters as a result of interpretation errors due to tendency to not translate sensitive material. (ibid). This issue is worsen for individuals who are court ordered to attend competency restoration programs as they must be able to talk about their mental illness and how it may have affected their arrest along with their own perception of the charges and factual knowledge of legal competency.

Without an interpreter to help with translating, mental health professionals run the risk of providing limited services, treatment errors such under or over-estimating psychological issues and having a limited and distorted understanding of the client. Miletic, Piu, Minas, Stankovska, Stolk and Klimidis (2006) proposed that to utilize interpreters in the mental health setting effectively, therapists need to be knowledgeable of and address issues such as: accuracy of the interpretation, technical language, confidentiality, stigma, interpreter attitudes, continuity and unprofessional behavior. These are also issues highlighted in research concerning mental health

providers utilizing interpreter services. This is very applicable to OCRPs; the accuracy of the interpretation is important, because it will help facilitators know if their learner is understanding the materials presented to them. Facilitators also need to be aware that the technical language may be confusing for the learner and they may need to adapt and teach the materials utilizing appropriate synonyms. Facilitators also need to be aware of the limits of confidentiality and resolve confidentiality concerns that the learner may have with an interpreter present. Facilitators also need to address stigma the learner may feel about mental illness and how having an interpreter present may or may not make it difficult for them to talk about their mental illness. Interpreter attitudes may affect the learning process, as it will be important to address any stigma or misinformation the interpreter may have about working in the mental health setting when present, and any issues concerning working with legally encumbered individuals that are accused of a variety of crimes. It will be more likely to make more progress with a learner who has a continuous interpreter they work well with to retain rapport and avoid having to address issues in new interpreter attitudes, confidentiality and stigma repeatedly. Addressing unprofessional behavior is paramount in ensuring that the dialogue does not shift from a patient-centered to interpreter-centric. Behaviors such as side conversations, failure to interpret every idea the patient is conveying and the interpreter attempting to speak for the patient should be addressed.

Tribe and Morrisey proposed that there are 4 different models that interprets use when working when working in the mental health context (2009). The first model is the linguistic model, is one where the interpreter tries to interpret word for word what the patient is communicating, and the interpreter adopts a neutral and distant position. The second model is the psychotherapeutic/constructionist model where the interpreter focuses on translating the meaning/feeling conveyed by the patient. The third model is the advocate/community where the

interpreter takes the role of advocate for the patient and represent their interest past interpretation. The fourth model is the Cultural Broker model, in which the interpreter translates for patient not only word-for-word, but also communicates the relevant cultural and contextual variables (Tribe & Morrisey, 2009).

Searight and Searight (2009) recommended that for psychologists to maintain a patient-centered dialogue versus an interpreter-centered dialogue, then it will be necessary to orient the interpreter to the pending encounter, clarify expectations, and discuss cultural issues. The usage of trained interpreters is stressed, interpreters are working in a specialized field and require advanced interpreter skills and knowledge. This has been echoed in various mental health and interpreter research that warns about the importance of utilizing trained interpreters that are aware of cultural issues in mental health along with ensuring that interpretation errors do not occur where important sensitive information are left out during translation. This responsibility of having an interpreter who is trained to work in a specialized area with the appropriate knowledge and skill may require training from health care institutionalizations and psychologists (Searight & Searight, 2009).

**The Search for Cultural Factors and Limited English Proficiency Research**

The evaluate the need and models utilized for addressing cultural factors that may affect the success of a patient's completion of OCRPs, studies cited in previous OCRP were examined. PsychINFO, PsycARTICLES were searched using the terms "outpatient competency restoration", "fitness to stand trial", "competency restoration", and for state departments that had OCRP reports, those were examined. Only studies in English and studies focused on the United States competency restoration process was examined. None of the research studies addressed

cultural components or LEP issues that may affect the successful completion of OCRP for patients. This study is attempting to fill that gap in research.

## Chapter 3: Case Conceptualization

### Previous Approaches

Hawaii's OCRP, much like those of other states, follows the model described by the 2009 Florida State Hospital CompKit. This instruction manual utilizes a systematic approach to teaching the various components of the trial process for individuals who were found unfit to stand trial but have the potential to become fit. However, some areas are left ambiguous, due to a scarcity in research concerning how best to serve individuals who are unfit and also have limited English proficiency, leading to much discretion regarding how a facilitator is expected to teach competency restoration courses to these individuals.

There are differences in who is responsible for teaching these classes. According to Gowensmith et al. (2016), 35 states have passed laws that allow for OCRP programs; of these, 16 states allow variability in who administers the classes. In some cases, it may be specific departments like the Department of Health's Adult Mental Health Division in Hawaii (2016). Others, like the Wisconsin Department of Health Services (2019), use contracted agencies. Connecticut's program is within their Department of Health and Addiction Services (2019). Minnesota's Department of Health ceased their program, due to changes in court judges, county attorneys and public defenders (2018). Nevada's OCRP program is embedded in their Department of Health and Human Services, Nevada Division of Public and Behavioral Health (2019); New York's OCRP is run by their Office of Mental Health's Division of Forensic Services (2019). Tennessee's Department of Mental Health and Substance Abuse Services provides OCRP to their residents (2019). Virginia's Department of Health, Behavioral Health and Development Services is charged with providing their OCRP program (2019). Texas' OCRP is run by the Department of State and Health Services. Other states house their OCRP program in

different state departments. These OCRPs never look exactly the same; the format might be similar, but the starting point and pathways individuals go through to reach an OCRP vary. The common theme explained in the most general terms is that an individual is arrested and charged with a crime, and an evaluation is later done to evaluate them for a potential mental illness and to determine whether they are fit to stand trial or whether they require competency restoration program treatment. Unfit individuals who are found to be safe to receive treatment in the community participate in their state's OCRP. Individuals who were found unsafe would be court-ordered to receive inpatient treatment if their state has such a program.

When ordered to participate in the outpatient competency restoration programs, individuals are typically evaluated at the baseline level for their understanding of the legal system and their specific charges are as per the CompKit (2009). The CompKit utilizes a two-phase approach to competency restoration, in which phase 1 introduces the various topics of competency, such as the trial process, courtroom personnel, charges, severity of charges, sentencing, pleas and plea outcomes. This is applied over 13 sessions using rote memory to help individuals learn these topics. Phase 2 capitalizes on the information from phase 1 and helps individuals synthesize this information into their own specific cases through case presentations, vignettes and problem-solving exercises.

The 2009 CompKit utilized by Hawaii's OCRP classifies participants into four levels. Level 1 is for individuals whose behavior is appropriate and their knowledge is intact. The focus on Level 1 sessions is review of materials and preparing for the trial process. Level 2 is for individuals who are advanced and delusional, possessing an adequate amount of awareness of their charges and courtroom proceedings, but likely to distort or misinterpret the reality of their situation. Individuals at this level are taught more realistic coping and communication skills.

Level 3 is for low functioning individuals whose ability to comprehend or retain information is limited. These sessions are more focused on rote memory, the role and function of courtroom personnel, procedures, words, and terms. Individuals at Level 4 are actively psychotic and confused and benefit more from individual classes as their disruptive behavior may require dismissal from group classes due to their difficulty in participation. These four levels of classification are based on the individual's mental health presentation, but not their difficulty in understanding due to limited English language proficiency.

This model is not quite appropriate for the LEP population but is used because it's the only one readily available. The 2009 manual does not provide insight on the process for utilizing an interpreter or ensuring that someone who must utilize an interpreter is properly evaluated and helped throughout the OCRP process. The assumptions and vagueness regarding a standard procedure for minority groups like LEP individuals leads to gaps that are open to interpretation. In addition, the confusing web of pathways and processes for unfit individuals varies by state and may involve different organizations or departments that oversee the process. The needs of LEP individuals are often overlooked, because the focus has been to help native English speakers participate in the process, to the exclusion of others.

**Application of Previous Approaches**

Previous approaches to understanding and treating cases like the one presented are nonexistent. There is no current research in how individuals with limited English language proficiency were helped in the competency restoration process. The manual typically used, the Florida CompKit (2009), provides a manualized approach for teaching legal competency for all legally encumbered individuals, but does not address specific interventions for those who require interpreters or those with limited understanding of English.

**The Florida CompKit Approach**

How can the Florida CompKit (2009) be used to address the case vignette of Ms. Nguyễn, who attended her first session with a Vietnamese interpreter? The facilitator for the outpatient competency restoration program followed the competency restoration manual, administering the intake session, asking her the pre-test questions to evaluate her baseline for competency and her understanding of the alleged crime of which she was accused.

Ms. Nguyễn participated in the intake session by answering questions with short responses, but the facilitator noted that when Ms. Nguyễn was providing longer responses, the translation was short. When the facilitator attempted to elaborate on questions and asked for more context around the responses, the interpreter only appeared to provide much shorter translations. When asked about her history with mental illness, she responded that she does not have a mental illness and she is not crazy. Further attempts to ask her questions were met with short responses and avoidance of eye contact.

Ms. Nguyễn completed the initial part of the OCRP process, in which she was evaluated for her understanding of her charges and of her legal process. Ms. Nguyễn's presentation and responses are heavily reliant on her interpreter. The facilitator is only able to rely on the information he is able to understand. Ms. Nguyễn would be noted as a level 3, which means she will be treated as if she were a low functioning individual, because her ability to comprehend or retain information appears to be limited. Sessions will be focused on rote memory, on material involving the role and function of courtroom personnel, procedures, words, and terms. The facilitator will have her complete the same assignments and worksheets as everyone else, relying on the interpreter to translate for her and receive confirmation that she is understanding. Concepts such as pleas and plea deals will rely on the interpreter being able to convey the

contextual information to her. If Ms. Nguyễn continues not to understand the information, the facilitator will simply have to move on to cover the 13 sessions in phase 1 and 10 sessions in phase 2.

