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# The Effects Of Race, Ethnicity, And Language On Competency To Stand Trial Evaluations

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# THE EFFECTS OF RACE, ETHNICITY, AND LANGUAGE ON COMPETENCY TO STAND TRIAL EVALUATIONS

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## ABSTRACT

Forensic evaluators receive training on multicultural assessment and most forensic assessment textbooks include guidelines addressing multicultural issues, but there is little research examining how race/ethnicity and linguistic differences may impact competency to stand trial evaluations. There is a need for research to better understand the needs of Hispanic individuals who are among the fastest growing populations in the United States. Prior studies suggest that clinicians may diagnose African American defendants and Hispanic individuals with a more severe diagnosis when compared to Caucasian individuals. When defendants communicate in their secondary language or require the use of an interpreter it may impact their clinical presentation, how examiners perceive impairment, and how defendants communicate with examiners during an evaluation. Using a sample from a competency restoration program, this study found that defendants who are foreign-born, are non-English speakers, or required the use of an interpreter were more likely to be found incompetent when compared to native-born and English-speaking defendants. However, there was no difference in competency decisions based on race/ethnicity. The issue of language presents several challenges to examiners when working in the legal arena. They are often faced with lacking culturally and linguistically equivalent forensic assessment instruments and may have limited training and guidance in assessing linguistically diverse populations. There is a need for more research exploring factors influencing competency evaluations with non-English speakers and defendants with immigration histories.

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# CHAPTER 1

## INTRODUCTION

A defendant must be competent to stand trial (CST) in order to protect their rights to have a fair trial and due process in legal proceedings (*Dusky vs. United States,* 1960*)*. *Drope v. Missouri* (1975) defines incompetency as "a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial." A defendant must have the rational and factual capacity to understand the legal proceedings and have the ability to consult with their attorney in a rational manner. If an attorney or the court suspects that a defendant's abilities are impaired, they will order a psychological evaluation to assess competency abilities. Bonnie and Grisso (2000) estimated that about 60,000 CST evaluations are conducted every year across the United States, making it one of the most frequent psychological evaluations requested in the legal system. According to Pirelli, Gottdiener, & Zapf (2011), about 20% of cases referred for competency evaluations result in a finding of incompetency.

When considering CST assessments, it is important to consider what factors contribute to a finding of incompetency. In a recent meta-analysis, Pirelli et al. (2011) found that defendants who are diagnosed with a psychotic disorder are eight times more likely to be found incompetent as compared to individuals who are not diagnosed with a psychotic disorder. They also found that defendants with a history of psychiatric hospitalizations are twice as likely to be found

incompetent when compared to individuals without a history of hospitalization. Neither of these findings is surprising given that each are associated with severity of mental illness. However, the authors also found that non-white defendants are one and a half times more likely to be found incompetent to stand trial when compared to white defendants. It is not clear why race is associated with competency findings.

CST evaluations often involve individuals of diverse racial and ethnic backgrounds. People of color make up about 30% of the U.S. population, but they represent about 60% of incarcerated individuals (Bureau of Justice Statistics, 2014). Non-Hispanic African Americans represent the biggest portion of male inmates representing about 37% of the prison population, followed by 22% of non-Hispanic whites, and 22% Hispanics. Non-Hispanic white females represent about 49% of the incarcerated populations followed by 22% of non-Hispanic African American females. Overall, African American individuals are incarcerated at about 5.8 times the rate (2,207 out of 100,000) of non-Hispanic whites (380 out of 100,000), and Hispanics were incarcerated at 2.5 times the rate (966 out of 100,000) of non-Hispanic whites (Prison Policy Initiative, 2012). The increase of the Hispanic population and over-representation of minorities in our incarcerated populations continues to increase the demands for culturally sensitive services in the legal system.

Overall, little research has explored the impact of race and ethnicity on the presentation of clinical symptoms, self-report, and diagnostic decisions that may be associated with competency determinations. Some studies have found that non-white males are more likely to be diagnosed with a psychotic disorder, tend to deny symptoms, and are hospitalized involuntarily more often when compared to white males (Hubbard & Zapf, 2003; Nicholson & Kugler, 1991; Pirelli et al., 2011). African American and Hispanic individuals tend to endorse more psychotic

symptoms when compared to whites (Hicks, 2004). Hicks also found that Hispanics are more likely to complain about somatic symptoms when experiencing psychological distress, which may result in clinicians attributing psychiatric symptoms to other medical conditions. Consequently, African American individuals are more likely to be diagnosed with a thought disorder and white individuals are more likely to be diagnosed with a mood or substance-related disorder, which may impact differences in competency findings (Caldwell, Mandracchia, Ross, & Silver, 2003). Stefan (1996) argues that the overrepresentation of minorities in psychiatric institutions may reflect differences in determinations of incompetence. However, Caldwell et al. (2003) noted differences between groups that are consistent with the distribution of psychiatric disorders in the general population.

There is also a need to better understand how language differences among Hispanic defendants might impact CST evaluations. Hispanics are among the fastest growing population segments in the United States. It is estimated that about 17.3% (55 million) of individuals residing in the United States identify as Latino or Hispanic (U.S. Census Bureau, 2015). Linguistically, three out of four Hispanics living in the United States who are age five and older speak Spanish. About 32% (15.7 million Hispanics) of Spanish-speakers living in the United States struggle with the English language and rate themselves as not speaking English "very well" (12.5 million) or do not speak English at all (3.2 million) (Pew Research, 2015). There is an ever-growing demand for assessment and clinical services that meet the demands of Spanish-speaking individuals in the U.S.

Linguistic differences may impact how clinicians perceive the clinical presentation of symptoms, but there is little research exploring the effects of language on competency determinations. In a study assessing symptom severity ratings with bilingual Hispanics as a

function of language and clinician ethnicity, Malgady and Costantino (1998) found that when bilingual patients (e.g. English and Spanish) were interviewed by bilingual clinicians, clinicians rated patients as having more severe symptoms when compared to the English-only interviews. There are several potential explanations for these findings, including that the use of a different language may have improved the communication of symptoms with clinicians or bilingual clinicians may have been more sensitive to linguistic differences since they are able to communicate in the patient's first language and better appreciate the subtle cues of verbal and non-verbal language. It is also possible that the race/ethnicity of clinicians may elicit a different response from patients. In another study exploring the influence of language, Varela, Boccaccini, Gonzalez, Gharagozloo, and Johnson (2011), found that when criminal defense attorneys were presented with a hypothetical client vignette, they rated Spanish-speaking defendants as less mentally ill and were less likely to make a referral for a competency evaluation when compared to English-speaking clients. Attorneys were more likely to under-pathologize symptom presentation of individuals who spoke another language when compared to English-speaking individuals. Even though this study focused on attorneys, it sheds some light on the possible biases and barriers in communication that are elicited by linguistic and ethnic differences when assessing mental health and competency issues. For example, examiners may not be able to get a complete diagnostic picture when individuals speak another language. Psychological impairment may be less discernible when individuals are not able to express themselves in their own language and/or when using an interpreter, and their communications may lose some of the meaning and linguistic cues in the process. These subtle differences in expression of symptoms and diagnostic differences may contribute to inconsistencies in competency opinions. There are guidelines available for forensic evaluators to consider

multicultural factors, but there is a lack of research exploring the relationship between language and competency to stand trial evaluations (Benuto, 2015; Drogin, 2011; Susuki & Ponterotto, 2008).

The present study examined the impact of race, ethnicity, and language on competency to stand trial evaluations. This study aimed to address the gap of knowledge in how these differences may impact competency decisions. As competency evaluations are the most frequently requested psycho-legal evaluation, it is important to provide culturally sensitive services that are reliable and valid as they can have significant impact in the disposition of legal cases.

# CHAPTER 2

# REVIEW OF THE LITERATURE

## Competency to Stand Trial

Competency in the United States is defined by the *Dusky* standard (*Dusky vs. United States,* 1960*).* The standard states that competency evaluations must "test whether he [defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding – and whether he has a rational as well as factual understanding of the proceedings against him" (p. 402). If defendants are allowed to proceed with legal proceedings when they are incompetent, it could result in a violation of their civil rights. The terms competence to stand trial, fitness for trial, and adjudicative competence all refer to the "legally determined capacity of a criminal defendant to proceed with criminal adjudication" at any phase of legal proceedings (Mossman et al., 2007, p. S4). Bonnie and Grisso (2000) estimated that about 60,000 CST evaluations are conducted every year across the United States, making it one of the most frequent psychological evaluations requested by attorneys and trial judges. Some estimate CST evaluations are requested in about 2% - 8% of criminal felony cases in the U.S. (Hoge, Bonnie, Poythress, & Monahan, 1992; LaFortune & Nicholson, 1995). According to Pirelli et al. (2011) about 20% of cases referred for a competency evaluation result in a finding of incompetency. The high stakes process of making a decision about competency can have lasting

impacts on the disposition of legal cases, so it is important that assessment practices are reliable and valid when applying them to diverse populations.

## History of Competency to Stand Trial Standard

The competency standard is rooted in English common law protecting defendants against trials in absentia (Powers Stafford & Sellbom, 2012). Common law established that a defendant has the right to be present at their trial and have the opportunity to confront and question their accusers. This requires that the defendant is physically present, but they also need to be mentally present to participate in the defense of their case. In modern times, this protection is articulated by the Fifth and Sixth amendments in the U.S. Constitution, stating that a defendant has the right to confront their accuser and has the guarantee of fairness and due process. Common law established that if a defendant became "mad" at any time during their legal proceedings, the case would be barred until the matter was addressed (Hale, 1736, cited in Powers Stafford & Sellbom, 2012, p. 939). The accused must also have the capacity to understand the legal proceedings and be capable of assisting with their defense. English courts documented one of the earliest examples of this practice in the 17$^{th}$ century, questioning whether an individual who was mute could proceed with legal proceedings because of absentia (mental impairment) (Gacono & Evans, 2007). The court questioned whether the man was mute as a result of "malice" or "visitation of God." If it was determined that the defendant was truly mute (by visitation of God), the legal proceedings were halted and the defendant was protected from further prosecution or even execution. In another example of questioning competency/absentia, Sir John Hawles argued that a "lunatick during his lunacy, by an Act of God…[is] disabled to make his just defense…[since] there may be circumstances lying in his private knowledge, which would prove his innocency, of which [he] can have no advantage, because [it is] not known to the persons

who shall take upon them his defense" (Howell, 1816, cited in Marouf, 2014, p. 939)." This argument helped to establish that the courts should not proceed with a case when an individual is considered to be in a state of "lunacy" because the defendant is not able to relay pertinent factual information that may exonerate them or help counsel with the defense of their case.

A key related decision by the U.S. Supreme Court, influenced by English Common law, was made in the case of *Youtsey v. United States* (1899), which established that an "insane person" cannot resolve a case via a plea, proceed to trial, receive a judgment, or be punished if there is evidence that the defendant "is not capable of making a rational defense" with the assistance of counsel (p. 947). Legal proceedings cannot continue until the "sanity of the person is assessed or restored." In the *Youtsey* case, the trial court denied the motion by the defendant's attorney to question competency due to memory deficits caused by severe epileptic seizures. On appeal, the U.S. Supreme Court remanded the case for retrial on the basis that a defendant must have the capacity to appreciate legal issues and have the ability to intelligently assist counsel with the defense of his or her case. This was one of the first U.S. Supreme Court decisions that articulated the concept of competency.

More recently, in *Dusky v. U.S.* (1960), the Supreme Court established the *Dusky standard*, which continues to be used as the standard for determining competence to stand trial today. In the *Dusky* case, a man diagnosed with schizophrenia was prosecuted and sentenced to prison without a thorough investigation of competency, even though he presented with severe impairments as reported by a psychiatrist during pre-trial proceedings. The petitioner of *certiorari* (requesting the courts to review court decision from lower courts) requested that the conviction be reversed since the defendant was not competent to stand trial at the time of the legal proceedings. The U.S. Supreme court held that the trial court's determination of his mental

state, on the basis that the man was oriented and could recall events, was not sufficient since it failed to consider his functional capacities (Mossman et al., 2007).

