



Overcoming Language Barriers to Public Mental Health Services in California

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These CPAC findings summarize a study to assess the effect of the California Department of Mental Health's existing "threshold language" policy on access to care, and to evaluate the effects of other county-level activities to improve access to mental health services for Medi-Cal beneficiaries with limited English proficiency. (A county's threshold language is "3,000 beneficiaries or 5% of the Medi-Cal population, whichever is lower, whose primary language is other than English." A primary language is the one beneficiaries identify as being needed to communicate effectively, including sign language.)

The number of Californians age five and over who speak a language other than English increased from 8.6 million in 1990 to 12.1 million in 2000. Approximately 40% of Californians speak a language other than English at home, while one in three children live in a home where a language other than English is spoken. Among Medi-Cal beneficiaries, approximately 54%—or 3,262,300 people—reported a primary language other than English in 2001.

Latinos are the fastest growing non-English-speaking group. Statewide, nearly 32% of Medi-Cal beneficiaries reported Spanish as their primary language, although the figure is more than 50% in some counties (Colusa, Imperial, and Monterey). The primary reason for these demographic changes is immigration; more immigrants come to California than to any other state. In 2002, California was home to 31% of the nation's foreign-born population.

Many immigrants have limited English proficiency. For example, approximately half of all Mexican immigrants in California have difficulty speaking English. Among Asian immigrants, with the exception of those from the Philippines and India, between 25% and 40% also struggle to communicate clearly in English.

Many people with limited English proficiency are unable to access health and mental health services because of language barriers that persist despite state and federal laws that grant them rights to equal access. The California

Language Access Coalition and other organizations have documented instances in which residents did not benefit from public services because linguistically proficient staff and services were not available. Health care providers, in particular, have been criticized for failing to provide linguistically proficient care.

In order for health and mental health services to be effective, providers must be able to communicate with patients and clients in ways that they can understand. Professionals who cannot communicate, or fail to consider a family's culture, run the risk of having their advice ignored, incorrectly diagnosing the cause of a problem, or failing to develop an appropriate solution. Thus, providers need to have the knowledge and skills to interpret, appreciate, and negotiate linguistic differences.

Study Objectives and Methods

Until this study, there has been no formal evaluation of the empirical effect of county efforts to provide access to mental health services for Medi-Cal populations with limited English proficiency. We set out to measure the effects of different approaches for increasing access to care to help policymakers understand which approaches are most effective and for which populations.

Using specialty Medi-Cal claims data from the Department of Mental Health, Medi-Cal eligibility data from the Department of Health Services, data from two prior surveys the study team conducted, and data from county department of mental health cultural competency plans, we examined how counties implemented the state's threshold language requirement through their mental health plans. We also examined the impact of other county access-related activities, including: 1) presence of bilingual staff; 2) staff training in cultural competency; and 3) presence of language-specific clinics or programs.

Findings

We found that Spanish and Cantonese speakers use county specialty mental health services at a lower rate than English speakers, and that people who speak Southeast Asian languages (Vietnamese, Hmong, and Cambodian) tended to use services at a higher rate. The study did not take into account the latter's need for services, however, which may be greater among this population because many were war refugees.

For Medi-Cal eligibles speaking Spanish and Asian languages, the threshold language requirements had a significant positive effect on mental health service use—and perhaps an even greater effect among Spanish speakers. A relatively high number of bilingual Spanish-speaking staff per eligible client was also significantly related to higher usage rates. Implementation of Spanish threshold language requirements had little additional effect on usage rates in counties with high levels of bilingual staff, but had a significantly greater effect in counties with low levels of bilingual staff.

Among Asians, the results suggest that threshold language requirements did increase access initially, but over time those increases diminished. Implementation of threshold Asian language requirements had a greater effect on usage rates in counties with relatively low levels of cultural competency training and no language-specific program than it did in counties with high levels of cultural competency training or language-specific programs.

These effects are likely to reflect the circular causal effects between usage rates and counties' choices regarding language access programming. Counties with lower usage rates (and that potentially need to put more effort into changing access) may have been more likely to respond to the threshold language designation with higher training levels, more bilingual staff, and establishing language-specific programs—resulting in a seemingly negative relationship between usage rates and programming.

Similarly, the bilingual staff results from the Spanish analysis indicate that counties with more Spanish bilingual staff appeared to have greater usage rates before Spanish was designated a threshold language and thus did not show an additional increase.

Overall, the effect of threshold language designation appeared to increase use of mental health services for Asian- and Spanish-speaking adults, with rates of change varying according to county program characteristics. It appears likely that language-specific programs and higher bilingual staff levels increase use of mental health services. However, the potential for circular causal effects hindered attempts to clearly identify these county program effects.

The lack of consistent findings concerning the effectiveness of cultural competency training may be due to the lack of consistency in and type of training.

The counties' Cultural Competency Plans have a wide variety of training methods, frequency, duration, attendance, and impact. Standardization of training efforts, including requirements for the training of interpreters in mental health services, may improve the overall effectiveness of training.

Policy Implications

The California Department of Mental Health requirement that county-operated mental health agencies provide information and services to Medi-Cal beneficiaries in their primary language when the number of beneficiaries reaches threshold levels appears to be effective in improving access to services, primarily in counties that had the lowest access rates and fewest language-access activities prior to the policy's initiation. Although we cannot speak to its cost-effectiveness, we can say that, overall, the policy appears to be accomplishing its goals by improving access in the counties where language access was previously the lowest.

The study also suggests that bilingual providers and language-specific clinics/programs have a positive effect on language access and, in some cases, have given a boost to the implementation of the threshold language policy. A number of California counties are engaging in innovative ways to increase the number of bilingual providers.

In addition, the passage of Proposition 63 provides resources for expanding the mental health workforce. Bilingual providers should be high on the priority list to improve access for California citizens with limited English proficiency. Standardization of training efforts, including requirements for the training of interpreters in mental health services, may improve the overall effectiveness of training activities.

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