Ms. Nguyễn may be able to sit through the first session, with lots of pauses and frustration caused by having to learn United States trial proceedings translated from English to Vietnamese, which may not be similar to the process where she is from. When attempting to schedule the follow-up session with Ms. Nguyễn, she became agitated, yelling that she thought the single session would be the end, not understanding why she must keep coming back, and stating that it is a waste of her time.

Ms. Nguyễn stated she would not return and doesn't care what happens as a result. This places her at risk of hospitalization due to violation of her court order. She would have to participate in inpatient competency restoration if she did not comply with her court ordered outpatient competency restoration. Such an event can prolong the duration of her legal proceedings substantially.

This is the likely outcome for Ms. Nguyễn, if existing approaches to OCRP are followed. If Ms. Nguyễn does come back to the OCRP, she will have to participate in a similar manner through the 23 sessions encompassing both phases. If her behavior or agitation becomes too difficult for the facilitator to handle, they will have to dismiss her and continue the session at a later date. There is no guarantee that Ms. Nguyễn's ability to participate without becoming agitated will change, and she risks continuing the cycle of being dismissed and coming back or will resolve herself to sit through the lesson with little guarantee that she has learned the materials provided.

**Cultural Broker Approach**

The previous approach for OCRP was focused on educating defendants on the criteria used to evaluate their legal competency. Because an individual's mental health is the reason why they were found unfit to stand trial, it may be difficult for them to comprehend their situation. Their presentation can vary, so utilizing a blanket method in solving this problem may have benefits in simplicity, but it ignores the dynamic nature of an individual.

Snowden et al. (2007) along with the United State Department of Health and Human services (2001) emphasized that there is a need to decrease the ethnic and racial disparity in mental health treatment and access, and that it requires overcoming language barriers associated with limited English proficiency. How we view criminal behavior and long-term crime control strategies needs to evolve in response to rapidly changing needs and newly acquired knowledge (Vila, 1994).

In addressing the barriers to mental health for ethnic minorities such as Pacific Islanders, Kwan et al. (2019) noted that the major difficulties to overcome were mental health stigma, culture, language barrier, concerns about care and cost of healthcare, family and friend support and the need for outreach and education to raise awareness concerning mental health. Overcoming language barriers to treatment access requires acknowledgement of these barriers and the negative effects that they have on the individual (Snowden et al., 2017). Bauer, Chen and Algria (2010) noted that LEP individuals are significantly less likely to identify a need for mental health care, are more likely to experience longer durations of untreated mental disorder, and havefewer healthcare services available to them for mental disorders than their English proficient counterparts. In addressing the language barrier in mental health treatment such as that provided

by OCRP, an interpreter must be engaged to help bridge the gap between service provider and individual/patient/consumer.

Interpreters for mental health providers and especially the OCRP process is paramount in helping LEP individuals understand the system in which they are court-ordered to participate. Usage of untrained interpreters poses a potential risk of interpretation errors due to tendency not to translate sensitive material (Baeuer & Alegria, 2010). To utilize an interpreter in the mental health setting effectively, therapists need to facilitate and ensure that expectations are set for interpreter services (Miltec et al., 2006). In addition, an approach to problem solving and awareness of difficulties LEP individuals may be experiencing due to cultural and contextual factors can ensure that the individual can focus on the OCRP material without risk of the system becoming untraversable. The Cultural Broker model poses a potential intervention to address many of these issues.

The rationale for utilizing the Cultural Broker model is that it is the most appropriate for the setting of OCRPs. According to Zarcadoolas, Pleasant and Greer (2006), culture consists of language, behavior, beliefs, traditions and other modes of expression. Individuals court-ordered to attend OCRPs are evaluated on their factual understanding of the legal process and also on their integration of that knowledge to their case specifically. Interpreters using a pure linguistic model may be able to translate word-for-word what the facilitator and patient say to each other, but if there are cultural and contextual factors that underlie the verbal expression, the patient may not fully be able to appreciate their legal status or mental health issues due to an underlying difference in their cultural experience. In the trial process, if an individual's culture did not acknowledge dementia or mania as symptom of mental illness, for example, the patient would

not be able to appreciate or consider the meaningful nature of a plea of "Not Guilty by Reason of Insanity."

The Cultural Broker model offers individuals the ability to convey their understanding of the modules taught to them in OCRP, as well as to resolve discrepancies between the functioning of the U.S. legal system and their cultural experience, which may be different. Facilitators have an opportunity to address these discrepancies and help an individual further their understanding, rather than being dismissed as lacking the capacity to understand. This model provides an intervention for program deficiencies that cause LEP to be more at risk for being provided limited services, treatment errors such as under- or over-estimating psychological issues and limited and distorted understanding by the client (Bauer & Alegría, 2010).

**Theoretical Foundations**

Cultural brokering has been referenced in different fields involved in patient and interpreter care. The Cultural Broker model specified in this study originated in intervention work for healthcare staff such as nurses who were providing services to refugees, disabled and displaced individuals. Jezewski (1995) originally established the Cultural Broker model as essentially a conflict resolution and problem-solving model. Problem-solving from a cultural diversity perspective was offered as a way to help understand the description of culture, setting intervention conditions that facilitate brokering when at times these conditions may hamper the brokering process.

**Core Assumptions**

The Cultural Broker model relies on the belief that culture is learned and shared, and that human beings learn culture from those they interact with from the moment they are born. Family and those who care for us teach us cultural values, beliefs and behaviors (Jezewski & Sotnik,

2001). Culture is a system comprising discrete but interconnected components of normative codes such as food practices, religion and child rearing practices, as well as both verbal and nonverbal communication codes. It is not enough for providers to be culturally sensitive to the diversity of others; cultural competency requires responding to issues related to culture, race, gender and sexual orientation (ibid). When we first learn about different culture groups, there is a tendency to apply facts we learn to everyone who is a member of the group. This is referred to as stereotyping, and is problematic with service providers, as it is seen as an end point in attempting to understand a consumer.

**Brokering**

Brokers are individuals who can function between different communities. For Jezewski, brokers came to be in her model as facilitators who were not only knowledgeable of the rehabilitation services system in the U.S. but also knowledgeable as individuals who are able to function in the communities of those who are receiving services (1995). Rehabilitation services are sometimes complex systems that are difficulty to navigate by most lay people and take experience to “work” the system to obtain benefits. The broker in this case is typically a provider from within the rehabilitation system who is able to navigate it and help others establish a connection to the system and encourage continued their participation through this connection (Center for International Rehabilitation Research Information and Exchange, 2001).

## The Model: An Overview

The Cultural Broker model for interpretation lists common conditions that inhibit the process of brokering. Conditions that it notes could either hamper or facilitate the process are type of disability, communication style, age, cultural sensitivity, time, cultural background,

gender, power/powerlessness, economics, bureaucracy, politics, network and stigma (Jezewski, 1995).

There are 3 stages referenced in the Cultural Broker Model. Stage 1 deals with Perception Problems, Stage 2 with Intervention Strategies, and Stage 3, Outcome. When the Intervention stage has not been successful and there appears to be a continued breakdown in brokering of communication, lack of resolution may result, which would require going back to Stage 2. The stages offer a framework for interpreter and service provider to work with the consumer. In ensuring successful brokering, the interpreter and service provider need to be sensitive to verbal and nonverbal areas of communication, including words, meaning and translations.

The first stage of the Cultural Broker model looks at breakdown in communication and assesses the cause of these problems. These breakdowns are typically potential barriers to access along with difficulty navigating a difficult system. The second stage is intervention, in which trust and rapport are established and connections are maintained. Strategies that typically help with the brokering process are advocating, negotiating, sensitizing, innovating and mediating when a breakdown is occurring. The intended outcome is to establish connections between consumers and the rehabilitation system, maintaining facilitation across the system. If there is a lack of resolution during the brokering process, then stage 2 needs to be readdressed to help establish a connection which would facilitate brokering with the consumer (Jezewski & Sotnik, 2001). In Table 4, **Error! Reference source not found.**, the core components of the Cultural Brokering model are shown.