Another influential decision came from *Drope v. Missouri* (1975), where the courts further clarified the standard of competency by establishing that "a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial" (p. 171). A trial judge must address the issue of competency if he or she is presented with evidence by the defense, prosecution, or his or her own evidence that raises significant doubts about the defendant's competency anytime during legal proceedings (*Drope v. Missouri*, 1975; *Pate v. Robinson,* 1966). This may include evidence of irrational behavior, an inability to manifest appropriate courtroom behavior, and prior findings of competency that can be introduced to raise significant doubts about a defendant's competency status. In the presence of one or more of these concerns, the trial court must hold a competency hearing to address the issue in question. Proceeding to trial with someone who is not competent would violate the dignity of the defendant and the courts, undermining the reliability and integrity of the state, and depriving a defendant of their fundamental rights.

The *Dusky* standard defines competency by considering two factors: factual and rational understanding. A defendant is unfit to stand trial if they do not have the ability to appreciate the legal process, do not have factual understanding (e.g. knowledge of the legal process), lack rational understanding that impairs their ability to understand legal proceedings, and lack the ability to consult rationally with counsel (Mossman et al., 2007; Otto, 2006; Powers Stafford & Sellbom, 2012). Factual understanding relates to having the necessary knowledge to understand the legal process or to having the capacity to gain this factual understanding (e.g. knowledge of

facts, knowledge of legal options). Rational understanding relates to having the capacity to make rational decisions (e.g. accepting a plea, developing a defense with counsel, considering risks and benefits) that are not impaired by psychological disorders (Otto, 2006).

Expanding on the concept, Bonnie (1992) theorized that competency is a construct composed of foundational competence and decisional competence. Foundational competence refers to "(i) capacity to understand the charges, the purpose of the criminal process and adversary system, especially the role of defense counsel; (ii) capacity to appreciate one's situation as a defendant in a criminal prosecution; and (iii) ability to recognize and relate pertinent information to counsel concerning the facts of the case" (Bonnie, 1992, p. 297). Decisional competence refers to the "defendant's ability to communicate a preference, the ability to understand relevant information about particular legal decision, the ability to appreciate the significance of that information on his or her own case, and ability to compare the benefits and risk of decisional options to reach a decision" (p. 302). Bonnie noted that the two-pronged model approach provides utility in the assessment of competence when working with individuals with any mental impairment by operationalizing the concept of competency and, therefore, making the assessment of competency more objective. For example, a psychotic defendant may be familiar with the legal process and able to communicate with counsel, but delusional or psychotic thinking can impair his ability to think logically about his legal options.

The *Dusky* standard sets the minimal constitutional standard for competency but does not provide much guidance on what contributes to the deficits in individuals who are found incompetent to stand trial, which makes it challenging for states to consistently apply the standard. It is important to note that examiners do not make adjudicative decisions regarding competency since trial judges make the ultimate decision in addressing the legal issue. However,

some have observed a 90-100% agreement between trial judges and recommendations made by forensic examiners in competency evaluations (Powers Stafford & Sellbom, 2012).

As noted by Morris, Haroun, and Naimark (2004), the *Dusky* standard can be viewed as a "cognitive test" that examines the defendant's thinking as it relates to adjudicative competencies. Across the U.S., some states have operationalized this by stating that competency impairments must be linked to a psychological disorder (Mossman et al., 2007; Otto, 2006). For example, the Florida state code stipulates that, "Mental health experts appointed…shall first determine whether the defendant has a mental illness and, if so, consider the factors related to the issue of whether the defendant meets the criteria for competence to proceed" (Fla. Stat. § 916.12, 2016). Gacono and Evans (2007) examined similarities in competency criteria across states and found that they are consistent with the *Dusky* standard, but vary in some aspects. For example, Florida defines competency across five domains: "i) appreciates charges against him/her, ii. appreciates possible consequences s/he might face, iii. discloses relevant information to an attorney, iv. exhibits appropriate courtroom behavior, v. ability to testify relevantly" (Fla. Stat. § 916.12, 2016). In comparison, Texas includes language that examines the defendant's ability to "engage in a reasoned choice of legal strategies and options."

Forensic assessment occurs in a multicultural context that is characterized by an overrepresentation of minorities and individuals of low socioeconomic status who are involved with the criminal justice system (Prison Policy Initiative, 2012). A brief review of the demographics of this population should help set the context in which competency assessments occur and highlight the need for culturally sensitive assessment practices.

## Demographics of Forensic Populations

When examining CST issues, it is important to consider the multicultural factors that may influence the assessment process since forensic clinical populations are very diverse. There are significant disproportionality issues in the criminal justice system. For example, African American and Latino defendants are arrested and incarcerated at significantly higher rates when compared to white defendants. Overall, African Americans are incarcerated at 5.8 times the rate (2,207 out of 100,000) of non-Hispanic whites (380 out of 100,000) and Hispanics are incarcerated at 2.5 times the rate (966 out of 100,000) of non-Hispanic whites (Prison Policy Initiative, 2012). Interestingly, Hispanics are also among the fastest growing population segments in the United States with at least 17% of individuals identifying as Latino or Hispanic (U.S. Census Bureau, 2015). Hispanics are also linguistically diverse; it is estimated that 75% of Latinos speak Spanish in the home and around 32% report having difficulty with the English Language.

Given this diversity, it is likely that forensic examiners performing CST evaluations will assess defendants who are members of a minority group and that speak another language. Forensic examiners have an ethical and professional duty to "consider the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, *linguistic*, and *cultural differences* that might affect their judgments or reduce the accuracy of their interpretations" (American Psychological Association, 2013, p. 15). Nicholson and Kugler (1991) assert that more research is necessary to examine the effects of demographic variables on competency findings. For example, they argue that there should be significant diagnostic differences between incompetent and competent individuals, as well as differential performance on instruments designed to assess

competency. It is important to tease out differences between groups that may be a result of true differences, referral bias, and differences in evaluators and clients that may be associated with demographic and socioeconomic variables (Nicholson & Kugler, 1991). The impact of language, race, and ethnicity on CST evaluations remains unclear.

**Correlates Associated with Findings of Incompetency**

Otto (2006) points out that the *Dusky* standard does not outline "predicate conditions" that may be attributed to impairments in capacity to stand trial such as psychopathology, intellectual disabilities, neurological impairments, or developmentally appropriate limitations (e.g. immaturity) associated with juvenile defendants. However, past research identifies common correlates associated with findings of incompetency in criminal cases. A recent meta-analysis by Pirelli et al. (2011) found that individuals diagnosed with a psychotic disorder are eight times more likely to be found incompetent than individuals who are not diagnosed with a psychotic disorder. This finding is consistent with those of Nicholson and Kugler (1991). Psychotic disorders are characterized by the experience of hallucinations, delusions, impaired insight, paranoia, grandiosity, or severe disturbances in thought process that can significantly impact a defendant's cognitive ability to participate in legal proceedings since their abilities for rational thought and appropriate courtroom behavior may be severely impaired. For example, Jacobs, Ryba, and Zapf (2008) explored the relationships between psychiatric symptoms, measured by the Brief Psychiatric Rating Scale (BPRS), and competency-related abilities, measured by the MacArthur Competence Assessment Tool – Criminal Adjudication (MacCAT-CA). They found that psychoticism was significantly correlated with all three competency abilities (understanding, reasoning, and appreciation). About half of all individuals with a

psychotic disorder who are evaluated for competency are found incompetent to proceed (Nicholson & Kugler, 1991; Pirelli et al., 2011).

Intellectual disabilities can also contribute to findings of incompetency in criminal cases. Defendants who are diagnosed with intellectual impairment represent about 2% to 7% of pretrial populations referred for a competency evaluation, 10% of defendants in forensic facilities, and about 10% of correctional populations (Bonnie, 1990). Previous studies have found that defendants with intellectual disabilities are overlooked since they often engage in compensatory behaviors (e.g. over-willingness to acquiesce and pretending to understand legal proceedings) in attempts to hide their disability. In these cases, attorneys may not identify competency issues that actually exist (Kalbeitzer & Benedetti, 2009; Siegert & Weiss, 2007). Bonnie (1990) estimates that up to half of defendants with intellectual impairment are not referred for pretrial competency evaluations.

Lastly, medical conditions that result in cognitive deficits (e.g. Alzheimer's disease, dementias, traumatic brain injuries, seizures) may also result in impairments associated with adjudicative incompetence (Kirkish & Sreenivasan, 1999). Deficits in memory, abstraction, concentration, and thought process have been associated with individuals diagnosed with dementia in the aging population (Frierson, Shea, & Shea, 2002). This may translate to significant deficits associated with understanding Miranda rights, legal charges, potential consequences of adjudicative decisions, ability to consult with an attorney, and making decisions that protect self-interest.

**Demographic Variables**

Research exploring the relationship of demographic variables and competency findings has yielded mixed results. Steadman (1979) found that a group of 539 defendants adjudicated

incompetent to stand trial were more likely to have low levels of education, limited ties to the community, and to have never been married. Steadman also found that 62% of individuals found incompetent were charged with violent crimes. There are some challenges to the interpretation of these findings because it is unclear if differences might be a result of selection bias in determining who is referred for evaluation of competency or possibly to differences in how evaluators determined competency.

Previous studies have found that incompetent individuals were more likely to be African American, unmarried, less educated, and have a history of a psychotic disorder. In attempts to explore these correlates, Nicholson and Kugler (1991) performed a meta-analysis of 30 studies comparing competent and incompetent individuals (N = 8,170) and found that non-white defendants were more likely to be found incompetent, although the correlation was small ($r$ = .09) and accounted for less than one percent of the variance in competency decisions. They did not find significant differences between competency status and socioeconomic variables, but found that incompetent defendants were more likely to be single, had few employment opportunities, and reported lower levels of educational achievement (e.g. $10^{th}$ grade or less). Lastly, individuals with prior legal histories and previous hospitalizations were more likely to be found incompetent ($r$ = .17 and .26, respectively).

Hubbard and Zapf (2003) examined the role of demographic, criminal, and psychiatric variables in the examiners' prediction of competency restorability with a sample of individuals found incompetent. They found that 19% of 468 defendants evaluated were found incompetent, which is consistent with the base rate of incompetency decisions in other studies. The majority of incompetent defendants were African American (68%), unmarried (69%), unemployed (80%), had some high school education (76%), had a history of previous arrest (72%), and had a history

of mental health treatment (70%). In a more recent meta-analysis using findings from 68 studies published between 1967 to 2008, Pirelli et al. (2011) found that non-white defendants were 1.5 times more likely to be found incompetent than white defendants. The meta-analysis compared 6,428 incompetent defendants to 19,711 competent defendants. Overall, 52% of defendants found incompetent were non-white, had a higher unemployment rate (71%), and a higher number were not married (84%). Among the incompetent group, 66% were diagnosed with a psychotic disorder, and 53% reported a previous psychiatric hospitalization. In a more recent study, McCallum, MacLean, and Gowensmith (2015) found differences between CST findings and the ethnic background of defendants in a sample from Hawaii. Asian defendants were more likely to be found incompetent (49% vs. 34%). Lastly, when compared to other ethnic groups Asians were arrested at a lower rate (8.6%), but were referred for an evaluation 36% of the time. They theorized that Asian defendants were less likely to seek mental health services and may be interfacing with the criminal system due to untreated and ongoing psychiatric issues, which is resulting in more competency referrals.

Previous studies have shown that African Americans of all age groups, from juveniles to older adults, are more likely to be diagnosed with a psychotic disorder than white individuals (Fabrega et al., 1994; Kilgus, Pumariega, & Cuffe, 1995; Strakowski, Shelton, & Kolbrener, 1993). In a more recent review of the literature, African American individuals were eight times more likely than white individuals to be diagnosed with Schizophrenia (Schwartz & Blankenship, 2014). It is estimated that African American individuals represent about 44% of patients diagnosed with schizophrenia in hospital settings, compared to 32% of patients being white.

Stefan (1996) argued that minorities are overrepresented in the mental health system. They are overrepresented in findings of incompetency and the diagnosis of psychotic disorders (e.g. schizophrenia), may deny mental illness and the need for treatment, and are involuntarily hospitalized at higher rates. For example, the McArthur study conducted by Grisso and Appelbaum (1995) found that 46% of hospitalized defendants were non-white, when compared to 37% of those diagnosed with depression, suggesting that non-white individuals are more likely to be hospitalized. African Americans are diagnosed about twice as often with schizophrenia, although these differences are less clear when accounting for socioeconomic variables (SES), gender, age, and marital status (Stefan, 1996). This may, in turn, result in differences in findings of incompetency across groups since some may be diagnosed with more severe psychotic disorders that are associated with more severe impairment of legal competency faculties.