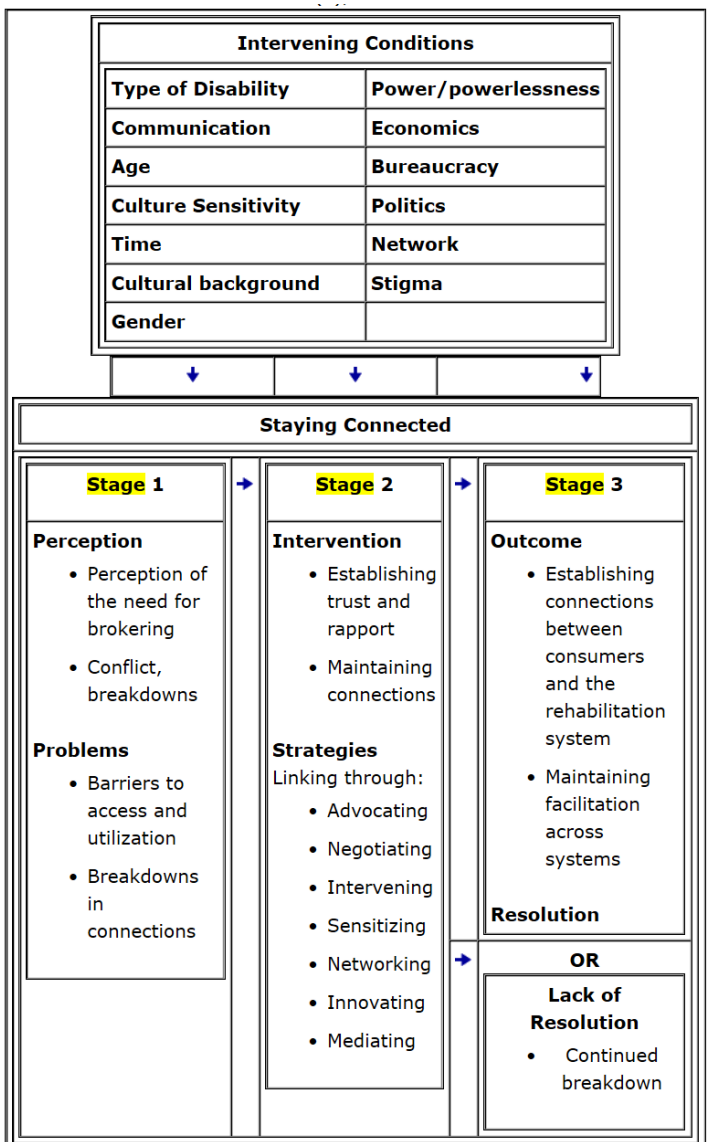



*Table 4: Reprinted from Culture Brokering: Providing Culturally Competent Rehabilitation Services to Foreign–Born Persons (Jezewsk and Sotnik, 2001).Copyright (2001) by the Center for International Rehabilitation Research Information and Exchange (CIRRIE)Reprinted with permission.*

## Application of the Cultural Broker Model

The application of the Cultural Brokering model to the case vignette would begin after Ms. Nguyễn's examination with the evaluator. The facilitator for the outpatient competency restoration program would need to request and meet with an interpreter prior to meeting with Ms. Nguyễn. This is done to address issues that were overlooked in the vignette. Applying the model

to the presented clinical case begins by first building a collaborative relationship with the interpreter to establish expectations and educate the interpreter in issues that may be common in incomplete translations during mental health services. The Cultural Broker could also be used to establish connections for Ms. Nguyễn's and encourage her participation in the outpatient competency restoration program.

The new strategy is proposed for understanding cases such as Ms. Nguyễn's because there are possible interventions that can be applied preemptively to increase participation in outpatient competency restoration and decrease the risk of unnecessary inpatient hospitalization, which would extend the legal process due to overlooking cultural context and background of the individuals. The proposed strategy for understanding such cases draws away from the "noncompliant client" narrative, as the issue presented in the vignette and possibly other LEP individuals court-ordered to participate in outpatient competency restoration simply require cultural brokering to address hesitations and concerns about mental illness and the legal system.

During the initial meeting, the facilitator provides the interpreter with psychoeducation and emphasizes the necessity of ensuring that interpretation errors do not occur, such as potentially leaving out important sensitive information during translation. There is also a need to ensure that the translator is comfortable working with legally encumbered individuals in the mental health setting. The facilitator and translator need to establish an agreement that they will work collaboratively to destigmatize mental health issues and be aware of cultural issues that might come up for non-native-English speakers like Ms. Nguyễn, who did not want to be perceived as a "crazy woman". Establishing a working alliance and setting expectations of both the facilitator and also interpreter is a cornerstone of good models for use of interpreter services (Searight & Searight, 2009).

***Stage 1: Perception/Problems***

After establishing a working relationship and setting expectations of both the facilitator and interpreter, Stage 1 of the Cultural Brokering model of interpretation can begin. In the case of Ms. Nguyễn, this step would have been taken prior to the initial intake session, but the issue at the end of the vignette also demonstrates why cultural brokering is necessary. The facilitator would determine that there is a problem or potential problem with Ms. Nguyễn's encounter with the program. The problem is likely an issue with a difference between Ms. Nguyễn's culture and the OCRP itself as a cultural system, one which is designed for individuals who lack legal competency and are required to take part in a program because their mental illness may affect their ability to participate in their own defense. This problem is also due to a breakdown in communication, as might commonly occur when navigating cultural and language differences. The concept of mental illness and how it is understood can be seen as a cultural stigma; Ms. Nguyễn has already labeled it as an issue for those who are "crazy." Ms. Nguyễn also does not fully seem to understand what the purpose of the program is and what expectations the court has for her. When the problem is recognized, the facilitator can attempt to understand the causes. This stage is important in increasing the facilitator's understanding of contextual and cultural sensitivity to the diversity issues that may have been overlooked. In identifying the problem and the cause, the facilitator is able to apply potential interventions and solutions.

***Stage 2: Intervention/Strategies***

Stage 2 is the intervention phase, in which interventions are put in place to address the identified problems, minimize conflict and establish a link between the individual and the program, encouraging continued participation in the program. Interventions typically used in Stage 2 are mediation and negotiation. Mediation consists of using a third party to help minimize

conflict between the individual and the program; an example might be the use of the interpreter to help correct or provide alternatives to phrases that were upsetting to Ms. Nguyễn. If Ms. Nguyễn was also bothered by having to attend weekly classes, then another strategy might be to ask her social worker to mediate this issue by helping transport her to and from the classes.

Negotiations are also used in Stage 2. This means reaching an agreement with an individual in order to come to terms with the individual's need for specific services. This again could entail ensuring that Ms. Nguyễn has transportation services, or that she is given an extended class time to allow for the interpreter to translate for her, or it could be a handout in Vietnamese for her to refer to while the lesson is ongoing. Advocating can be a helpful part of the negotiation strategy; for example, the facilitator may have to advocate for the needs of Ms. Nguyễn, such as more time to complete the program or to use the same interpreter to help her participate in the examiner's evaluations.

The last type of intervention which may not be necessary in Ms. Nguyễn's case is networking or helping Ms. Nguyễn establish links to service providers that can be helpful in her rehabilitation. It would be appropriate for someone like her social worker to help her obtain necessary resources through networking.

***Stage 3: Outcome/Resolution or Lack of Resolution***

In the third stage of the Cultural Broker model, the facilitator assesses the outcome after identifying the problem and implementing the intervention. If the outcome of the intervention is successful, then the problem is resolved. If not, the facilitator would start again from Stage 1 and systematically attempt to further identify the problem and its cause, and then address the newly hypothesized issues through Stage 2, evaluating for success in Stage 3. If the cause of Ms. Nguyễn's decrease in participation in the OCRP was not due to her lack of understanding of the

program and her desire not to be labeled “crazy,” then there may be another cause that the facilitator would have to address. As proposed above, the issue may be transportation to and from the program that Ms. Nguyễn views as a barrier to her participation.

In applying the Cultural Broker model to the case vignette, the facilitator acted as a broker. A broker is someone who is able to function in both communities, that of the OCRP program and that of Ms. Nguyễn’s culture. The broker must be educated in the needs of the rehabilitation program and the court’s expectations, as well as Ms. Nguyễn’s cultural background. Gaining the competency to understand the cultural context and issues Ms. Nguyễn faces may be difficult; it would require consultation with the interpreter and researching cultural issues that may impact Vietnamese individuals who are receiving mental health services and are legally encumbered. The limited research has shown that there are no interventions currently in place for specific individuals like Ms. Nguyễn, but this brokering model may be a step in increasing the conversation toward ensuring that individuals like Ms. Nguyễn are not overlooked in the forensic setting.

This proposed study will apply the Cultural Broker model for utilizing interpreters with LEP individuals in the OCRP setting. The Cultural Broker model for interpreters proposed by Tribe and Morrisey (2009) is one that would best help convey contextual and cultural issues that may arise during OCRP participation. The model itself focuses not only on the word-for-word translation for what is being conveyed by the individual, but also on the contextual and cultural factors that may not be understood by the facilitators of the OCRP. This model is realistic and can help resolve problems caused by cultural issues not addressed in current OCRP research.

## Model Application to Case Vignette

Utilizing the Cultural Broker model to Ms. Nguyễn ‘s case, the outcome would be different starting from the point after Ms. Nguyễn being court ordered to participate in the OCRP program. After obtaining consent from Ms. Nguyễn , the facilitator met with the interpreter prior to the initial session with Ms. Nguyễn.

During the meeting between facilitator and the interpterer, facilitator explained the OCRP process and the necessity for full translation of both the facilitator and also Ms. Nguyễn as it would help ensure that Ms. Nguyễn  is understanding the material. The facilitator agreed and stated that there may be lengthier translationsas English words pertaining to the United States legal process may not have direct Vietnamese translation. The interpreter stated that he would inform the facilitator that this is being done in session so that the facilitator is aware. The facilitator also asked the translator if there will be any problems with translating for someone who has a mental illness that is also legally encumbered. The facilitator stated that it is not a problem and that they have experience working in such setting.

In preparation for the initial meeting with Ms. Nguyễn , the facilitator noted that Ms. Nguyễn had difficult understanding the concept of mental illness and would often become agitated when the topic of mental health comes up as she does not like others to think that she is “crazy.” The interpreter suggested that it may be important to talk about mental health misconceptions with Ms. Nguyễn. The facilitator also noted that the process OCRP process is oftendifficult to understand and to ask for clarification when necessary. The interpreter request that more time is given to explain the process along with a handout to provide for Ms. Nguyễn.

Ms. Nguyễn attended her first session with the OCRP program. Prior to beginning the session, they explain the process of the program and its purpose. The facilitator provided Ms.

Nguyễn with a short pamphlet of the purpose and outline of the program in Vietnamese. When Ms. Nguyễn became agitated and stated that she is “not crazy, it’s all a mistake.” The facilitator explained mental health misconceptions and how the OCRP is designed to help her during the legal process as the topics covered are all areas that will affect her case. Ms. Nguyễn agreed to continue the program but requested the facilitator to slow down as there was a lot of information to process. Ms. Nguyễn scheduled for her next session with OCRP program.

After the session, the facilitator evaluated how the session went. He determined that when the topic of mental health came up in session, Ms. Nguyễn became agitated but was receptive to the information provided. Ms. Nguyễn also agreed to continuing the program and she also negotiated with the facilitator to slow down the materials during class as it was too fast. The Facilitator noted that the intervention of providing the pamphlet along with the negotiation proposed by Ms. Nguyễn to be successful. The perceived problem was resolved, the facilitator will continue to monitor the sessions for any problems that come up to assess for intervention from the Cultural Broker model.

Ms. Nguyễn completed the 23 week program and her legal case is eventually adjudicated. Ms Nguyễn is contacted by a different facilitator from the OCRP program via telephone for a voluntary informal interview concerning the OCRP process. Ms. Nguyễn is asked about the quality of the program and how/if it was easy for her to understand the sessions. Ms. Nguyễn is also asked if the program was easy for non-native-English speakers. She is asked what could have been done to help LEP individuals in the program

## Comparison and Contrast of the Two Approaches

### Initial Treatment

A comparison of the two approaches begins with Ms. Nguyễn being court ordered to attend the OCRP. The first comparison approach, as traditionally applied, adheres to the Florida CompKit (2009) as a manual for treatment, according to which the facilitator administers the outpatient competency restoration program's pre-test questions to evaluate Ms. Nguyễn's baseline for her competency and her understanding of the alleged crime of which she was accused.

Under the Cultural Broker Model, the facilitator initiates a meeting with the interpreter prior to meeting with Ms. Nguyễn. The facilitator addresses issues that may come up during Ms. Nguyễn's participation in the program. Applying the Cultural Broker model, the facilitator is attempting to build a collaborative relationship with the interpreter to establish expectations and educate the interpreter in issues that may result from imprecise translations during mental health services. The interpreter is questioned to ensure that he is comfortable working with legally encumbered individuals in a mental health setting. The facilitator emphasizes that it is important to destigmatize mental health issues and ask questions about cultural issues that might come up for non-native-English speakers like Ms. Nguyễn. Only after this is done does the program facilitator meet with both the interpreter and Ms. Nguyễn together.

### Stage 1

Utilizing the comparison approach, Ms. Nguyễn participated in the intake session by answering questions in short responses. The translations and the length of Ms. Nguyễn's responses do not match at times. When asked about Ms. Nguyễn's mental illness she just respond that she "is not crazy," she avoids eye contact, and her responses continue to be short. The

facilitator heavily relies on Ms. Nguyễn's interpreter in evaluating Ms. Nguyễn and classifies her as a level 3, meaning she has limited ability to participate.

In the Cultural Broker model, this point in the vignette would be considered Stage 1. The facilitator had met with the interpreter and brainstormed potential problems that might come up in Ms. Nguyễn's participation in the program. Issues that came up included possible differences between Ms. Ngyugen's culture and the OCRP itself as a cultural system. This was likely due to a breakdown in communication. Ms. Nguyễn does not fully appear to understand what the purpose of the program is and what the expectation the court has for her. In recognizing the problem and its cause, the facilitator can begin to look at possible interventions in helping Ms. Nguyễn.

**Stage 2**

In the comparison approach, Ms. Nguyễn would be treated as if she is a low functioning individual, due to her apparent inability to comprehend, and her information retention is evaluated as being limited. Sessions will be focused on rote memory, role and function of courtroom personnel, procedures. The facilitator will have to continue the sessions with limited ability to fully confirm that Ms. Nguyễn is understanding the concepts.

The Cultural Broker Model would identify this point in Ms. Nguyễn's story as Stage 2, at which the facilitator attempts to apply an intervention to minimize conflict and establish a link between Ms. Nguyễn and the program. Ms. Nguyễn is offered an extended amount of time so that her interpreter has time to translate the information to her, and she is provided handouts in Vietnamese for her to refer to during the lesson. Ms. Nguyễn receives more complete support from the program, ensuring that she can fully participate in it.

**Stage 3**

In the comparison approach, Ms. Nguyễn will be expected to continue to participate in the program. If she does not participate in the program, she might be court ordered to participate in the inpatient competency restoration program. This will likely prolong the process. She will likely not gain much from participating in these programs, other than avoiding further immediate issues with the judicial system.

The Cultural Broker model views this period in Ms. Nguyễn's vignette as Stage 3. This stage is where the facilitator would assess the outcome after identifying the cause of the problem and implementing the intervention of providing Ms. Nguyễn more time for translation and handouts in her primary language. If the problem had persisted, then it is likely that the cause of the problem was not correctly identified, and there would continue to be a breakdown in communication. The facilitator would go back to Stage 1 to evaluate for the cause of the problem again, so that he may implement an intervention more appropriate to Ms. Nguyễn's situation.

## Summary of Comparison

The two approaches varied significantly in their outcomes. The comparison approach, while simplistic, was akin to dismissing the client as being unable to participate and doing little to establish her true competency. It is noted that the facilitator had ignored Ms. Nguyễn's problems and continued to press through with the sessions. This approach is expected of an OCRP program that lacks interventions to assist LEP individuals in navigation of the process. The Cultural Broker model began before the initial meeting with Ms. Nguyễn, when the facilitator built a collaborative relationship with the interpreter, setting expectations for the sessions and educating about common problems that may occur. The facilitator and translator

working as a team were then able to identify the cultural and communication issues that led to a breakdown in communication.

Stage 1 was the turning point for assessing the problem and determining its cause using the Cultural Broker model, versus ignoring the problem completely by the comparison approach. The comparison approach was quick to label Ms. Nguyễn's behavior as problematic and that it would likely not change, while the Cultural Broker model attempted to find the cause of the problem and start developing interventions to help Ms. Nguyễn.

During Stage 2, the comparison approach continued with status quo treatment of Ms. Nguyễn. She was provided a watered-down version of the lesson to match what the facilitator believed she would be able to comprehend. The Cultural Broker model attempted interventions to aid Ms. Nguyễn build a connection with the program, in the hopes of furthering her participation.

In Stage 3, the expectation for Ms. Nguyễn in the comparison approach was that she would participate to the extent she appeared able, or she would risk violating her court order. In the latter outcome, her legal proceeding might be prolonged, or she might risk inpatient hospitalization to receive competency restoration services. The Cultural Broker model in this stage instead evaluated the effectiveness of the interventions. If they were not effective, the process would restart to identify and resolve issues, providing aid to Ms. Nguyễn systematically.

When comparing an actual intervention versus that of nothing, it is easy to see that doing nothing would likely accomplish nothing. Individuals in Ms. Nguyễn's situation are at risk of being overlooked in a complicated system that has no interventions in place for LEP individuals. The Cultural Broker model requires the facilitator to be a broker between the cultural system

experienced by Ms. Nguyễn as well as the system of the rehabilitation process to which OCRP belongs.

**Implementation of The Cultural Broker Model**

The implementation of the Cultural Broker Model in Hawaii's OCRP can be done in 4 phases. In implementing the model in phases, facilitators are adequately trained and given the opportunity to practice applying the method before implementing it in vivo. In the first phase of implementing the Cultural Broker model to Hawaii's OCRP, stakeholders need to be trained in the theoretical foundation, rational and purpose of the model. This can be done in in 4 training sessions were the first topic is an overview of the model, the next training would be the theoretical foundation and core assumptions of the approach, then the stages of the approach, finally the application of the approach in case vignettes. The session would roughly consist of 30-minute lectures with time at the end for opportunity for participants to ask questions and better understand the model.

The second phase of implementing the Cultural Broker model to Hawaii's OCRP would be training and having facilitator's implementing the Stage 1 of the Cultural Broker model. This stage is the assessment of problems and conflicts the OCRP participant might be experience. This can be one prior to each intake the facilitator receives. When receiving an intake, the facilitator would go through Stage 1, writing down the potential conflict and problems likely due to communication breakdown in the client notes. The training facilitator for the implementation of the model would be able to assess new facilitators' ability to apply Stage 1 of the model and provide feedback.

The third phase of implementing the Cultural Broker model to Hawaii's OCRP would require new facilitators to start implementing their intervention strategies after completing Stage

1 of the Cultural Broker model for their participants. The interventions provided by the new facilitators would have to be linked to their Stage 1 assessment of the participant's conflict or problems. This would be noted in client notes and feedback would be provided by the training facilitator. The training facilitator will help the new facilitators troubleshoot intervention strategies to help ensure that they will be effective in helping their participants.

The last phase of implementing the Cultural Broker model would be the full integration and applying the Cultural Broker model to Hawaii's OCRP. This phase would entail the facilitators initiating the meeting with interpreters setting expectations for interpretation services to meeting the participants. Facilitators would then also apply Stage 1 to evaluate potential conflicts and problems that participants are experiencing along with the cause of these problems. Facilitators will utilize their evaluation from Stage 1 to inform their creation of intervention in Stage 2. After applying Stage 2, facilitators will evaluate their intervention for effectiveness in Stage 3. For interventions that are successful, facilitators will continue running the sessions, for interventions that were no successful, they will need to return to Stage 1 to assess for conflict and problems affecting the participants.

The implementation of the Cultural Broker model can be done as the intervention method is systematic and has a pattern. It will be important to ensure that stakeholders are informed about the model and how it can positively affect participants. In ensuring that facilitators are set up for success, training facilitators will need to assess new facilitator progress and provide appropriate feedback.