When taking a closer look at the Hispanic population using epidemiological data collected from the National Comorbidity Survey-Replication (NCS-R) and the National Latino and Asian American Study (NLAAS), Alegría et al. (2008) found that Latinos had a lower risk of lifetime anxiety and mood disorders, but substance use disorders were similar to non-Latino whites. Overall, they found that 29% of Latinos reported a history of any mental disorder during their lifetime, compared to 43% of non-Latino whites. When considering specific disorders, 15% of Latinos reported any anxiety disorder compared to 25% in non-Latino whites. For any depressive disorder, 15% of Latinos reported history of disorder, compared to 22% for non-Latino whites. The subgroups represented in the NCS-R and NLAAS mainly included people from Mexico, Puerto Rico, and Cuba, and other smaller groups represented by Dominican Republic, Colombia, El Salvador, Guatemala, and other Latin American countries. When compared by sub-ethnic subgroups, Puerto Ricans had the highest rate for any lifetime disorder

with 37%, followed by 29% of Mexicans, 28% Cubans, and 27% Latinos (Alegría et al., 2008). Overall, Latinos born in the United States reported a higher prevalence of lifetime disorders (30%) when compared to Latino immigrants (20%), suggesting that there is a protective factor for individuals immigrating to the US, which has been called by some the *immigrant paradox* (Alegría et al., 2008). It is important to consider that Latino individuals may appear to be a homogeneous group, but in reality they tend to be a heterogeneous group from many different countries of origin, and clinicians must be careful to not stereotype or over-generalize this "protective effect" observed in comorbidity studies (Alegría et al., 2008). Consistent with previous studies, Latinos reported lower levels of educational achievement and lower incomes when compared to non-Latino whites.

With regard to psychotic disorders, few studies have examined the prevalence of severe mental illness in the Latino community. Rather, previous epidemiologic studies have focused on mood disturbances and substance abuse within this population (Alegría et al., 2008; Walters, Kessler, Demler, & Chiu, 2005). Worldwide prevalence rates of schizophrenia are estimated to range from 0.5 to 1% of the international population (Simeone, Ward, Rotella, Collins, & Windisch, 2015). Although large differences in prevalence rates of mental disorders have not been observed across race and ethnicity variables in the general population, significant differences have been shown in clinical populations presenting with persistent mental disorders (Choi et al., 2012; Minsky, Vega, Miskimen, Gara, & Escobar, 2003; Schwartz & Blankenship, 2014). African American and Latino males are more likely than white males to be diagnosed with schizophrenia spectrum disorders. Latino and African American patients may be misdiagnosed with psychotic disorders when they may be suffering from a mood disorder (Choi et al., 2012; Minsky et al., 2003; Schwartz & Blankenship, 2014). Interestingly, Latinos are three

times more likely to be diagnosed with schizophrenia when compared to non-Latino whites (Schwartz & Blankenship, 2014). It is unclear if these are true differences between groups, differences in expression of symptoms, biases in the diagnostic criteria, or clinician bias in the assessment of mental disorders. Some propose that clinicians may be attributing affective symptoms to more severe symptoms of schizophrenia and under-diagnosing mood disorders (Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983).

**Cultural Differences**

Differences in the perception and understanding of mental illness may also partially account for differences in diagnosis across groups. For example, African American defendants are more likely than white individuals to attribute symptoms of mental illness to social and situational stressors rather than to attribute their symptoms to a biological or medical illness model (Stefan, 1996). Differences in the perception of illness should not be taken as a lack of insight from individuals, but as cultural differences in understanding mental illness and differences in reporting styles that should be considered within a historical and cultural context (Hicks, 2004). Hicks argues that discrepancy in diagnosis of more severe psychopathology may be a result of clinicians not eliciting information about affective signs and symptoms to help clarify a diagnosis in non-white individuals that may present with a different symptom profile or communicate their distress differently, since studies have shown that when clinicians use structured clinical interviews, fewer differences are observed. For example, Hispanic individuals are more likely than whites and other minority groups to endorse somatic symptoms (Chong, Reinschmidt, & Moreno, 2010; Malgady & Costantino, 1998).

Furthermore, individuals from Latin American countries may report a wide range of unusual behaviors and experiences that may simulate psychotic symptoms (Vega, Sribney,

Miskimen, Escobar, & Aguilar-Gaxiola, 2006). Latinos may report having spiritual or supernatural experiences that may mimic psychotic symptoms, but those may be considered normative cultural experiences, especially among Caribbean populations. Mexican American patients are more likely to report somatic symptoms when compared to Caucasian Americans (Weisman et al., 2000). More specifically, Latinos tend to conceptualize psychotic disorders as a problem that is associated with their nerves (nervios), and one that is primarily attributed to bodily/somatic causes that are beyond their control. Somatization of symptoms may serve as a coping mechanism to deal with psychopathology and some suggest that symptom presentation may be a result of not having concepts and vocabulary in their own culture to describe psychotic symptoms (Weisman et al., 2000). It has also been suggested that these differences may be a result of Latino communities having more positive and receptive attitudes about severe mental illness since they are less likely to blame the individual for their troubles and attribute difficulties to be somatic in nature and an illness that is beyond their control (Weisman et al., 2000). It is important that clinicians are aware of the nuances in the expression of symptoms and make room for normative cultural experiences that can reduce the chances of pathologizing normative life experiences.

Furthermore, recent studies exploring cognitive bias may help to explain differences observed across groups by exploring how evaluators may introduce bias into forensic evaluations (Zapf & Dror, 2017). Evaluators may perceive symptom presentation, functional ability across groups, and information gathered and reviewed during an evaluation differently, which might ultimately lead to differences in diagnosis and competency findings. For example, an evaluator's life experiences (i.e. upbringing, economic status, education, training, and personal traits) can influence how an individual perceives the world and, therefore, how they perceive information

during the evaluation process (Zapf & Dror, 2017). As fallible human beings, we tend to take shortcuts in thinking and information processing that can result in distortion that is context driven (Zapf & Dror, 2017). For example, an anchoring bias (priming effect) may influence how evaluators proceed with an assessment based on information that is initially presented to them by the defense or prosecution. They may overestimate the prevalence of disorder (e.g. Psychotic disorder) in some groups that may be explained by base rate bias or availability bias. This can lead to a confirmation bias. Evaluators may only assess issues or ask questions that support their "hunch" or hypothesis. As conceptualized by Goldyne (2007), bias may originate from "emotionally driven motivations that conflict with the expert's motivation to be objective, and non-emotional factors, including the expert's information processing style or fund of knowledge, that may impair objectivity" (p. 60). Emotional-driven factors can influence an individual's decisions and approach to their work. For example, someone's opinion may be influenced by their concerns of avoiding harm to others and appearing more competent than they are as a professional. Non-emotional factors can include the influence of availability heuristics and relying on a limited fund of knowledge that can lead to differences in competency findings. When introducing variables of race, language, and economic status we must remain aware that we cannot eliminate bias, but can address some of these influences by increasing objectivity in the evaluation process using an approach that elicits and evaluates information in a more objective manner.

## Linguistic Issues

When working with individuals in the Latino community, the issue of language is an important one. The prominence of monolingual Spanish speakers and bilingual speakers in the Latino community can make clinical assessments a complex process due to cultural and

linguistic differences (Marin et al., 2007; Minsky et al., 2003). Marin et al. (2007) noted that culturally sensitive assessments should account for variability in the cultural expression of symptoms, unexplained medical conditions, and idioms used across cultural groups that may be attributed to clinical disorders. In the same vein, clinicians must be careful when applying these differences too broadly in a stereotypical manner that can lead to misdiagnosis. Little research has examined the effects of language in the psychological assessment process. Del Castillo (1970) describes several cases in which he found that bilingual individuals communicating with clinicians in their secondary language (e.g. English) presented in a less pathological manner, often leading clinicians to miss part of the diagnostic picture. Del Castillo proposed that communicating in their secondary language may have resulted in "unconscious vigilance over their emotions" that can result in less severe clinical presentation since it may require more cognitive control to speak in a second language that can help patients keep more contact with reality. The use of a second language may limit a patient's ability to express their concerns to the clinicians, and their presentation of symptoms could lead to a misdiagnosis. Del Castillo noted that Latino patients were less likely to disclose psychotic symptoms when communicating in English than when communicating in Spanish. Patients appeared less psychotic when communicating in English, even though their behaviors appeared to be "overly psychotic." Patients presented as more cognitively disorganized, spoke more freely about their delusions, and appeared more affectively expressive when communicating in their native language when engaging clinicians and medical staff. Del Castillo's observations were drawn from his own experiences of select cases and, therefore, generalizibility of findings are significantly limited, but provide observations that deserve further empirical inquiry.

Mezzich and Caracci (2008, p. 122) note that “language identifies and codifies an individual’s experience, which is not readily translated from one language to another without distortion.” This is an important observation since there are nuances to symptom presentation, vocabulary, body language, and affect that may be misinterpreted when differences in language are mediating communications between the patient and clinician. For example, defensiveness, frustration, humor, and assertiveness may be restricted by someone’s ability to communicate when using a secondary language (Mezzich & Caracci, 2008). Communicating in an unfamiliar language can limit an individual’s ability to openly express their emotions, which can lead to variability in symptom presentation and the use of vocabulary may appear less severe or pathological to clinicians.

Interestingly, Malgady and Costantino (1998) assessed symptom severity as a function of clinician ethnicity and language of interview in 148 bilingual Hispanic patients and found that Hispanic clinicians rated symptom severity higher with bilingual (English and Spanish) patients diagnosed with schizophrenia than monolingual (Spanish or English only) patients. The study included patients diagnosed with depression, anxiety, and schizophrenia. They found that the differences were most pronounced with severe psychopathology. They argue that when bilingual patients communicate in Spanish, they are likely to provide more detailed replies that are more descriptive, increase self-disclosure, and may even rely on both languages to enhance communications because they have a more expansive vocabulary to rely upon. Alternatively, Malgady and Costantino also suggest that bilingual patients may use more cognitive resources to communicate in both languages, which can lead to more cognitive difficulties that may, in effect, result in higher ratings of symptom severity. They also suggest that ethnic distance (e.g. differences and similarities in ethnicity) between patient and clinician could enhance cultural

sensitivity in a clinician's ability to identify differences in emotional expression and account for linguistic variations in communication and symptom presentation. Ethnic distance may also elicit different response styles from patients when interacting with clinicians from similar ethnic backgrounds that speak their language. Malgady and Costantino note that it is unclear whether the variation captured in their study was due to clinicians over-pathologizing symptoms or due to clinicians with similar ethnic background being more culturally sensitive to differences in symptom presentation and, thus, capturing true differences.

In contrast, Marcos, Alpert, Urcuyo, and Kesselman (1973) found that individuals who communicated in an unfamiliar language (e.g. English) presented with more overtly psychopathological symptoms, had frequent misunderstandings with the interviewer, provided shorter responses to clinicians, and exhibited a higher frequency of speech difficulties that were attributed to symptoms and signs of anxiety in a sample of 10 individuals diagnosed with schizophrenia. In comparison, when they communicated with clinicians in Spanish they tended to speak at a slower pace, had longer pauses, and provided longer and more detailed responses that were characteristic of symptoms and signs of depressive symptoms. Based on these observations, Marcos et al. suggested that unfamiliar language could result in significant difficulties for patients who may present with more severe disturbances because of their inability to speak fluently in an organized manner due to language difficulties, but not necessarily because of impairment due to psychopathology. Therefore, they argued that patients may appear to be more impaired then they actually are when using a secondary language. In another study, Price & Cuellar (1981) explored the effects of clinical interview language and expression of symptoms. They found that Spanish-speaking clinicians rated symptom presentation during interviews done in Spanish as more severe using the Brief Psychiatric Rating Scale. This was compared to ratings

when the same patients who were bilingual were interviewed in English. Other researchers, however, have argued that interview language and ethnicity of clinicians were confounded in this study since non-Latino clinicians rated English interviews and Latino clinicians rated Spanish interviews (Malgady & Costantino, 1998).

Most of these studies were conducted using a small sample size and have limited generalizability, but they highlight potential issues that are elicited when working with individuals who speak another language. Overall, it remains unclear as to what accounts for differences in symptom presentation and diagnostic decisions with bilingual individuals. These differences might be a result of assessment bias or might represent true cultural differences. Most importantly, these differences may contribute to variability in decisions of adjudicative competence when working with individuals who speak another language.