**Ethical Considerations**

There are ethical concerns of the comparison approach, in that it does nothing to serve the unique needs of LEP clients. It would only label Ms. Nguyễn's behavior as problematic and

respond in an almost retaliatory way. This would not help minimize conflict between Ms. Nguyễn and the system. This would be an example of mental health disparity for LEP individuals such as that noted by Bauer, Chen and Alegría (2010). The system is doing a disservice to Ms. Nguyễn by having her sit through a program she is required to participate in but may not benefit from.

An ethical concern for the Cultural Broker model is that there are assumptions made about Ms. Nguyễn that did not involve bringing her into the conversation. The assumption for the cause of the problem was not based on her input. The facilitator is reliant on making judgements based on what he knew of her background, and upon input from the interpreter. This model is reliant on the interpreter also being culturally aware of problems Ms. Nguyễn might be facing, and relaying them to the facilitator. Such awareness may be lacking if this is a gender-specific problem, or generational problem of which the interpreter has no experience with or awareness of.

## Summary of Model and Research Answers

The proposed model of Cultural Broker for interpreting will help address an area of diversity in competency restoration programs, mainly Hawaii's OCRP. LEP individuals who are court-ordered to participate in OCRPs are at risk of not being provided with appropriate translation that would enable their success in the OCRP. Utilizing the Cultural Broker model, it is possible that LEP individuals are given an opportunity to communicate cultural and contextual information that could better their understanding of competency restoration topics. The model along with good interpreter practices will help ensure that the interpreter assigned to the individual will accurately translate what is being conveyed by the individual, but also that they are a good fit for the needs and background of the individual. The framework of the model

ensures that both the facilitator and interpreter have a discussion about conditions that may inhibit the success of the individual in the program. In addressing potential issues, the interpreter and facilitator are able to work toward interventions in Stage 2 of the model, and if the intervention appears unsuccessful, they can reevaluate until they reach a resolution in Stage 3.

The application of the model for Hawaii's OCRP program would be applicable for LEP individuals who are court ordered to participate in the OCRP. Individuals legally encumbered are provided with interpreters in the courtroom per the Hawaii Revised Statute §606-9. But it is the responsibility of the Department of Health to provide an interpreter for these individuals when participating in the OCRP. In accordance with good practices in working with interpreters, service providers such as the facilitator of the program should provide an interpreter who can consistently translate to and from the individual's preferred or primary language. The facilitator should meet with the interpreter first to educate them on the Cultural Broker model. The facilitator will also need to cover the topics of accuracy in interpreting, usage of technical language, confidentiality, stigma, interpreter attitude, interpreter continuity and unprofessional behavior.

These are all topics which are stressed in Miltec et al. (2006), Jezewski (2001) and Tribe and Morrisey (2004) research concerning good practices when working with an interpreter. The topics covered are to ensure that the interpreter adheres to Cultural Broker expectations and provide accurate translation for the legally encumbered individual. These individuals are court ordered to attend the OCRP program, and their competency will be evaluated post-completion of the program by the judiciary system, which is why it is important that the interpreter is accurately interpreting what is being communicated by the facilitator and by the individual when discussing the OCRP modules. The individual will also be introduced to technical language with

which they may be unfamiliar, so the interpreter needs to act as a cultural broker in translating cultural and contextual factors which would be relevant. The interpreter and the individual will need to be aware of the confidentiality factor of the program as non-LEP peers would not require an interpreter, and would therefore not have to worry about another party being privy to their legal and mental health information as it pertains to the OCRP. The interpreter will also need to be aware of potential stigma individuals have concerning mental health issues, as well as the dual stigma of being legally encumbered and accused of a crime. The interpreter's attitude will also be important to address, as their own biases and beliefs could present difficulties to the brokering process. If the interpreter has attitudes that would inhibit the brokering process or limit the individual's ability to communicate the problem, then the interpreter should be dismissed and a different interpreter should be requested. Continuity of interpreter will be very important in this process, as new interpreters would need to be educated by the facilitator about the Cultural Broker method and the topics expected of good interpreter practices in this setting. There should also be post-session review in which the facilitator meets with the interpreter to discuss and review issues that came up during the session that may have inhibit the brokering process.

The Cultural Broker model for interpreting is a framework which allows the conditions that may be roadblocks to brokering to be addressed after the initial session with the client. Starting at Stage 1, the perception or need for brokering should be evident, as are the conditions that may result in problems brokering, such as age, gender, cultural background, and disability. In addressing the need, the interpreter and facilitator will move to Stage 2, applying strategies and continuing to build rapport and connection with the individual in sessions, and working toward Stage 3, the resolution of building connection for the individual to the system through which they must navigate.

This model is important for all stakeholders. The program will benefit LEP individuals who are overlooked in the OCRP process. They are provided with an actual intervention and model that will ensure they are receiving a broker that will help them navigate the rehabilitation program system which is often confusing and difficult. The stakeholders who are running the OCRP program can benefit from implementing this model, because without it, there currently is not an intervention for how to assist LEP individuals in the OCRP process. The expectation and watering down of material is only feeding into the disparity between LEP individuals and mental health services. By testing and implementing this model, AMHD will be adhering to its guiding principle of identifying and providing best-practice mental health care to these individuals, and developing and providing best-practice forensic services to integrate with and collaborate with the courts, corrections system, and law enforcement agencies to reduce recidivism (AMHD, 2020).

**Answer to Research Questions:**

1. **Is Hawaii's OCRP inclusive of legally encumbered individuals with English language proficiency issues?**

Utilizing the comparison approach in the vignette, it is apparent that Hawaii's OCRP is not inclusive of legally encumbered individuals with language proficiency issues. The treatment of individuals like Ms. Nguyễn is equivalent to doing nothing, or just watering down the materials through rote memorization of the bare basics of competency restoration. This would not allow her to be an active participant her own legal proceedings. This an example of this approach is show on page 42.

2. **What are the needs of the legally encumbered individuals with LEP issues?**

The needs of LEP individuals are shown throughout the Cultural Broker model as a collaborative relationship between the facilitator, interpreter, and that of the individual. The facilitator needs to set clear expectations of interpreter services to minimize translation errors during interpretation. LEP individuals also require facilitators who can act as brokers for the individual's cultural system and that of the OCRP and broader rehabilitation system. To broker between the two systems, the facilitator must be educated about the rehabilitation system, but also needs to be culturally competent to understand and implement interventions in aiding LEP individuals in the OCRP process. This process is expanded in page 50 where the model is applied to Ms. Nguyễn's case vignette along with the model application of the case vignette on page 54.

3. **What revisions to the manuals used for the OCRP are needed for the culturally diverse population of Hawaii?**

Revisions to Hawaii's OCRP manual show a lack of interventions for LEP individuals. The classification of participants utilizes a mental health presentation classification. An

individual is classified into one of four levels, due to their presentation, such as disruptive behavior, intact knowledge, and reality orientation (Florida State Hospital, 2009). This disregards individuals who fail to comprehend the materials due to LEP. This issue is shown in the comparison and contrast of approaches on page 56.

4. **What would a model geared towards individuals with LEPs in mandatory OCRPs look like?**

Revisions for how to assist LEP individuals would be important. If possible, different language versions of the materials in the participant's native language should be provided. Implementation of the Cultural Broker model would also be a great step in ensuring an OCRP geared towards LEP individuals. The strength of the model is that it would help bridge the discrepancy in cultural intervention in Hawaii's OCRP or other states' OCRPs. The common language used for diversity needs or issues was typically 'customize according to the population of the program'. This Cultural Brokering model will incorporate the interpreter into the treatment of an LEP individual who was court ordered to the OCRP program. The feasibility of this is still unknown; it will require continuity in interpreter for the application to be successful.

The Cultural Broker model and application of good practices in interpreting will highlight an issue that may not have been addressed prior in using interpreter for the OCRPs, which is that of interpreter attitudes and unprofessional behavior. This model will help ensure that the interpreter will help translate not only what is being communicated, but also cultural and contextual information that would be relevant for the individual's successful understanding of the factual situation and application of OCRP materials. This is expanded on page 61.

5. **How might this model be evaluated for quality assurance?**

To evaluate this model for quality assurance, a course evaluation would be conducted at the end of the process. This would be done in an informal interview with a different facilitator or therapist asking the participant if they felt the OCRP program was easy for them to understand. They would also be asked if the program was easy for non-native-English speakers, and what had been done to also help LEP individuals in the program. This would be done through phone interview and would be voluntary to avoid the participant feeling pressured that they are required to present a positive response. An example of evaluating this model for quality is shown on page 55 of the model approach to the case vignette.

## Chapter 4: Discussion

The Outpatient Competency Restoration Programs offers services to adults charged with a crime adjudicated as not competent to stand trial but likely to regain competency. Program participants do not require the full structure, services, and security of an inpatient setting; services are provided in a community setting. The level of services provided is determined on a case-by-case basis. Unique to Hawaii, the OCRP not only addresses one's competency in factual knowledge and application of factual knowledge in legal proceedings; it goes beyond this to provide a basis of fitness restoration, as the Department of Health is based on a recovery model. Not only does the individual receive fitness restoration classes; the recovery aspects also address the individual's psychiatric, rehabilitation and housing needs.

There is a surprising lack of research concerning diversity, Limited English Proficiency individuals, and interpreter usage in the outpatient competency restoration programs. There also appears to be little research concerning these topics in the inpatient competency restoration programs. The proposed Cultural Broker model for interpreter services is an attempt to address that deficit in Hawaii's OCRP. This model will help maintain a patient-center focus, but ensure

that the conversation of cultural diversity along with LEP is address when working between the facilitator of the OCRP, the interpreter and the individual.