The studies reviewed so far have focused on clinical interviews between clinicians and patients. In a study exploring differences in language spoken between attorneys and their clients, Varela et al. (2011) found that attorneys were more likely to rate Spanish-speaking clients as less mentally ill and were less likely to refer these clients for a competency evaluation. Using vignettes to describe defendants, they found that attorneys were more likely to under-pathologize symptom presentation of individuals who spoke Spanish when compared to identical individuals who spoke English. Even though this study focused on attorneys rather than clinicians, it sheds some light on possible biases or barriers that defendants face during psychological examinations and communications with legal professionals.

There is little known about how forensic examiners approach their work with individuals that speak another language. To shed some light on this, Canales, Kan, and Varela (2017) surveyed forensic examiners from various organizations (n = 79) to assess the practice of

assessing Hispanic defendants with limited English proficiency. In their sample, 90% of psychologists reported evaluating English-speaking Hispanic defendants and about 55% reported evaluating defendants with limited English proficiency. Consistent with the known shortage of Spanish-speaking psychologists in the field, only eight psychologists in their sample spoke Spanish and rated themselves as being competent enough to conduct evaluations in Spanish. The rest of the examiners reported using certified and ad hoc interpreters. Some examiners reported that they relied on interpreters to facilitate test administration and some translated testing materials to Spanish on their own. Using interpreters to help with testing administration and test translation may threaten the reliability and validity of assessments with individuals who have limited English proficiency. Lastly, they found that most psychologists considered acculturation status of defendants as part of their assessments, but it is unclear how much weight they gave to differences in acculturation status and how they conceptualized cultural/linguistic differences in their assessments.

As stated previously, a large majority of Hispanic and foreign-born individuals speak more than one language and report limited proficiency with the English language. Another way to explore the effects of language that are not explicitly addressed by examiners is to compare competency findings of defendants that are foreign-born. There is limited research in the area of competency and differences that may exist between foreign-born and non-foreign defendants. Crocker, Favreau, and Caulet (2002) found that defendants with an immigration history were more likely to be found incompetent when compared to native-born defendants in a Canadian based sample. In a more recent study, Paradis et al. (2016) found no association between competency decisions and the birthplace of defendants in an American sample. In an earlier study, Rogers, Gillis, McMain, and Dickens (1988) found no association between a defendant's

birthplace and competency findings in a Canadian sample. The Canadian studies have limited generalizability to defendants in the United States.

**Use of Interpreters**

Linguistically, 75% of Hispanics living in the United States who are ages five and older speak Spanish and about 32% of that group rate themselves as not speaking English "very well" or not speaking English at all (Pew Research, 2015). Most clinicians will use an interpreter to communicate with individuals who speak another language or they might refer the individual to a clinician who speaks their language. Little research, however, has examined the effects of using interpreters in clinical and forensic assessment. Although guidelines provided to forensic examiners recommend they use interpreters and find culturally appropriate assessment measures that are sensitive to language needs and cultural differences, not much is known about actual practice related to language and cultural differences in competency to stand trial evaluations (Benuto, 2015; Drogin, 2011; Maddux, 2010; Susuki & Ponterotto, 2008). Distortions in interpretation have been attributed to an interpreter's lack of language proficiency, their lack of psychological knowledge that may normalize or pathologize a patient's symptom presentation, their attitudes, "editorializing" their interpretations, or interpreters providing answers to questions without inquiry to patients (Bauer & Alegría, 2010; Marcos, 1979). Price (1975) audiotaped communications mediated by interpreters between patients and psychiatrists conducting clinical assessments and found that interpreters commonly omitted information in their translation, which resulted in missing diagnostic information that could ultimately lead to misdiagnosis. Interpreters were also twice as likely to make interpretive errors when working with psychotic patients. Interpreters attributed errors in interpretations with psychotic individuals

to difficulties in identifying meaning behind statements that are often convoluted with disorganized content.

Professional interpreters tend to make fewer errors as compared to ad hoc interpreters (e.g. bilingual staff, nurses, family members) (Bauer & Alegría, 2010). Using professional interpreters versus ad hoc interpreters appears to facilitate increased disclosure of traumatic events and psychological histories from patients in psychiatric assessments. There are some disagreements in the field of interpreting as to how much latitude interpreters should have in providing contextual meaning that is culturally sensitive in order to facilitate communication with examiners without distorting meaning or resulting in biased responses from patients and examiners (Bauer & Alegría, 2010).

Maddux (2010) notes that even though APA recommends that Non-English speakers be provided with an examiner that is fluent in the primary language of the client, the majority of forensic evaluations are mediated by the use of an interpreter when language is an issue. There is a significant shortage of Spanish-speaking clinicians and it would be neither practical nor logistically possible to reach that standard, so the best alternative may be to use well-qualified interpreters. Maddux notes that interpretation can challenge the reliability and validity of assessments, and it is imperative that interpreters are properly trained. Therefore, it is important to explore how language and the use of interpreters may affect competency determinations in CST evaluations.

## Present Study

The present study explored the influence of language, race, and ethnicity on CST evaluations. Previous research suggests that some groups may be diagnosed with more severe psychopathology (e.g. psychotic disorder), and linguistic differences may influence symptom

presentation that may lead to diagnostic differences. There are significant knowledge gaps in the literature that do not address how race, ethnicity, and linguistic differences may influence recommendations made by examiners in competency to stand trial evaluations. Forensic populations are very diverse because minorities are typically overrepresented in the criminal justice system, so it is important to explore the effects of race, ethnicity, and language on the competency assessment process that can contribute to a knowledge base to help provide culturally sensitive services.

**Hypotheses**

This study explored the following hypotheses:

1. Spanish and Bilingual speaking defendants will be found incompetent at a higher rate when compared to the English-speaking group.
2. Evaluations mediated by an interpreter will have higher rates of recommendations for incompetence when compared to evaluations without the use of interpreters.
3. African American defendants will be found incompetent to stand trial at a higher rate when compared to White defendants.
4. Latino defendants will be found incompetent to stand trial at a higher rate when compared to White defendants.
5. African American/Latino defendants will be diagnosed with psychotic disorders at higher rates when compared to White defendants.

# CHAPTER 3

# METHODOLOGY

## Overview and Design

The purpose of this study is to compare differences between competent and incompetent groups of defendants across the following variables: race and ethnicity, primary language of defendant, interpreter use, and psychiatric diagnosis. This study used archival data from competency evaluations completed in 2016 that were ordered by attorneys or trial courts for clients of a Public Defender's office based out of Florida. Group membership was determined by reviewing competency evaluation reports and dividing into competent and incompetent groups based on competency findings made by forensic examiners and target demographic variables.

## Power Analysis

An a priori power analysis was conducted to estimate the suggested sample size with a recommended power of .80 and medium effect size of .30 with α set at .05. Based on a review of the literature that examined similar variables, small to medium effects were expected (Hubbard & Zapf, 2003; Nicholson & Kugler, 1991; Pirelli et al., 2011). Using Cohen's (1992) recommendation for sample size using chi square analyses, this study required a sample size of at least 87 participants to identify a medium effect and 785 participants to identify a small effect. The larger sample estimate was used to guide sampling in order to ensure that there were enough

members from minority groups (e.g. Latino, African American), monolingual Spanish speakers, foreign-born defendants, and cases that required the use of interpreters in the study.

## Participants

The files selected for this study represent defendants that were selected for a competency evaluation in a Florida-based Public Defender's office associated with a competency restoration program. The participants selected include defendants that were screened through a competency restoration program, were identified as incompetent, and referred to a forensic examiner for a competency evaluation. These evaluations are typically conducted by independent forensic psychologists or psychiatrists that have participated in the Florida Adult Forensic Examiners Training. This is a requirement for all independent forensic examiners that conduct forensic evaluations in the state of Florida. This training provides examiners with a review of the Florida Statute requirements, ethical obligations, rules of evidence, roles of examiners, guidelines for the assessment of competency, and strategies for report writing and testifying in court.

The Public Defender's office represents defendants who have an income that is below 200% of the poverty line or defendants who cannot afford a private attorney without undue financial hardship and are in need of legal representation in criminal court. The demographic profile of this Florida community is 46% Non-Hispanic White, 20% African American, 26.9% Hispanic/Latino, and 4.9% Asian (U.S. Census Bureau, 2015). The gender ratio is a 49.5:50.5 male to female ratio.

A total of 1545 evaluations were conducted between January 2016 to December 2016 and 809 were selected for this study. The exclusion criteria used in the study pertained to multiple evaluations for a single defendant. In cases where multiple evaluations had been performed for a single defendant, only the first conducted evaluation was selected for this study. Table 1 presents

sample characteristics of defendants that were included in this study along with descriptive data on primary research variables. Defendants were between the ages of 16 to 81 with an average age of 37.5. Six defendants were included that were under the age of 18 since the cases were filed in adult court. In terms of gender, the sample was predominantly male (82.6%). The defendants in this sample were identified as 24.7% White, 46.8% African American, 22% Hispanic/Latino, and 6.4% other.

In regards to language, 87.5% of individuals were classified as monolingual English speakers, 7.4% monolingual Spanish speakers, 3.6% monolingual speakers of other languages (Creole, Vietnamese, Bengali, American Sign Language, Swahili, and Russian), and 1.5% were identified as bilingual speakers. Due to language differences, 8.5% of evaluations used an interpreter and 2.7% ($N = 22$) were conducted in the native language spoken by the defendant with an examiner that spoke the same language. Lastly, about 22% of defendants reported that they were foreign-born.

## Materials

Archived competency evaluation reports were accessed using an encrypted connection through a virtual private network that provided secured access to electronic records for each defendant selected for this study. In order to protect the identity of defendants, a numerical identifier was used for each file reviewed. An encrypted password-protected master file was kept separate in order to track subjects selected for the study and assisted with the inspection of files when assessing reliability of coding. The data collected during the file review included demographic information (race, age, gender), language spoken, birthplace (foreign-born, native), psychiatric diagnosis, interpreter use, and competency recommendation.

The variables examined in this study were coded as reported in the competency evaluation. This kept the categories of each variable consistent with the evaluator's report and accounted for their perception of each defendant during the evaluation process. Race and ethnicity were categorized across four levels that included White, African American, Latino/Hispanic, and Other for any other race and ethnic group represented in the sample. Language was coded as reported by the examiner on the evaluation. If language was not mentioned in the evaluation, subjects were coded as monolingual English speakers. If linguistic differences were mentioned in the report and the evaluation was conducted in English, the individual was coded as bilingual. Lastly, if the evaluation was conducted in Spanish or required the use of an interpreter the subject was coded as a monolingual Spanish speaker (or other language used). To account for language differences, another variable was included to determine if there were differences between foreign-born and native-born defendants. Lastly, defendants diagnosed with a psychotic disorder (i.e. schizophrenia) were grouped in the psychotic disorder group and other psychiatric diagnoses (e.g. major depression) were assigned to the non-psychotic disorders group.

## Procedures

Archival data was collected by generating a list of all competency evaluations conducted from January 2016 through December 2016. Two individuals from the Public Defender's Office coded data, and each person was provided with training on the coding criteria. To assess the reliability of coding, 17 files were coded by the two raters, and the data was examined for agreement. Kappa values ranged from .83 to 1.00 across the primary variables of the study, suggesting strong agreement between the two raters.

A pilot study was conducted by collecting archival data for the first 25 files selected for this study to determine if archived competency evaluation reports contained the information needed for statistical analysis and to also assess the feasibility of data collection. Files were reviewed to determine if data collected could be coded reliably. Based on these findings, additional training between raters was undertaken to minimize any inconsistencies in future coding. Any errors or inconsistencies identified during the pilot study were reviewed and adjustments were made to increase the reliability and accuracy of data collection.

# CHAPTER 4

# RESULTS

## Data Analysis Plan

The statistical analysis was conducted using the IBM Statistical Package for Social Sciences Version 23 (SPSS, 2015). Descriptive statistics were analyzed to assess characteristics of the sample (e.g. age, gender, race/ethnicity, education, criminal charge) (See Table 1). Chi-square analyses were used to assess whether significant differences exist between the competent and incompetent group of defendants across the following variables: race/ethnicity, language, interpreter use, and psychotic disorders. Finally, a logistic regression analysis was used to determine which predictor variables contributed to an increase or decrease in findings of competency.

## Chi-square Analyses

In order to explore the effects of language, race, and ethnicity on competency to stand trial evaluations, a chi-square analysis was conducted for each hypothesis to determine if differences exist between primary research variables and competency findings.

### Language

Due to the higher than expected number of non-English speakers of other languages found in this study (Creole, Vietnamese, Bengali, American Sign Language, Swahili, and Russian), a comparison was conducted to determine if any significant differences existed

between English and all non-English speakers. The non-English-speaking group for this comparison included defendants that spoke Spanish as well as other languages. There was a significant difference observed between English and non-English speakers, $X^2$ (1, $N$ = 807) = 6.55, $p$ = 0.010 (See Table 3) on competency decisions, with non-English speakers being more likely to be found incompetent. The size of the effect was small ($\phi$ = .090).

Taking a closer look at the largest non-English-speaking group, it was predicted that Spanish-speaking and bilingual defendants would be found incompetent at a higher rate when compared to English speakers. There were no significant differences found between language spoken by defendants (English vs. Spanish) and competency findings, $X^2$ (1, $N$ = 766) = 1.69, $p$ = 0.193, $\phi$ = .047 (See Table 2). Due to the small sample size of bilingual defendants a separate analysis was not conducted with this group.

A comparison was also conducted between foreign-born and native-born defendants. This comparison was conducted to capture linguistic and cultural differences that are not explicitly addressed by examiners on written reports. There was a significant difference between the foreign-born and native-born groups and findings of competency, $X^2$ (1, $N$ = 747) = 10.589, $p$ = 0.001 (See Table 4). Defendants that were identified as foreign-born were found incompetent at a higher rate than native-born individuals. The size of the effect was small $\phi$ = -.119).

**Use of an Interpreter**

It was hypothesized that evaluations mediated by an interpreter would have higher rates of recommendations for incompetence when compared to evaluations without the use of interpreters. There was a significant difference found between the use of an interpreter and findings of competency, $X^2$ (1, $N$ = 785) = 5.406, $p$ = .020 (see Table 5). Defendants that

required the use of an interpreter were found incompetent at a higher rate than individuals who did not require the use of an interpreter. The size of the effect was small ($\phi$ = -.083).

**Race and Ethnicity of Defendant**

It was hypothesized that African American defendants would be found incompetent to stand trial at a higher rate when compared to white defendants. When comparing African American to white defendants and competency findings there were no significant differences observed between groups, $X^2$ (1, $N$ = 578) = 1.17, $p$ = .279, $\phi$ = .045 (see Table 6).

It was hypothesized that Latino defendants would be found incompetent to stand trial at a higher rate when compared to white defendants. When comparing Hispanic and white defendants on competency findings, there were no significant differences observed between these two groups, $X^2$ (1, $N$ = 378) = 3.02, $p$ = .082, $\phi$ = .089 (see Table 7). Although African Americans and Hispanics were not found incompetent at higher rates than white defendants when compared individually, an additional comparison was conducted between white and non-White (African American, Hispanic/Latino, Other) defendants with all non-White defendants combined into a single group. There were also no significant differences found between these two groups, $X^2$ (1, $N$ = 807) = 2.49, $p$ = .114, $\phi$ = .056 (see Table 8).

It was hypothesized that African American and Latino defendants would be diagnosed with psychotic disorders at higher rates when compared to white defendants. There were no significant differences found between race/ethnicity and a diagnosis of psychosis, $X^2$ (2, $N$ = 739) = .921, $p$ = .631, $\phi$ = .035 (see Table 9).

## Logistic Regression

A logistic regression was conducted to estimate odds ratios (OR) for significant differences observed across target demographic variables and competency findings. When

including all of the variables that were associated with significant differences between groups into the model, the foreign-born classification, psychotic disorder diagnosis, and intellectual disability diagnosis were significant and provided predictive value to the model. Interpreter use and language spoken (English vs. Non-English) were not significant. The OR for foreign-born defendants and finding of incompetency was 0.602 (95% CI: .364 -.997). This suggests that native-born defendants are a little more than half as likely to be found incompetent when compared to foreign-born defendants. The OR for psychotic diagnosis was 0.240 (95% CI: .171 – .338), and the OR for intellectual disability diagnosis was 0.139 (95% CI: .073 – .267). These findings are consistent with a diagnosis of a psychotic disorder or an intellectual disability resulting in a higher likelihood of incompetency decisions. The full model correctly classified 70% of evaluations.

## Supplementary Analyses

Supplementary analyses were conducted to assess if group differences observed in previous studies were found within this sample of defendants to address generalizability of the study.

### Psychotic Diagnosis and Competency Findings

In regards to competency findings, 61.6% of defendants were found incompetent. Diagnostically, the majority of defendants had a primary diagnosis of psychosis (55.3%). About 17% of defendants were diagnosed with an affective disorder, 16% with an intellectual disability or cognitive impairment, and 8.5% with a personality disorder, substance use, or malingering. Lastly, the majority of defendants (73.8%) were charged with a felony. A chi-square analysis was conducted to determine if there were significant differences between individuals diagnosed with a psychotic disorder and competency findings. Previous studies have suggested that

psychotic symptoms can result in significant impairments in competency abilities. There was a significant difference found between defendants diagnosed with a psychotic disorder and competency findings $X^2$ (1, $N$ = 786) = 55.99, $p$ < .001 (see Table 10). Defendants diagnosed with a psychotic disorder were more likely to be found incompetent. The size of the effect was small to moderate ($\phi$ = -.267). Lastly, there were no significant differences found between an assigned diagnosis (psychotic vs. non-psychotic) and race/ethnicity, language spoken (english vs. non-english), or birthplace (foreign-born vs. native-born) of defendants.

**Intellectual Disability and Competency Findings**

A chi-square analysis was also conducted to determine if there were significant differences in findings of competency with defendants diagnosed with an intellectual disability versus those without. Consistent with previous studies, there was a difference found between defendants diagnosed with an intellectual disability and competency findings, $X^2$ (1, $N$ = 793) = 27.96, $p$ < .001 (see Table 11). Defendants diagnosed with an intellectual disability were more likely to be found incompetent in this study, and the size of the effect was small ($\phi$ = -.188), $p$ < .001.

# CHAPTER 5

# DISCUSSION

The changing demographics of the American landscape is increasing the likelihood that psychologists will see individuals from ethnically, culturally, and linguistically diverse backgrounds. In particular, forensic examiners are increasingly likely to see defendants that are minorities, foreign-born, or speak other languages (Canales et al., 2017; Pew Research, 2015; Prison Policy Initiative, 2012; U.S. Census Bureau, 2015). The present study adds to the current literature by examining the effects of language, race, and ethnicity on competency to stand trial (CST) evaluations. Previous studies have found mixed results associated with race and ethnicity variables, and the effects of language on CST evaluations remains largely unexplored (Crocker et al., 2002; Hubbard and Zapf, 2003; McCallum et al., 2015; Nicholson & Kugler, 1991; Paradis et al., 2016; Pirelli et. al, 2011; Varela et al., 2011). Overall, this study found that defendants with limited English proficiency and defendants identified as foreign-born were more likely to be found incompetent. This study did not find significant differences based on the race and ethnic backgrounds of defendants and competency decisions.

## Language and Foreign-born Defendants

When considering the influence of language, it was predicted that monolingual Spanish speakers were more likely to be found incompetent when compared to English speakers. However, this study did not find significant differences between the two groups. It should be

noted that 36% (22 out of 60) of the evaluations conducted with monolingual Spanish speakers were conducted with examiners that spoke the same language as the defendant. The majority of non-English-speaking defendants (64%) required the use of an interpreter. However, when conducting a larger comparison of defendants that were identified as non-English speakers (including languages other than Spanish) to English speakers, non-English speakers were more likely to be found incompetent.

Furthermore, when comparing foreign-born to native-born defendants, foreign-born defendants were more likely to be found incompetent as well. This comparison was done to explore linguistic and cultural differences that may not be explicitly addressed or documented by examiners on their written reports. This is an important distinction since most individuals that are foreign-born are more likely to speak more than one language and report having limited English proficiency (Pew Research, 2015). This study sheds light on the differential rates of incompetency findings with defendants identified as foreign-born or individuals that speak other languages. Consistent with results from a Canadian-based study, defendants with a history of immigration were more likely to be found incompetent when compared to native-born defendants (Crocker et al., 2002). It is unclear as to what is driving the differences in foreign-born and non-English-speaking groups. These findings add to the gaps in the literature by exploring differences of competency findings with diverse populations (Paradis et al., 2016; Rogers et al., 1988). It should be noted that most foreign-born defendants in our sample came from Latin American and Caribbean countries. Although the comparisons in this study yielded small effect sizes, it is a largely unexplored topic in the field that should be investigated. There are many possible explanations for these findings based on the results of this study and the broader literature.

A possible explanation to differences observed in this study may be that attorneys are likely to refer the most severe cases for a competency evaluation because they are unable to proceed with a defendant presenting with significant impairments. There is evidence to suggest that attorneys are less likely to refer non-english speakers and Hispanic defendants for a competency evaluation because they may attribute competency issues (e.g. lack of factual/rational understanding) to cultural differences instead of mental illness (Varela et al., 2011). If this is true, we may see diagnostic differences associated with Hispanic defendants diagnosed with a higher prevalence of more severe diagnosis. However, there were no significant differences found between an assigned diagnosis (e.g. psychotic vs. non-psychotic) and race/ethnicity, language spoken (english vs. non-english), or birthplace (foreign-born vs. native-born) of defendants.

Another possible explanation of the variability observed in this study may be that evaluations are being conducted in English with foreign-born defendants who may not be proficient in English. For example, a majority of Hispanic individuals report speaking Spanish in the home and about 36% report limited English proficiency (Pew Research, 2015). This may be leading to linguistic and cultural differences that may impact competency assessments that are going unnoticed. Linguistic differences may go undetected by referral sources (e.g. attorneys, judges) and examiners. For example, a defendant may go into an evaluation communicating in their secondary language in order to match the examiner's English language. Thus, even though a defendant may not speak or comprehend English well, an examiner might miss these challenges if they do not assess English proficiency (Bauer & Alegría, 2010; Malgady & Costantino,1998; Marcos, 1979; Mezzich & Caracci, 2008).

It is also plausible that examiners may be rating individuals that are foreign-born as being more impaired when assessing competency abilities. Previous studies have found that Hispanic individuals presenting with psychotic symptomology may be given a more severe diagnosis (e.g. schizophrenia) when they rely on their secondary language to communicate during a clinical interview as compared to interviews conducted in their primary Spanish language, while other studies have found mixed results (Marcos, 1979; Mezzich & Caracci, 2008; Malgady & Costantino,1998). The lack of research in this area along with mixed findings suggests that linguistic differences can result in obscure mental status assessments (Bauer & Alegría, 2010). As mentioned previously, the current study did not find evidence of diagnostic differences across groups, but this trend may shed light on how examiners may perceive individuals who are foreign-born or speak another language as more impaired when estimating their competency abilities. Previous studies have found that race/ethnic and linguistic differences between the patient and the clinician conducting the clinical interview may elicit a different response style from patients (Malgady & Costantino, 1998). This can lead to variances in emotional expression, impact rapport building, and differences in how individuals communicate their distress during interviews. Overall, the variability in presentation that is mediated through language and cultural differences may contribute to some of the variability observed in this study.

Furthermore, it is plausible that examiners may perceive impairment differently when defendants are less familiar with the American legal system. Examiners may have limited knowledge about a defendant's understanding of their respective justice system (e.g. Mexican, Salvadorian, Dominican legal systems). This may limit an examiner's ability to assess competency when they lack an understanding of culturally equivalent legal concepts when assessing individuals from other countries. Examiners should consider the impact of

acculturation in their competency assessments to assess familiarity with the American legal system (Canales et al., 2017). Benuto (2017) raises the concern that cultural differences in language and knowledge of the American legal system can make competency restoration more complex due to differences in judicial systems that vary across Latin American countries. However, these differences should be explored earlier in the process during competency assessments, which involve making "determinations of culturally appropriate behaviors and legal outcomes" unique to the American justice system (Benuto, 2017, pg. 513). For example, legal concepts such as innocent until proven guilty and due process may be unfamiliar to individuals from other countries. These differences may influence how examiners perceive competency abilities that may conflate their perception of psychological impairment.