In ensuring that the individual is set up for success when participating the in OCRP, good practicing in interpreter services is also required. The factors which also need to be address in ensuring the Cultural Broker model is effective requires accuracy in interpreting, usage of technical language, confidentiality, stigma, interpreter attitude, interpreter continuity and unprofessional behavior. The facilitator is tasked with educating both the interpreter along with the individual. The framework of the Cultural Broker model is one which is conflict-resolution and problem solving focused. Brokers have a systematic approach assess and implement interventions to minimize and resolve conflict. After the implementation of the interventions, the broker assess whether the conflict was reached a resolution or whether it will be necessary to return to stage one and reassess the problem's causes and potential interventions (Jezewski & Sotnik, 2001). Ultimately, while the influence of culture and LEP is focused, the framework ensures that the individual connected to the rehabilitation problem and encourages continued participation in the program through these connections.

In terms of ethical considerations when applying this model, it is important to understand that it was created by Jezewski (1995) as a way to help rehabilitation program providers and brokers help individuals navigate the often-complicated rehabilitation system. This model requires that the broker is educated in the rehabilitation system such as the OCRP, but also requires the broker to educate themselves in the cultural factors that might deter an individual from engaging with the program. This model strives to resolve conflicts in communication but also fosters a sense of empowerment in the individual through establishing a connection to the rehabilitation system. The broker's being knowledgeable of the rehabilitation system is

important, but they must continue to educate themselves in the system the individual operates in. Being culturally competent and aware of the cultural system the individual or receiver of services the individual is part of requires being aware of biases and stereotypes that may not be easy for everyone.

The model itself warns about the potential risk factors such as stereotyping consumers and avoiding confronting our beliefs and challenging our knowledge about an individual's culture. Another ethical consideration is that there is a nearly nonexistent amount of research on how programs like OCRP are addressing cultural factors that may inhibit or impede an individual's success in the programs. All the programs in the different state need to customize for their own individual population. What may be helpful for the population of Hawaii may not be as successful for those in Texas or Washington. This model attempts to bring the issue of culture and LEP into light and offer a model and intervention when there is not one.

In applying the model, interventions such as networking along with advocating may not be applicable in this setting. These interventions may be more important for the individual's social worker as that is what they are assigned to help the individual within the trial process. This model also requires the consent of the individual in continuing to work with the interpreter assigned to their case. The expectation that there will be one interpreter who will be able to stay in the case may not be possible and the process would need to begin again with establishing expectations and working alliance all over again.

This model requires continuing education from the mental health facilitator. They need to be able to identify and understand the problems from the context of the individual. With the help of the interpreter who may or may not be fully aware of the culture they are translating for, the

onus is on the facilitator to seek consultation along with research the cultural context which may impact the individual.

## Clinical Implications

An important clinical implication of this study is that it can potentially act as a catalyst for positive change in Hawaii's OCRP in better serving individuals with mental health illness, are legally encumbered and are LEP individuals. The State of Hawaii's Adult Mental Health Division's mission statement is:

"The Adult Mental Health Division provides integrated mental health services for consumers with serious mental illness who are uninsured or underinsured, those who are court ordered for evaluation, care and custody to the Department of Health and individuals in crisis (Adult Mental Health Division, 2020, Mission Statement)."

This mission statement is guided by principles such as supporting the use of intervention strategies to reduce involvement of individuals with mental illness in the criminal justice system, identifying and providing best practice mental health care of these individuals, and developing and providing best-practice forensic services to integrate with and collaborate with the courts, corrections system, and law enforcement agencies to reduce recidivism. This proposed model is in line with the Hawaii State Department of Health's Mental Health Division's mission statement and guiding principles.

## Limitations

A limitation of this study is that individuals who have gone through the panel evaluation process and been given the legal status of Unfit to Proceed and Released on Conditions (406(1)) are addressed, while individuals who are were found unfit and committed to inpatient treatment

would likely differ in the level of intervention and what their needs are. For example, individuals who suffer from severe persistent mental illnesses that require intensive care and are not released to the community. This proposed model of intervention would likely apply more to individuals who have reached a level of psychiatric stability along with have a good enough level of insight to be able to convey their contextual and cultural needs. The emphasis of the model is that continuity of interpreter is also very important. While this is preferred it may not always be feasible. The OCRP program consist of 23 lessons and would require an interpreter who not only needs to be willing to work without someone in the forensic psychology setting but able to commit to these lessons. Continuity of interpreter is important in ensuring rapport is established and built throughout the different stages, while it is possible to bring a new interpreter into the framework, individuals need to be able to build rapport and have a working relationship that would ensure that they are able to relaying personal and sensitive information.

**Recommendations for Future Study.**

The recommendation for future study is the application and trial of this program in vivo. This will require collaboration between a steady interpreter service agency and the facilitator of the OCRP in Hawaii or Oahu. Further study concerning the diversity needs of the OCRP program may be helpful in highlighting what areas are not quite addressed in regard to research. The focus on LEP individuals would require data collection of what type of individuals typically participate in OCRP. The area of diversity and OCRP is extremely limited. In first acknowledging that there is a gap in the research, it may help open the conversation for individuals who may not be receiving the types of interventions they need to be successful in OCRPs.

## Conclusion

The United States Supreme Court case of Dusky v. United States, 362, U.S. 402 (1960) was the catalysis for competency restoration programs. Outpatient Competency Restoration programs (OCRP) started initially started to ensure that psychiatrically stable legally encumbered individuals with mental illness were provided with an opportunity to learn about the trial process and how to actively participate in their own defense. These programs are important as individuals can receive the treatment; they need in the appropriate setting versus being hospitalized when it may not be fully appropriate.

Not all states with the U.S offer OCRP programs. Hawaii is 1 of 16 states that offer such program even though about 35 states have it written into their state laws for these programs to exist. Each state differ in regard to what state agency are responsible for the program, in Hawaii it is the Department of Health's Adult Mental Health Division (DOH-AMHD). In accordance to the mission statement of AMHD, this study is attempting to help in supporting "the use of intervention strategies to reduce involvement of individuals with mental illness in the criminal justice system, identifying and providing best practice mental health care of these individuals, and developing and providing best-practice forensic services."

Culture includes language, behavior, beliefs, traditions and other modes of expression (Zarcadoolas et al. 2006). But there is a lack of research regarding how OCRPs are addressing culture in their programs. This study focuses on limited english proficiency (LEP) individuals and proposes an intervention that helps address the discrepency in cultural intervention.

The proposed intervention is the Cultural Broker model of interpretation. This mode ensures the topic of culture and language to be addressed between OCRP facilitator, interpreter and individual. The legally encumbered individuals are given a voice and ability to have cultural

and contextual issues translated in the OCRP lessons so that prevelent issues such as limited services, treatment errors such under or over-estimating psychological issues and limited and distorted understanding of client. This proposed model would require the facilitator to coordinate and also educate the interpreter assigned, but it is an extra step which would ensure good interpreter practice. The aspiration of this research is that it helps promote the discussion in how to better serve the diverse clients who are participating in OCRP.

References

Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The Recent Past and Near Future of Risk and/or Need Assessment. *Crime & Delinquency, 52*(1), 7-27.

Adult Mental Health Division (2017) Provider Manual. https://health.hawaii.gov/amhd/

Adult Mental Health Division (2020) Mission, Vision, Guiding Principles. Retrieved fromhttps://health.hawaii.gov/amhd/home/mission/

Bauer, A. M., Chen, C. N., & Alegría, M. (2010). English language proficiency and mental health service use among Latino and Asian Americans with mental disorders. *Medical care*, *48*(12), 1097.

Bauer, A. M., & Alegría, M. (2010). Impact of patient language proficiency and interpreter service use on the quality of psychiatric care: a systematic review. *Psychiatric Services*, *61*(8), 765-773.

Bonnie, R. J., & Grisso, T. (2000). Adjudicative competence and youthful offenders. In T. Grisso & R. G.Schwartz (Eds.), *Youth on trial: A developmental perspective on juvenile justice. Chicago University of Chicago Press*.

Burt, C. & Simons, R. (2013). Self-Control, Thrill Seeking, and Crime Motivation Matters. *Criminal Justice and Behavior*, *40*, 1326-1348

Campbell, M. A., Canales, D. D., Wei, R., Totten, A. E., Macaulay, W. A. C., & Wershler, J. L. (2015). Multidimensional evaluation of a mental health court: Adherence to the risk-need-responsivity model. *Law and Human Behavior, 39*(5), 489-502.

Castillo, E. G., Ijadi-Maghsoodi, R., Shadravan, S., Moore, E., Mensah, M. O., 3rd, Docherty, M., … Wells, K. B. (2019). Community Interventions to Promote Mental Health and Social Equity. *Current Psychiatry Reports*, *21*(5), 35. doi:10.1007/s11920-019-1017-0

Center for International Rehabilitation Research Information and Exchange. (2001). Culture Brokering: Providing Culturally Competent Rehabilitation Services to Foreign–Born Persons. Retrieved May 17, 2020, from http://cirrie-sphhp.webapps.buffalo.edu/culture/monographs/cb.php

Colorado Department of Human Services. (2015). Needs Analysis: Current Status, Strategic Positioning, and Future Planning. Falls Church, VA*: National Association of State Mental Health Program Directors Research Institute.*

Connecticut Department of Mental Health & Addiction Services (2019). ct.gov/dmhas

Dyck, H. L., Campbell, M. A., & Wershler, J. L. (2018). Real-world use of the risk–need–responsivity model and the level of service/case management inventory with community-supervised offenders. *Law and Human Behavior, 42*(3), 258–268. https://doi-org.ezproxy.chaminade.edu/10.1037/lhb0000279

eCourt Kōkua (2019) retreived from jimspss1.courts.state.hi.us

Federal Berau of Investigation (2017) *Uniform Crime Reporting Program*. Retrieved from crime-data-explorer.fr.cloud.gov

Florida State Hospital (2009) Florida CompKit, Judicial Competency Training Resources.