Another possible source of differences in competency findings may be cognitive and cultural bias from examiners (Goldyne, 2007; Zapf & Dror, 2017). Examiners can make assumptions based on their own experiences and limited knowledge about a cultural reference group that may impact their perception of competency abilities. For example, an examiner may associate a defendant's difficulty in understanding the American legal system, their distrust in the legal process, their limited range in emotional expression, and hesitancy in talking about their legal situation as evidence of psychological and competency impairment, when in reality, these are culturally normative experiences. From another vantage point, the impact of stereotypes has been observed with Mexican American defendants in mock juror studies offering some evidence that Mexican American defendants may be rated as less competent in their work, less ethical and likeable, cold, insensitive, and lazy (Espinoza & Willis-Esqueda, 2008). This can raise concerns in forensic assessment as stereotype effects may impact the perception of functional competency abilities by assigning negative attributes to a group of defendants. It is worth mentioning that

Hispanic American individuals are a heterogeneous group representing over 20 countries that span across the Caribbean, Central American, and South American regions. An examiner's cultural knowledge and personal experience with diverse populations can vary significantly, resulting in decision making that may be based on stereotypic information about Hispanic defendants.

Another alternative explanation may be that examiners are taking a more conservative approach with defendants from other countries and want to ensure that competency issues are addressed before proceeding to trial. In this situation, examiners might correctly recognize cultural differences and err on the side of caution. The consequences of a false negative, finding a defendant competent, can lead to significant legal and life-altering consequences for defendants who proceed with their legal cases when they are truly impaired. This can provide examiners with information on how examinees respond to psychiatric treatment and restoration services to address competency issues. Furthermore, they are followed closely while undergoing restoration services over a period of time and this can help to rule out any other issues (e.g. malingering, intellectual capacity) that may be present in the process. In the same vein, finding someone incompetent that is actually competent (false positive) can result in adverse consequences leading to the deprivation of liberty if they are committed to a psychiatric hospital for restoration, involuntary medication treatment, and it continues to delay the resolution of their legal case. Thus, an examiner's cautious approach can also have deleterious effects for a defendant.

Lastly, there is the possibility that foreign-born defendants may actually be more incompetent as a group when compared to native-born individuals. This could be a result of a lack of access to mental health services in the community, increased stress associated with immigration, and adverse experiences with the American legal system. Overall, these alternative

explanations deserve further inquiry through research to determine why foreign-born defendants are more often found incompetent as compared to native-born defendants.

**Use of Interpreters**

The results of this study suggest that defendants requiring the use of an interpreter during competency evaluations were more likely to be found incompetent (74% vs. 60%). It is recommended that examiners use interpreters with individuals who are not proficient in the English language, but there is little research exploring the effects of their use in clinical and forensic assessments (Benuto, 2015; Drogin, 2011; Maddux, 2010; Susuki & Ponterotto, 2008). For example, interpreters may experience difficulties when attempting to interpret statements made from individuals that are actively psychotic which can lead to distortions in their interpretation, they may "editorialize" their interpretations, and may even answer questions without inquiry from patients (Bauer & Alegría, 2010; Marcos, 1979; Price, 1975). It is reassuring that most evaluators in this study utilized a certified court interpreter.

When taking a closer look, it is unclear what style of interpretations were used during the assessments (e.g., consecutive vs. simultaneous) and which modality they used (e.g. literal translation vs. allowing translation for meaning). Canales et al. (2017) found that most examiners report having a preference for consecutive translations (taking turns) and literal translations (word for word). The effects of using interpreters during forensic assessments remain uknown as there are large gaps in research exploring these issues. It remains unclear how informed examiners are on the use of certified interpreters and if they are aware of the different styles and modalities that interpreters can use during assessments. Interpreters may also be used as cultural consultants. For example, they can help examiners to assess differences in body language, posture, and eye contact to determine if behaviors observed are culturally normative or

associated with psychopathology (Canales et al., 2017). As mentioned previously, interpreters have acknowledged having difficuties interpreting for individuals presenting with disorganized speech and active psychosis since it can be very challenging to keep track of their conversation. This may lead to distortions in translations and obtaining an incomplete clinical picture. Overall, there is a need to examine the effects of interpreters in forensic assessments and a need to educate examiners about the importance of relying on certified interpreters familiar with the culture and language of defendants.

**Race/Ethnicity and Competency Findings**

In this study there were no significant differences found between race and ethnicity and competency findings. Previous studies have found mixed findings associated with race and ethnicity and competency decisions (Nicholson & Kugler, 1991; Hubbard & Zapf, 2003; Pirelli et al, 2011; McCallum et al., 2015). There were also no differences in rates of psychotic diagnoses by race and ethnicity as discussed in the results section. This is in contrast with other studies finding that non-white individuals are more likely to be diagnosed with a psychotic disorder (Fabrega et al., 1994; Kilgus et al., 1995; Schwartz & Blankenship, 2014; Strakowski et al., 1993). This in comparison with studies which have found some evidence that African American and Latino individuals are more likely to be diagnosed with a psychotic disorder in clinical populations (Choi et al., 2012; Minsky et al., 2003; Schwartz & Blankenship, 2014). A similar comparison was completed between language (English vs. Non-English), country of origin (Native vs. Foreign-born), and psychotic diagnosis that did not result in significant differences between groups and diagnosis relative to competency findings.

Perhaps the lack of diagnostic differences observed across groups may be that individuals in this sample were prescreened through a competency restoration program before they were

referred for an evaluation, impacting the types of defendants that were ultimately seen for a competency assessment. Defendants are typically first interviewed by a team of social workers to make an initial determination of competency. Defendants are only referred for a full evaluation if they are believed to be incompent during the screening process and thus increasing the likelihood that defedants in this sample would be found incompetent. It is also plausible that this process could have reduced bias from initial referral sources captured in other studies (Varela et al., 2011). They are more likely to see defendants that are truly impaired resulting in fewer group differences across diagnostic profiles. Previous studies have found differences in competency findings across samples comparing hospital, attorney referred, outpatient, and jail samples (Pirelli et al., 2011). This sample represents a mix of defendants from county jails, inpatient, and outpatient settings, which is different from previous studies that usually represent samples from a single setting. The sample in this study is also very unique since 75% were identified as non-white which may limit comparison to other studies. This is consistent with previous surveys finding that a majority of minorities in the criminal justice system are represented by public defenders or court appointment counsel (Harlow, 2000). This sample is also reflective of the overrepresentation of minorities in the criminal justice system.

Lastly, consistent with previous studies, defendants assigned a psychotic diagnosis were more likely to be found incompetent (Nicholson & Kugler, 1991; Hubbard & Zapf, 2003; Pirelli et al., 2011). It should be noted that this sample is mostly composed of defendants that are prescreened through a competency restoration program. This may have contributed to a significantly higher base rate of incompetent defendants at about 61% in this sample since they were only referred for an evaluation if they were identified as incompetent. That is in comparison

to the estimated overall base rate of 20% to 30% declared incompetent observed in the field (Hubbard & Zapf, 2003).

**Clinical Implications for Forensic Practice**

This study explored the effects of demographic variables on CST evaluations with the goal of examining whether culturally and linguistically diverse populations have higher rates of incompetency findings. This study found that defendants with limited English proficiency or defendants that were identified as foreign-born were more likely to be found incompetent. These differences highlight the complexity of competency evaluations when using interpreters, assessing individuals with limited English proficiency, and cultural variables that might impact the assessment of individuals that are foreign-born.

Individuals that required the use of an interpreter were more likely to be found incompetent, which introduces concerns about how examiners are using interpreters during the evaluation process and how it can impact communication. The American Psychological Association (2013) recommends that individuals with limited English proficiency are provided with examiners that are fluent in their primary language, but the lack of bilingual psychologists in the field makes this a far-reaching goal (Canales et al., 2017; Maddux, 2010). Maddux (2010) notes the importance of relying on well-qualified interpreters to maintain the reliability and validity of assessments, but it is unclear how interpretations may impact assessments due to the lack of research in this area. There is a need for psychologists to increase their knowledge about the dynamics of interpretations as a matter of increasing their cultural sensitivity and competence in working with diverse populations. For example, examiners should be well versed in the different styles and modalities that can be used during assessments that may impact the quality of clinical information collected during competency assessments (Canales et al., 2017; Weiss &

Rosenfeld, 2012). It is recommended that examiners meet with interpreters before starting the evaluation to discuss expectations, style of interpretation, purpose of the evaluation, and issues that may arise during the evaluation (Weiss & Rosenfeld, 2012). Examiners are also encouraged to rely on the same interpreters when multiple sessions are required. This may enhance rapport building and the consistency of the data collected via interpretations (Maddux, 2010). There is some evidence to suggest that some examiners may use interpreters during test administration and rely on ad hoc interpretations of testing materials (Canales et al., 2017). This is generally discouraged because it can result in errors due to inaccuracies in translations, potential distortions of questions and responses, semantic difference in translations, and lack of training in translating tests (Weiss & Rosenfeld, 2012). It is important to remain aware that linguistic and cultural differences may impact assessments and examiners should refer to cultural consultants, attorneys, and collateral sources of information to inform their opinions (Maddux, 2010).

Another alternative explanation to differences observed in this study that should be considered is interviewer bias that may be impacting competency screening interviews and examiner bias impacting competency evaluations. Zapf & Dror (2017) provide some guidelines in helping to reduce bias in forensic evaluations and guarding against a "bias blind spot" in which professionals may recognize bias in others but do not see their own biases. For example, examiners can reduce bias by using a standardized approach when assessing competency to increase the reliability and validity of their assessments. This will help to reduce idiosyncratic approaches that examiners may use when working with individuals of different cultural backgrounds and limited English proficiency. Forensic examiners are encouraged to attend professional trainings geared towards adopting effective strategies in reducing cognitive bias in forensic evaluations (Zapf & Dror, 2017). For example, examiners should develop systematic

ways in collecting and reviewing data (Neal & Brodsky, 2016). This can force examiners to slow down and reduce the influence of heuristics by helping them to integrate multiple sources of information, encourage consultation with colleagues, and limit exposure to information that may bias their work. Lastly, another way to reduce the influence of bias is to make use of standardized measures and/or checklists that ensure coverage of essential elements in competency assessments that will help examiners rely on relevant information to answer the ultimate legal question and regularly consider rule outs and/or disconfirming information that contradicts their working hypothesis (Neal & Brodsky, 2016).

These strategies should be adapted to increase multicultural sensitivity during the evaluation process by encouraging examiners to develop systematic ways of considering cultural factors. For example, the DSM-5 encourages clinicians to use a cultural formulation interview that can help to elicit information about an individual's cultural identity, cultural variances in conceptualizing clinical issues, and cultural features of the relationship between the individual and the clinician (American Psychiatric Association, 2013). The cultural formulation interview may be used as a checklist to help examiners consider cultural and linguistic factors that examiners may not be actively considering during the assessment and conceptualization of cases. This may reduce cognitive biases by challenging heuristics and stereotypic information about defendants from different ethnic and cultural backgrounds.

Another way to systematically consider cultural factors may be to use structured acculturation measures, such as the Short Acculturation Scale for Hispanics or the Bidimensional Acculturation Scale for Hispanics, that can inform examiners about an individual's familiarity with the American culture, assess proficiency with the English language, and consider time spent in the United States (Canales et al., 2017; Weiss & Rosenfeld, 2012). Examiners may use

structured measures to assess acculturation or develop their own checklist of questions that can facilitate exploration of cultural factors to inform competency assessments. This would be an important step in helping examiners to rule out cultural differences (e.g. distrust in legal system, unfamiliarity with American System) that are not associated with psychological impairment and/or competency abilities.

Lastly, it is paramount that those in the forensic psychology field develop forensic assessment instruments that are normed with diverse populations and translate instruments with good psychometric support into other languages so normative data can be collected. This will help to increase the reliability and validity of forensic assessments by ensuring that psychologists have the tools necessary to serve defendants with limited English proficiency. Canales et al. (2017) found that examiners reported using objective assessment instruments less often with non-English speakers and English-speaking Hispanic defendants. This may be a result of limited testing instrument availability in the marketplace, the lack of familiarity with tests that could be used with non-English speakers, and the lack of representative norms. The differences found in the current study suggest we should also be exploring performance differences on competency to stand trial measures and other forensic assessment instruments between foreign-born and native-born defendants. The results in this study serve as a reminder that examiners should remain aware of how cultural and linguistic differences may impact clinical interviews, test performance, and how they perceive symptom severity and competency abilities.

**Limitations and Future Research**

One limitation of the present study is related to the use of archival data that relied on information documented in an examiner's report. This potentially led to distortions in how target variables were captured in this study. Furthermore, there may be linguistic and cultural factors

that influenced an examiner's opinion that are not documented in the report (e.g. birthplace, linguistic proficiency). These factors might be subtle and not apparent to an examiner, and the variables that were coded might not capture such factors. For example, identifying defendants that were bilingual was challenging since examiners did not address this regularly in their reports. It was expected that a much higher number of individuals would be identified as bilingual since the sample in this study is composed of a large proportion of Hispanic and/or foreign-born defendants. The inability to consistently capture this is a weakness of this study, as examiners may not have documented linguistic ability consistently. It is interesting to note that even with these challenges in isolating target variables there were significant differences found across some demographic variables.

Due to the reliance on information only available in reports, this study did not allow for exploration of other factors, such as race/ethnic and linguistic differences between examiner and examinee, which may influence the examiner to examinee relationship. For example, Malgady and Costantino (1998) found that race/ethnic differences between clinician and patient may influence clinical presentation and an examiner's perception of psychological issues during clinical interviews. The use of interpreters could also influence the examiner to examinee relationship (Maddux, 2010). These types of factors may influence the examiner/examinee relationship that are largely unexplored in the research literature. Future research may explore how ethnic and cultural differences between an examiner and examinee may influence clinical presentation, rapport building, perception of clinical issues, test performance, and potential impact on examiner opinion in regards to psycholegal issues (e.g. competency, criminal responsibility) (Maddux, 2010; Malgady & Costantino, 1998).

The current study contributes to the field exploring group differences relative to competency findings. This study is one of the few studies exploring how linguistic and cultural differences in foreign-born defendants may impact competency decisions. There are significant gaps in the research exploring the effects of forensic assessments on diverse populations. This is important as the demographics of the U.S. population continue to change and forensic evaluators have a very limited toolset to use with individuals who speak other languages. Lastly, the impact of using forensic assessment instruments with foreign-born individuals remains largely unexplored. New research should not only consider race and ethnicity variables, but also consider linguistic and immigration histories that may impact forensic assessments.

The present study considered the influence of demographic variables (e.g. language spoken, birthplace, race/ethnicity) on CST evaluations. The mixed results suggest that the influence of language and cultural variables on CST evaluations is complex and merits further exploration. Future research should explore how the use of interpreters, translations of forensic assessment instruments, and cognitive bias may impact assessment with defendants that are foreign-born and/or speak other languages. Given the continued influx of Hispanic and other minorities into the criminal justice system, it is imperative that the research explores how linguistic and cultural differences may lead to differences in competency findings. The consequences of inaccurate forensic assessments may carry significant consequences for defendants going through the criminal justice system, and the lack of research limits the ability of forensic examiners to rely on evidence-based practices to inform their work with diverse populations.

# REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5™ (5th ed.)*. Arlington, VA: American Psychiatric Publishing, Inc.

American Psychological Association. (2013). Specialty guidelines for forensic psychology. *The American Psychologist*, *68*(1), 7-19. doi:10.1037/a0029889

Alegría, M., Canino, G., Shrout, P. E., Woo, M., Duan, N., Vila, D., . . . Meng, X. L. (2008). Prevalence of mental illness in immigrant and non-immigrant U.S. Latino groups. *American Journal of Psychiatry, 165*(3), 359-369. doi: 10.1176/appi.ajp.2007.07040704

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. doi: 10.1176/appi.ps.61.8.76510.1176/ps.2010.61.8.765

Benuto, L. T. (Ed.). (2015). *Guide to psychological assessment with Hispanics.* Boston, MA: Springer US.

Benuto, L. T. (2017). *Toolkit for Counseling Spanish-Speaking Clients : Enhancing Behavioral Health Services*. Cham: Springer.

Bonnie, R. (1990). The competence of criminal defendants with mental retardation to participate in their own defense. *Journal of criminal law and criminology, 81*(3), 419-446. doi:10.2307/1143845

Bonnie, R. (1992). The competence of criminal defendants: A theoretical reformulation. *Behavioral Sciences and the Law, 10*(3), 291-316. doi:10.1002/bsl.2370100303

Bonnie, R., & Grisso, T. (2000). Adjudicative competence and youthful offenders. In T. Grisso & R. Schwartz (Eds.), Youth on trial: A developmental perspective on juvenile justice (pp. 73-104). Chicago: University of Chicago Press.

Bureau of Justice Statistics. (2014). *Bulletin: Prisoners in 2013*. (NCJ 247282). Washington, DC: U.S. Government Printing Office.

Caldwell, R. M., Mandracchia, S. A., Ross, S. A., & Silver, N. C. (2003). Competency to stand trial and criminal responsibility: An examination of racial and gender differences among African American and Caucasian pretrial defendants. *American Journal of Forensic Psychology, 21*(3), 5-19.

Canales, E. J., Kan, L. Y., & Varela, J. G. (2017). Forensic assessment with Hispanic and limited English-proficient Hispanic evaluees: A survey of practice. *Professional Psychology: Research and Practice, 48*(2), 122-130. doi:10.1037/pro0000112

Choi, M. R., Eun, H. J., Yoo, T. P., Yun, Y., Wood, C., Kase, M., . . . Yang, J.C. (2012). The Effects of sociodemographic factors on psychiatric diagnosis. *Psychiatry Investigation, 9*(3), 199-208. doi:10.4306/pi.2012.9.3.199

Chong, J., Reinschmidt, K. M., & Moreno, F. A. (2010). Symptoms of depression in a Hispanic primary care population with and without chronic medical illnesses. *Primary care companion to The Journal Of Clinical Psychiatry, 12*(3), 212-248. doi: 10.4088/PCC.09m00846blu

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*, 155-159. doi:10.1037/0033-2909.112.1.155

Crocker, A. G., Favreau, O. E., & Caulet, M. (2002). Gender and fitness to stand trial. A 5-year review of remands in Québec. *International Journal Of Law And Psychiatry, 25*(1), 67-84. doi:10.1016/S0160-2527(01)00089-9

Del Castillo, J. C. (1970). The influence of language upon symptomatology in foreign-born patients. *American Journal of Psychiatry, 127*(2), 242-244. doi:10.1176/ajp.127.2.242

Drogin, E. Y. (2011). *Handbook of forensic assessment: Psychological and psychiatric perspectives.* Hoboken, N.J: John Wiley and Sons.

Drope v. Missouri, 420 U. S. 162 (1975).

Dusky v. United States, 362 U.S. 402 (1960).

Espinoza, R. K. E., & Willis-Esqueda, C. (2008). Defendant and defense attorney characteristics and their effects on juror decision making and prejudice against Mexican Americans. *Cultural Diversity and Ethnic Minority Psychology, 14*(4), 364-371. doi:10.1037/a0012767

Fabrega, J. H., Mulsant, B. M., Rifai, A. H., Sweet, R. A., Pasternak, R., Ulrich, R., & Zubenko, G. S. (1994). Ethnicity and psychopathology in an aging hospital-based population. A comparison of African-American and Anglo-European patients. The Journal of Nervous and Mental Disease, 182(3), 136-144. doi:10.1097/00005053-199403000-00002

Florida Statute § 916.12, 2016

Frierson, R. L., Shea, S. J., & Shea, M. E. (2002). Competence-to-stand-trial evaluations of geriatric defendants. *Journal of the American Academy of Psychiatry and the Law Online, 30*(2), 252-256. doi:10.1016/j.ijlp.2009.02.009

Gacono, C. B., & Evans, B. (Eds.). (2007). *The handbook of forensic rorschach assessment (personality and clinical psychology)* (1 ed.). New York, NY: Routledge.

Goldyne, A. J. (2007). Minimizing the influence of unconscious bias in evaluations: A practical guide. *Journal of the American Academy of Psychiatry and the Law Online, 35*(1), 60-66.

Grisso, T., & Appelbaum, P. (1995). The MacArthur Treatment Competence Study. III: Abilities of patients to consent to psychiatric and medical treatments. *Law and Human Behavior, 19*(2), 149-174. doi:10.1007/BF01499323

Harlow, C. W. (2000). *Defense counsel in criminal cases*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Hicks, J. (2004). Ethnicity, race, and forensic psychiatry: Are we color-blind? *The Journal of the American Academy of Psychiatry and the Law, 32*, 21-33.

Hoge, S. K., Bonnie, R., Poythress, N., & Monahan, J. (1992). Attorney-client decision-making in criminal cases: Client competence and participation as perceived by their attorneys. *Behavioral Sciences and the Law, 10*, 385-394. doi:10.1002/bsl.2370100308

Hubbard, K. L., & Zapf, P. A. (2003). The role of demographic, criminal, and psychiatric variables in examiners' predictions of restorability to competency to stand trial. *International Journal of Forensic Mental Health, 2*(2), 145-155. doi: 10.1080/14999013.2003.10471186

Jacobs, M. S., Ryba, N. L., & Zapf, P. A. (2008). Competence-related abilities and psychiatric symptoms: an analysis of the underlying structure and correlates of the MacCAT-CA and the BPRS. *Law and Human Behavior, 32*(1), 64-77. doi: 10.1007/s10979-007-9086-8

Kalbeitzer, R., & Benedetti, R. (2009). Assessment of competency to stand trial in individuals with mental retardation. *Journal of Forensic Psychology Practice, 9*(3), 237-248. doi: 10.1080/15228930902809955

Kilgus, M. D., Pumariega, A. J., & Cuffe, S. P. (1995). Influence of race on diagnosis in adolescent psychiatric inpatients. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*(1), 67-72. doi:10.1097/00004583-199501000-00016

Kirkish, P., & Sreenivasan, S. (1999). Neuropsychological assessment of competency to stand trial evaluations: A practical conceptual model. *Journal of the American Academy of Psychiatry and the Law, 27*(1), 101-113.

LaFortune, K., & Nicholson, R. (1995). How adequate are Oklahoma's mental health evaluations for determining competency in criminal proceedings? The bench and the bar respond. *Journal of Psychiatry and Law, 23*, 231-262. doi:10.1177/009318539502300202

Maddux, J. (2010). Recommendations for forensic evaluators conducting interpreter-mediated interviews. *International Journal of Forensic Mental Health, 9*(1), 55-62. doi:10.1080/14999013.2010.483343

Malgady, R. G., & Costantino, G. (1998). Symptom severity in bilingual Hispanics as a function of clinician ethnicity and language of interview. *Psychological Assessment, 10*(2), 120-127. doi:10.1037/1040-3590.10.2.120

Marcos, L. R. (1979). Effects of interpreters on the evaluation of psychopathology in Non-English-Speaking patients. *American Journal of Psychiatry, 136*(2), 171-174. doi:10.1176/ajp.136.2.171

Marcos, L. R., Alpert, M., Urcuyo, L., & Kesselman, M. (1973). The effect of interview language on the evaluation of psychopathology in Spanish-American schizophrenic patients. *American Journal of Psychiatry, 130*(5), 549-553. doi:10.1176/ajp.130.5.549

Marin, H., Bernal, G., Karno, M., Guarnaccia, P., Alvidrez, J., Lopez, S., . . . Vega, W. A. (2007). Research issues for improving treatment of U.S. Hispanics with persistent mental disorders. *Psychiatric Services, 58*(3), 385-394. doi:10.1176/ps.2007.58.3.385

Marouf, F. (2014). Incompetent but deportable: the case for a right to mental competence in removal proceedings. *Hastings Law Journal, 65*(4), 929-998.

McCallum, K. E., MacLean, N., & Neil Gowensmith, W. (2015). The impact of defendant ethnicity on the psycholegal opinions of forensic mental health evaluators. *International Journal of Law and* Psychiatry, 39, 6-12. doi: 10.1016/j.ijlp.2015.01.015

Mezzich, J. E., & Caracci, G. (2008). *Cultural Formulation: A Reader for Psychiatric Diagnosis*. Lanham, MD: Jason Aronson, Inc.

Minsky, S., Vega, W., Miskimen, T. M., Gara, M., & Escobar, J. (2003). Diagnostic patterns in Latino, African American, and European American psychiatric patients. *Archives of General Psychiatry,* 60, 637-644. doi:10.1001/archpsyc.60.6.637

Morris, G. H., Haroun, A. M., & Naimark, D. (2004). Assessing competency competently: toward a rational standard for competency-to-stand-trial assessments. *Journal of the American Academy of Psychiatry and the Law Online, 32*(3), 231-245.