Georgia Department of Behavioral Health and Developmental Disabilities (2019). bhdd.georgia.go

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), 293-305.

Criminal Procedure Law (CPL) §730.40(1) and CPL §730.50(1) Temporary Orders and CPL 730.50 Commitment Orders.

Hawaii Department of Business, Economic Development and Tourism (2016) retrieved from http://dbedt.hawaii.gov/economic/reports_studies/non-english-speaking-population-in-hawaii/

Hawaii State Hospital (2018) retrieved from https://health.hawaii.gov/amhd/hawaii-state-hospital-about-us/documents/

Hawaii Code Division 4. Courts and Judicial Proceedings Title 32. Courts and Court Officers.606. Clerks, Reporters, Interpreters, Etc.§§606-9 to 11 REPEALED

Hawaii Penal Code -Penal Responsibility and Fitness to Proceed, HRS § 704-406, Chapter 0701-0853, HI, 2011

Hawaii Penal Code -Penal Responsibility and Fitness to Proceed, HRS § 704-406(1), Chapter 704, HI, 2011

Heard, C. (2014). Outpatient Competency Restoration Programs: An Overview. Austin, TX: *Mental Health & Substance Abuse Division.*

Hubbard, K., Zapf, P., & Ronan, K. (2003). Competency Restoration: An Examination of the Differences between Defendants Predicted Restorable and Not Restorable to

Competency. *Law and Human Behavior, 27*(2), 127-139. Retrieved from http://www.jstor.org/stable/1394370

Jezewski, M. A. (1995). Evolution of a grounded theory: Conflict resolution through culture brokering. *Advances in Nursing Science*.

Jezewski, M. A., & Sotnik, P. (2001). *Culture brokering: Providing culturally competent rehabilitation services to foreign-born persons*. Buffalo, NY: Center for International Rehabilitation Research Information and Exchange.

Johnson, N. R., & Candilis, P. J. (2015). Outpatient competence restoration: A model and outcomes. *World Journal of Psychiatry*, *5*(2), 228–233. doi:10.5498/wjp.v5.i2.228

Kwan, P. P., Soniega-Sherwood, J., Esmundo, S., Watts, J., Pike, J., Sabado-Liwag, M., & Palmer, P. H. (2019). Access and utilization of mental health services among Pacific Islanders. *Asian American Journal of Psychology.* https://doi-org.ezproxy.chaminade.edu/10.1037/aap0000172

Lamb, H. (2017). Treat or Repeat A State Survey of Serious Mental Illness, Major Crimes and Community Treatment. *Treatment Advocacy Center.*

Lousiana Department of Health (2019). http://ldh.la.gov

Lowenkamp, C. T., Latessa, E. J., & Holsinger, A. M. (2006). The Risk Principle in Action: What Have We Learned From 13,676 Offenders and 97 Correctional Programs? *Crime & Delinquency, 52*(1), 77–93. https://doi.org/10.1177/0011128705281747

Lowenkamp, C. T., Latessa, E. J., & Holsinger, A. M. (2006). The risk principle in action: What have we learned from 13,676 offenders and 97 correctional programs?. *Crime & Delinquency*, *52*(1), 77-93.

Masters, E. (2003). Counseling Criminal Justice Offenders.Thousand Oaks: *SAGE publications*.

Miletic, T., Piu, M., Minas, H., Stankovska, M., Stolk, Y., & Klimidis, S. (2006). *Guidelines for working effectively with interpreters in mental health settings*. Victoria, Australia: Victorian Transcultural Psychiatry Unit.

Miami-Dade Forensic Alternative Center Pilot Program Status Report. (2016). Retrieved from: https://www.neomed.edu/wp-content/uploads/CJCCOE_11_FACStatus.pdf

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. https://doi-org.ezproxy.chaminade.edu/10.1002/bsl.546

Minnesota Department of Health (2019). health.state.mn.us

Mossman, D., Noffsinger, S. G., Ash, P., Frierson, R. L., Gerbasi, J., Hackett, M., ... & Wall, B. W. (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.

Morris, D. R., & DeYoung, N. J. (2012). Psycholegal Abilities and Restoration of Competence to Stand Trial. *Behavioral Sciences & the Law*, *30*(6), 710–728. https://doi-org.ezproxy.chaminade.edu/10.1002/bsl.2040

New York State Office of Mental Health(OMH) Division of Forensic Services (2019). omh.ny.gov

Prendergast, M. L., Pearson, F. S., Podus, D., Hamilton, Z. K., & Greenwell, L. (2013). The Andrews' Principles of Risk, Need, and Responsivity as Applied in Drug Abuse Treatment Programs: Meta-Analysis of Crime and Drug Use Outcomes. *Journal of Experimental Criminology*, *9*(3), 275–300. doi:10.1007/s11292-013-9178-z

Pretrial Services Agency for the District of Columbia (2019). psa.gov/

Prins, S. J., Skeem, J. L., Mauro, C., & Link, B. G. (2015). Criminogenic factors, psychotic symptoms, and incident arrests among people with serious mental illnesses under intensive outpatient treatment. *Law and Human Behavior*, *39*(2), 177-188.

Ramos-González, N. N., Weiss, R. A., Schweizer, J., & Rosinski, A. (2016). Fitness to stand trial evaluations in immigration proceedings. Canadian Psychology/Psychologie Canadienne, 57(4), 284–290. https://doi-org.ezproxy.chaminade.edu/10.1037/cap0000070

Romani, C. J., Morgan, R. D., Gross, N. R., & McDonald, B. R. (2012). Treating criminal behavior: Is the bang worth the buck? *Psychology, Public Policy, and Law, 18*(1), 144-165.

Searight, H. R., & Searight, B. K. (2009). Working with foreign language interpreters: Recommendations for psychological practice. *Professional Psychology: Research and Practice, 40*(5), 444–451. https://doi-org.ezproxy.chaminade.edu/10.1037/a0016788

Simpson, J. (2019) Principles of Community-based Behavioral Health Services for Legally encumbered Individuals: A Research-Based Guide. Substance Abuse Mental Health Services administration. Rockville, MD.

Sinha S. (2016). Personality correlates of criminals: A comparative study between normal controls and criminals. *Industrial Psychiatry Journal, 25*(1), 41–46. doi:10.4103/0972-6748.196058

Snowden, L. R., Masland, M., & Guerrero, R. (2007). Federal civil rights policy and mental health treatment access for persons with limited English proficiency. *American Psychologist, 62*(2), 109–117. https://doi-org.ezproxy.chaminade.edu/10.1037/0003-066X.62.2.109

Tennessee Department of Mental Health and Substance Abuse (2017) Mandatory Outpatient Treatment (MOT) Annual Report

Treatment Advocacy Center (2017) Treat or Repeat: A State Survey of Serious Mental Illness, Major Crimes and Community Treatment. treatmentadvocacycenter.org

Tribe, R., & Lane, P. (2009). Working with interpreters across language and culture in mental health. *Journal of Mental Health*, *18*(3), 233-241.

Texas Department of State and Health Services (2019). dshs.texas.gov

U.S. Department of Health and Human Services. (2001). Race, culture, ethnicity and mental health: A supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Department of Justice. (2002, July 8). A Message to Recipients from Ralph F. Boyd, Jr. Assistant Attorney for Civil Rights, United States Department of Justice. July 8, 2002. Washington, DC: Office of the Assistant Attorney General, Civil Rights Division.(Available at http:// www.usdoj.gov/crt/cor/Pubs/BoydLEPArt.htm)

Vila, Bryan. 1994. A General paradigm for understanding criminal behavior: Extending evolutionary ecological theory. *Criminology*, *32*(3): 311–360.

Virginia's Department of Health of Behavioral Health and Developmental Services (HBHD), Forensic Services (2018) Adult Outpatient Competency Restoration Manual for Community Services Boards & Behavioral Health Authorities. dbhds.virginia.gov

Warren, J. I., Chauhan, P., Kois, L., Dibble, A., & Knighton, J. (2013). Factors influencing 2,260 opinions of defendants' restorability to adjudicative competency. *Psychology, Public Policy, and Law*, *19*(4), 498-508. http://dx.doi.org/10.1037/a0034740

Walczyk, J. J., Sewell, N., & DiBenedetto, M. B. (2018). A Review of Approaches to Detecting Malingering in Forensic Contexts and Promising Cognitive Load-Inducing Lie Detection Techniques. *Frontiers in Psychiatry*, *9*, 700. doi:10.3389/fpsyt.2018.00700

Wall, B.& Krupp, B. & Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *The journal of the American Academy of Psychiatry and the Law. 31*. 189-201.

Wik, W.(2018) Alternatives to Inpatient Competency Restoration Programs: Jail-Based Competency Restoration Programs. Falls Church, VA: *NRI Analytics Improving Mental Health.*

Wisconsin Department of Health Services (2019) dhs.wisconsin.gov

Wong, A. (2011). A Matter of Competence: Lawyers, Courts, and Failing to Translate Linguistic and Cultural Differences. *S. Cal. Rev. L. & Soc. Just.*, *21*, 431.

Zarcadoolas, C., Pleasant, A. F., & Greer, D. S. (2006). Advancing health literacy: A framework for understanding and action. San Francisco, CA: Jossey-Bass.