Mossman, D., Noffsinger, S. G., Ash, P., Frierson, R. L., Gerbasi, J., Hackett, M., . . . Zonana, H.V. (2007). AAPL Practice Guidelines for the forensic psychiatric evaluation of competence to stand trial. *The Journal of the American Academy of Psychiatry and the Law, 35*(4 Suppl), S3. doi:10.29158/JAAPL.003781-18

Mukherjee, S., Shukla, S., Woodle, J., Rosen, A. M., & Olarte, S. (1983). Misdiagnosis of schizophrenia in bipolar patients: a multiethnic comparison. American Journal of Psychiatry, 140(12), 1571-1574. doi: 10.1176/ajp.140.12.1571

Neal, T. M. S., & Brodsky, S. L. (2016). Forensic psychologists' perceptions of bias and potential correction strategies in forensic mental health evaluations. *Psychology, Public Policy, and Law, 22*(1), 58-76. doi: 10.1037/law0000077

Nicholson, R. A., & Kugler, K. E. (1991). Competent and incompetent criminal defendants: A quantitative review of comparative research. *Psychological Bulletin, 109*(3), 355-370. doi: 10.1037/0033-2909.109.3.355

Otto, R. K. (2006). Competency to stand trial. *Applied Psychology in Criminal Justice, 2*(3), 82-113.

Paradis, C. M., Owen, E., Solomon, L. Z., Lane, B., Gulrajani, C., Fullar, M., . . . McCullough, G. (2016). Competency to stand trial evaluations in a multicultural population: Associations between psychiatric, demographic, and legal factors. *International Journal of Law and Psychiatry, 47*, 79-85. doi: 10.1016/j.ijlp.2016.02.039

Pate v. Robinson, 383 US 375 (1966).

Pew Research. (2015). English proficiency on the rise among Latinos. Retrieved from http://www.pewhispanic.org/2015/05/12/english-proficiency-on-the-rise-among-latinos/

Pirelli, G., Gottdiener, W. H., & Zapf, P. A. (2011). A meta-analytic review of competency to stand trial research. *Psychology, Public Policy, and Law, 17*(1), 1-53. doi: 10.1037/a0021713

Powers Stafford, K., & Sellbom, M. O. (2012). Assessment of competence to stand trial. In R. K. Otto (Ed.), *Handbook of psychology: Forensic Psychology* (2nd ed., Vol. 11). Hoboken, NJ: John Wiley & Sons.

Price, J. (1975). Foreign language interpreting in psychiatric practice. *The Australian and New Zealand Journal of Psychiatry, 9*(4), 263-267. doi:10.3109/00048677509159860

Price, C. S., & Cuellar, I. (1981). Effects of language and related variables on the expression of psychopathology in Mexican American psychiatric patients. *Hispanic Journal of Behavioral Sciences, 3*(2), 145-160. doi:10.1007/s11606-007-0311-4

Prison Policy Initiative. (2012). *United States incarceration rates by race and ethnicity, 2010*. Northampton, MA: Wagner, P.

Rogers, R., Gillis, J. R., McMain, S., & Dickens, S. E. (1988). Fitness evaluations: A retrospective study of clinical, criminal, and sociodemographic characteristics. *Canadian Journal of Behavioural Science/Revue canadienne des Sciences du comportement, 20*(2), 192-200. doi: 10.1037/h0079925

Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World Journal of Psychiatry, 4*(4), 133-140. doi: 10.5498/wjp.v4.i4.133

Siegert, M., & Weiss, K. J. (2007). Who is an expert? Competency evaluations in mental retardation and borderline intelligence. *The Journal of the American Academy of Psychiatry and the Law, 35*(3), 346-349.

Simeone, J. C., Ward, A. J., Rotella, P., Collins, J., & Windisch, R. (2015). An evaluation of variation in published estimates of schizophrenia prevalence from 1990-2013: A systematic literature review. *BMC Psychiatry, 15(*1), 193-207. doi:10.1186/s12888-015-0578-7

Steadman, H. J. (1979). *Beating a rap?: Defendants found incompetent to stand trial.* Chicago: University of Chicago Press.

Stefan, S. (1996). Race, competence testing, and disability law: a review of the MacArthur Competence Research. *Psychology, Public Policy, and Law, 2*, 31-44. doi:10.1037/1076-8971.2.1.31

Strakowski, S. M., Shelton, R. C., & Kolbrener, M. L. (1993). The effects of race and comorbidity on clinical diagnosis in patients with psychosis. *The Journal of Clinical Psychiatry, 54*(3), 96-102.

SPSS. (2015). *IBM SPSS Statistic 23.0 Command Syntax Reference*. Chicago: SPSS Inc.

Susuki, L. A., & Ponterotto, J. G. (2008). *Handbook of multicultural assessment: Clinical, psychological, and educational applications* (3rd ed.). San Francisco: Jossey-Bas.

U.S. Census Bureau (2015) *Census Demographic Profile Summary File.* Retrieved fom https://www.census.gov/population/www/cen2010/glance/

Varela, J. G., Boccaccini, M. T., Gonzalez, E., Jr., Gharagozloo, L., & Johnson, S. M. (2011). Do defense attorney referrals for competence to stand trial evaluations depend on whether the client speaks English or Spanish? *Law and Human Behavior, 35*(6), 501-511. doi:10.1007/s10979-010-9253-1

Vega, W. A., Sribney, W. M., Miskimen, T. M., Escobar, J. I., & Aguilar-Gaxiola, S. (2006). Putative psychotic symptoms in the Mexican American population. *The Journal Of Nervous And Mental Disease, 194*(7), 471-477. doi:10.1097/01.nmd.0000228500.01915.ae

Walters, E. E., Kessler, R. C., Demler, O., & Chiu, W. T. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62*(6), 617-627. doi:10.1001/archpsyc.62.6.617

Weisman, A. G., Lopez, S. R., Ventura, J., Nuechterlein, K. H., Goldstein, M. J., & Hwang, S. (2000). A comparison of psychiatric symptoms between Anglo Americans and Mexican-Americans with schizophrenia. *Schizophrenia Bulletin, 26*(4), 817-824. doi:10.1093/oxfordjournals.schbul.a033496

Weiss, R. A., & Rosenfeld, B. (2012). Navigating cross-cultural issues in forensic assessment: recommendations for practice. *Professional Psychology: Research and Practice, 43*(3), 234-240. doi: 10.1037/a0025850

Youtsey v. United States, 97 F. 937 (1899).

Zapf, P. A., & Dror, I. E. (2017). Understanding and mitigating bias in forensic evaluation: Lessons from forensic science. *International Journal of Forensic Mental Health*, *16*(3), 227-238. doi:10.1080/14999013.2017.1317302

Table 1

*Sample Characteristics*

| Variable | *N* | *%* | *M* | *SD* | Range |
|---|---|---|---|---|---|
| Sex | | | | | |
| Male | 668 | 82.6% | | | |
| Female | 140 | 17.3% | | | |
| Age | | | 37.5 | 14.4 | 16-81 |
| Race/Ethnicity | | | | | |
| Caucasian | 200 | 24.7% | | | |
| African American | 378 | 46.8% | | | |
| Hispanic/Latino | 178 | 22.0% | | | |
| Other | 52 | 6.4% | | | |
| Non-White | 609 | 75.3% | | | |
| White | 200 | 24.7% | | | |
| Education | | | | | |
| No High School | 412 | 50.9% | | | |
| At least HS Diploma | 188 | 40.4% | | | |
| Language | | | | | |
| English | 708 | 87.5% | | | |
| Spanish | 60 | 7.4% | | | |
| Bilingual | 12 | 1.5% | | | |
| Other | 29 | 3.6% | | | |
| English Speakers | 720 | 89.0% | | | |
| Non-English Speakers | 89 | 11.0% | | | |
| Foreign-born | | | | | |
| Yes | 178 | 22.0% | | | |
| No | 570 | 70.5% | | | |
| Interpreter Use | | | | | |
| Yes | 67 | 8.5% | | | |
| No | 720 | 89.0% | | | |
| Competency Finding | | | | | |
| Incompetent | 498 | 61.6% | | | |
| Competent | 309 | 38.2% | | | |

Table 1 (continued)

| | | |
|---|---|---|
| Primary Diagnosis | | |
| Psychotic Disorder | 447 | 55.3% |
| Affective Disorder | 139 | 17.2% |
| Intellectual/Cognitive | 133 | 16.4% |
| Other* | 69 | 8.5% |
| Offense Type | | |
| Felony | 597 | 73.8% |
| Misdemeanor | 211 | 26.1% |

*Note.* *Other = Personality Disorder, Substance Use, Malingering

Table 2

*Results of Chi-square test: Language and Competency Findings (English vs. Spanish)*

| | Competency Finding | |
|---|---|---|
| | Competent | Incompetent |
| English | 284 (40.2%) | 422 (59.8%) |
| Spanish | 19 (31.7%) | 41 (68.3%) |

$X^2$ (1, $N$ = 766) = 1.69, $p$ = 0.193, $\phi$ = .047

Table 3

*Results of Chi-square test: Language and Competency Findings (English vs. Non-English)*

| | Competency Finding | |
|---|---|---|
| | Competent | Incompetent |
| English | 286 (39.8%) | 432 (60.2%) |
| Non-English | 23 (25.8%) | 66 (74.2%) |

$X^2$ (1, $N$ = 807) = 6.55, $p$ = 0.010; $\phi$ = .090

Table 4

*Results of Chi-square test: Country of Origin and Competency Findings (Foreign-born vs. Native-born)*

| | Competency Finding | |
|---|---|---|
| | Competent | Incompetent |
| Foreign-born | 52 (29.2%) | 126 (70.8%) |
| Native-born | 244 (42.9%) | 325 (57.1%) |

$X^2$ (1, $N$ = 747) = 10.589, $p$ = 0.001; $\phi$ = -.119

Table 5

*Results of Chi-square test: Use of Interpreter and Competency Findings*

| | Competency Finding | |
|---|---|---|
| | Competent | Incompetent |
| Interpreter | 17 (25.4%) | 50 (74.6%) |
| No Interpreter | 286 (39.8%) | 432 (60.2%) |

$X^2$ (1, $N$ = 785) = 5.406, $p$ = .020; $\phi$ = -.083

Table 6

*Results of Chi-square test: Race and Competency Findings (African American vs. White)*

| | Competency Finding | |
|---|---|---|
| | Competent | Incompetent |
| African American | 145 (38.4%) | 233 (61.6%) |
| White | 86 (43.0%) | 114 (57.0%) |

$X^2$ (1, $N$ = 578) = 1.17, $p$ = .279, $\phi$ = .045

Table 7

*Results of Chi-square test: Race/Ethnicity and Competency Findings (Latino/Hispanic vs. White)*

| | Competency Finding | |
|---|---|---|
| | Competent | Incompetent |
| Latino/Hispanic | 61 (34.3%) | 117 (65.7%) |
| White | 86 (43.0%) | 114 (57.0%) |

$X^2$ (1, $N$ = 378) = 3.02, $p$ = .082, $\phi$ = .089

Table 8

*Results of Chi-square test: Race and Competency Findings (Non-White vs. White)*

| | Competency Finding | |
|---|---|---|
| | Competent | Incompetent |
| Non-White | 223 (36.7%) | 384 (63.3%) |
| White | 86 (43.0%) | 114 (57.0%) |

$X^2$ (1, $N$ = 807) = 2.49, $p$ =.114, $\phi$ = .056

Table 9

*Results of Chi-square test: Psychotic Diagnosis and Race (African American/Latino vs. Caucasian)*

| | Diagnosis | |
|---|---|---|
| | Psychotic | Non-Psychotic |
| White | 107 (54.0%) | 91 (46.0%) |
| African American | 214 (58.0%) | 155 (42.0%) |
| Latino/Hispanic | 95 (55.2%) | 77 (44.8%) |

$X^2$ (2, $N$ = 739) = .921, $p$ =.631, $\phi$ = .035

Table 10

*Results of Chi-square test: Psychotic Diagnosis and Competency Findings*

| | Competency Finding | |
|---|---|---|
| | Competent | Incompetent |
| Psychotic | 116 (26.0%) | 330 (66.9%) |
| Non-Psychotic | 177 (52.1%) | 163 (47.9%) |

$X^2$ (1, $N$ = 786) = 55.99, $p$ < .001; $\phi$ = -.267