# Appendices

IRB Certification Letter

**7. Outcome of Determination (to be completed by the IRB Chair only)**

*If 5A and 5B are checked and at least one of 5 C-F is checked then the project DOES CONSTITUTE Human Subjects Research.*

*If J (b) is checked then the project DOES CONSTITUTE Human Subjects Research.*

*If G, H or I, K (including all subcomponents of I) or J (a) are checked then your activity is in a category that the IRB has determined DOES NOT represent human subject research and no further submission of Form II or III is required. However, it is recommended you document this determination by placing a copy of this completed application in your files to address any future queries about the project. This form may still be submitted for an official determination by the IRB if required by the sponsor.*

*IRB Chair Certification:*

*Based on the information provided this proposal:*

*DOES* ☐ *constitute Human Subjects Research and the investigator should submit Form II or III for further review of the protocol. Research cannot start until Form II or III is approved by the IRB.*

*DOES NOT* ☒ *constitute Human Subjects Research and the IRB will not review it further. However, if changes to the proposed research plan occur that makes the protocol IRB-reviewable, the investigator is required to complete a new Form I and Forms II or III as required.*

*Signed,*

04/04/2020

*IRB Chairperson* *Date*

[

Tables

**Table 1: Treatment Advocacy Center's report patterns concerning treatment of individuals with mental Illness.**

| Total inmate population 2005 | Estimated population of SMI inmates | Total psychiatric inpatient population 2004 | Likelihood of incarceration vs. hospitalization |
|---|---|---|---|
| 5,705 | 913 | 311 | 2.9 to 1 |

Reprinted from Treatment Advocacy Center's report patterns concerning treatment of individuals with mental Illness (MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A Survey of the States, Treatment Advocacy Center, 2010) Copyright (2010) by Treatment Advocacy Center. Reprinted with permission.

**Table 2: Grading of States on Efforts to create a system to decrease re-arrest by individuals with serious mental illness who have committed major crimes.**

| | | | |
|---|---|---|---|
| **A** | State is making an excellent effort and has most components of a model program. | **A** | No state received an A grade. |
| **B** | State is making a commendable effort and has many components of a model program. | **B+** | Hawaii, Maine, Missouri, Oregon |
| | | **B** | California, Connecticut, Louisiana, Ohio, Tennessee, Washington, Wisconsin |
| | | **B–** | Colorado, Georgia, Minnesota, New York, Virginia |
| **C** | State is making a modest effort and has some components of a model program. | **C+** | Michigan, Oklahoma |
| | | **C** | Arizona, Arkansas, Illinois, Kentucky, Maryland, South Carolina |
| | | **C–** | Nevada, New Hampshire, Rhode Island, Utah, West Virginia |
| **D** | State is making a small effort and has few components of a model program. | **D+** | Delaware, Kansas, North Dakota |
| | | **D** | Alabama, Florida, Nebraska, New Jersey, Pennsylvania, South Dakota, Vermont |
| | | **D–** | Iowa, Montana, North Carolina |
| **F** | State is making almost no effort. | **F** | Alaska, Idaho, Indiana, Massachusetts, Mississippi, New Mexico, Texas, Wyoming |

**Note:** The grade refers specifically to the state's forensic services and corrections programs for individuals with serious mental illness. Other aspects of the state's mental health services program may be rated higher or lower than this grade.

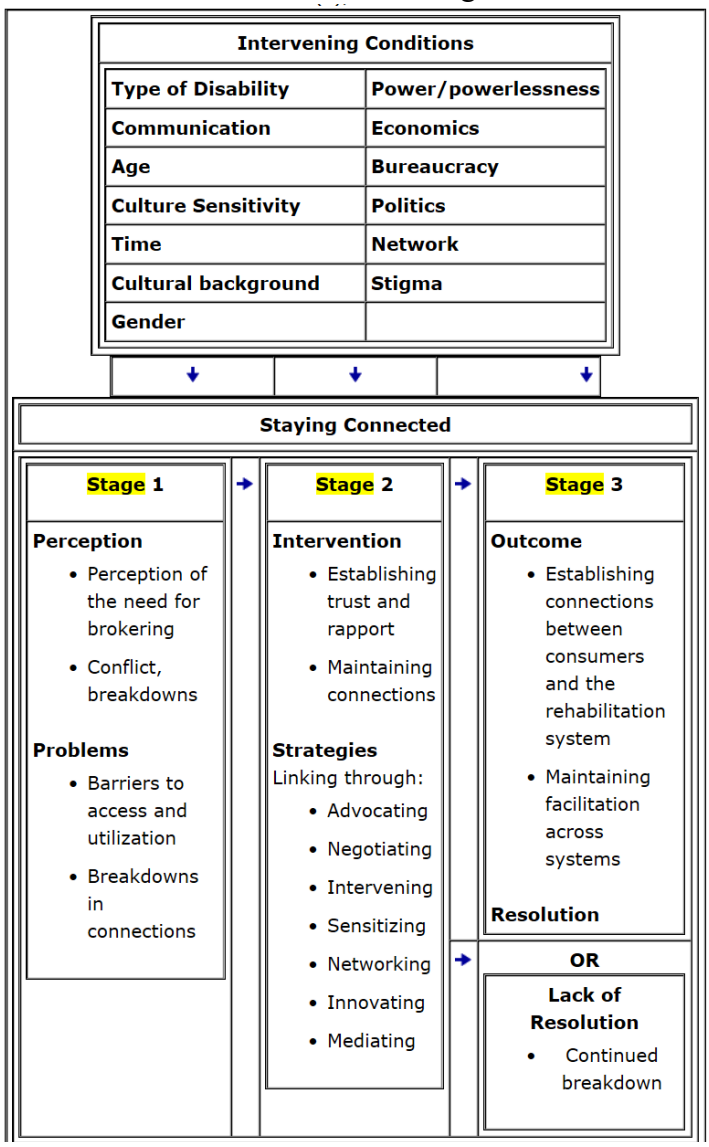
*Reprinted from Grading of States on Efforts to create a system to decrease re-arrest by individuals with serious mental illness who have committed major crimes (Treatment Advocacy Center, 2017).Copyright (2017) by Treatment Advocacy Center. Reprinted with permission.*

**Table 3:Tennessee Department of Mental Health and Substance Abuse Treatment, Mandatory Outpatient Services.**

| T.C.A. § 33-6-602 | T.C.A. § 33-7-303(b) | T.C.A. § 33-7-303(g) |
|---|---|---|
| Starts in the hospital for those committed under Title 33, Chapter 6, Part 5 | Starts in the community for NGRI acquittees after evaluation under T.C.A. § 33-7-303(a) | Is required for service recipients found not guilty by reason of insanity of murder or a class A felony under Title 39, Chapter 13 whether released after evaluation under 33-7-303(a) or after commitment under 33-7-303(c). |
| Expires six months after release or previous renewal unless renewed | Does not expire | Need for continued treatment reviewed by court after an initial six month mandatory period, thereafter the court reviews annually |
| Can be modified or terminated by provider | Can only be terminated by the court | Can only be terminated by the court |
| A court finding of non-compliance can result in re-hospitalization | Does not allow for hospitalization, may result in civil or criminal contempt | Allows for hospitalization for those judicially committed, or may result in civil or criminal contempt |

*Reprinted from Tennessee Department of Mental Health and Substance Abuse Treatment, Mandatory Outpatient Services. (Tennessee Department of Mental Health and Substance Abuse Treatment, 2019). Copyright (2019) Treatment Advocacy Center. Reprinted with permission.*

**Table 4:** Cultural Brokering Model




*Reprinted from Culture Brokering: Providing Culturally Competent Rehabilitation Services to Foreign–Born Persons (Jezewsk and Sotnik, 2001).Copyright (2001) by the Center for International Rehabilitation Research Information and Exchange (CIRRIE)Reprinted with permission.*

# Legal Competency and Language Proficiency V18

Final Audit Report 2020-06-20

| | |
|---|---|
| Created: | 2020-06-20 |
| By: | Lianne Philhower (lphilhower.psyd@gmail.com) |
| Status: | Signed |
| Transaction ID: | CBJCHBCAABAAhyC8Fzb3u1NzhggUS7Fyo9YoXZl_U-cX |

## "Legal Competency and Language Proficiency V18" History

Document created by Lianne Philhower (lphilhower.psyd@gmail.com)
2020-06-20 - 3:06:32 AM GMT- IP address: 66.91.252.108

Document e-signed by Lianne Philhower (lphilhower.psyd@gmail.com)
Signature Date: 2020-06-20 - 3:08:59 AM GMT - Time Source: server- IP address: 66.91.252.108

Document emailed to SEan W. Scanlan, Ph.D. (sean.scanlan@chaminade.edu) for signature
2020-06-20 - 3:09:01 AM GMT

Email viewed by SEan W. Scanlan, Ph.D. (sean.scanlan@chaminade.edu)
2020-06-20 - 8:05:22 AM GMT- IP address: 66.249.84.160

Document e-signed by SEan W. Scanlan, Ph.D. (sean.scanlan@chaminade.edu)
Signature Date: 2020-06-20 - 9:29:36 PM GMT - Time Source: server- IP address: 65.174.252.8

Document emailed to Ricky Trammel, PhD (ricky.trammel@chaminade.edu) for signature
2020-06-20 - 9:29:39 PM GMT

Email viewed by Ricky Trammel, PhD (ricky.trammel@chaminade.edu)
2020-06-20 - 9:29:44 PM GMT- IP address: 66.249.84.189

Document e-signed by Ricky Trammel, PhD (ricky.trammel@chaminade.edu)
Signature Date: 2020-06-20 - 9:40:58 PM GMT - Time Source: server- IP address: 66.8.166.169

Signed document emailed to Lianne Philhower (lphilhower.psyd@gmail.com), SEan W. Scanlan, Ph.D. (sean.scanlan@chaminade.edu) and Ricky Trammel, PhD (ricky.trammel@chaminade.edu)
2020-06-20 - 9:40:58 PM GMT