
Federal Civil Rights Policy and Mental Health Treatment Access for Persons With Limited English Proficiency

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As noted in the supplement to the U.S. Surgeon General's report on mental health (U.S. Department of Health and Human Services, 2001), overcoming language access barriers associated with limited English proficiency (LEP) should help to eliminate racial and ethnic disparities in mental health care access and quality. Federal policy requires remedial action to overcome language barriers: Under Title VI of the Civil Rights Act of 1964, Medicaid and other federally funded programs must provide assistance to LEP persons. Some state-level public and mental health authorities have responded by instituting "threshold language" policies. The history and terms of federal civil rights policy, and of threshold-language-policy-inspired initiatives, should be understood by everyone concerned with overcoming ethnic disparities in mental health services use. Concerned parties should promote implementation of required measures for language assistance and help to evaluate their implementation and effectiveness.

Keywords: language access, barriers to care, limited English proficiency, minority, treatment disparities

The presence of large numbers of persons with limited proficiency in English is a significant and growing fact of life in the United States. The 2000 Census showed that over 26 million American citizens or residents speak Spanish at home and almost 7 million individuals speak an Asian or Pacific Island language at home (U.S. Census Bureau, 2000). If people have a limited ability to read, write, speak, or understand English, they have limited English proficiency, or LEP (U.S. Department of Justice, 2002).

As we show in this article, persons with LEP demonstrate the highest levels of disparities in public mental health care access and quality. Because they tend to be recent immigrants who generally lack economic opportunities, they are overrepresented among the poor and among persons eligible for Medicaid and other public health and mental health programs. Their LEP status creates a language barrier that makes it difficult for them to enter and continue treatment. Untreated mental health problems then lead to greater personal suffering and functional disability, thus even further limiting these persons' capacity to care for themselves and their families and complicating their

attempts to master English. One of the key objectives set forth in the report *Race, Culture, Ethnicity and Mental Health: A Supplement to Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services [DHHS], 2001) is the elimination of disparities in access to specialty mental health care. Advocacy is important for meeting that objective, and LEP policy provides strong arguments for advocates. Research is important too—research that can inspire advocacy and guide outreach and remediation efforts.

Discussions focusing on ways to increase providers' capacity to offer mental health treatment in non-English languages are important, but they often overlook the role of federal policy aimed at the language barrier and other disparities (Smedley, Stith, & Nelson, 2003). Under Title VI of the Civil Rights Act of 1964, assistance *must be provided* to persons designated as "limited English proficiency" when they access Medicaid and other federally funded programs. A number of state-level public health and mental health authorities have responded to this legislation by instituting "threshold language" policies to address beneficiaries' language-related needs. All of these policies are similar in that they specify a number or proportion of speakers of a language that, when exceeded, triggers a variety of programmatic steps that must be taken to accommodate the group's language-related needs and thus provide linguistic access to public services (Alcalde & Morse, 2000). States vary widely in their demographic characteristics, state and local health care delivery system charac-

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We gratefully acknowledge the California Program on Access to Care at the University of California for research funding and the California Department of Mental Health for research data and consultation. We also gratefully acknowledge the National Institute of Mental Health for research funding in the form of Grant R01MH070942 to study the impact of California's threshold language policy requirements on access and continuity of care for Medi-Cal beneficiaries ages 19–64 during the period from July 1997 to June 2003.

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teristics, and state and local policies and customs; therefore, states vary widely in their threshold language definitions and in their individual capacities to respond to their LEP populations.

We begin to redress these gaps in the present article. We restrict our discussion to mental health services even though Title VI has been applied largely to reducing LEP barriers to general medical care. General medical care and mental health care share important features: Good communication is a cornerstone of each. However, we believe that a particular focus on mental health is justified because mental health conditions are especially stigmatizing, opportunities for cultural misunderstanding are particularly great, and the mental health treatment system is highly specialized. Furthermore, LEP appears to be more closely linked to the need for mental health care than to the need for general medical care (Eibner & Sturm, 2006) and may interfere especially with mental health treatment seeking.

We first discuss how language proficiency and preference—with regard to LEP—are tied to understanding disparities and to the wider field of minority mental health. Turning to LEP and access to mental health care, we document just how significant a deterrent to mental health treatment the language barrier poses. We next present some of the intent and enforcement history of Title VI of the Civil Rights Act of 1964 as it applies to LEP and has been enacted in threshold language policy, in order to increase familiarity with the issues. We then address two barriers to successful implementation: absence of a capacity to provide language assistance and lack of funding for language assistance services. Finally, from the foregoing, we consolidate arguments for advocates and propose promising areas for research. We hope that by focusing attention on Title VI, we can increase the possibility that its full potential to serve as a vehicle for overcoming the all-too-prominent language barrier to accessing and receiving high-quality mental health treatment will be realized.

Language Proficiency and Limited English Proficiency in Research on Minority Mental Health

Investigators addressing the mental health of ethnic minority populations have long worked to document barriers to treatment access (e.g., Barrera, 1978). As they have paid greater attention to other priorities—particularly to understanding whether minority persons and White persons differ in their response to evidence-based psychological treatments (Miranda et al., 2005)—researchers have continued to focus on disparities in treatment access (Cauce et al., 2002; Leong & Lau, 2001; Snowden & Yamada, 2005; Vega & Lopez, 2001).

In various guises, LEP has played an important role in attempts to understand treatment access barriers and in the wider attempt to understand mental illness and mental health as they are experienced by ethnic minority populations. Acculturation (Chun, Balls-Organista, & Marin, 2003) is central to much psychological theorizing, and research and acculturation measurement instruments often

include indicators of language preference or language proficiency. Conceiving of mental health problems in culturally preferred terms and expressing one's suffering in an "idiom of distress" (e.g., "*ataque de nervios*"; Lopez & Guarnaccia, 2000) reflect deeply held, culturally sanctioned understandings of mental-health-related sufferings. Many such idioms are formulated in languages other than English. A sense of affiliation and ethnic and cultural identity (e.g., Dana, 1998; Uba, 1994) can be reinforced by living in a community of speakers of a language other than English and by interacting in primary group relationships with speakers of a common non-English language. Intergenerational conflict in immigrant and refugee families (Ying, 1999; Ying, Combs, & Lee, 1999; Ying & Han, in press) is manifest and can be exacerbated by differences in the rates at which parents and children learn English. Acculturative stress (Berry, Kim, Minde, & Mok, 1987; Vega & Rumbaut, 1991) partly reflects conflict and the frustration arising as a non-English speaker struggles through day-to-day encounters with persons who speak only English (Yeh & Inose, 2003).

Providing mental health treatment in a culturally competent manner (Sue, 1998) can be understood to include being fluent in a client's cultural outlook and shifting from the perspective of a professional mental health practitioner to that of a culturally committed client. The process goes forward through communication in a shared vocabulary and with a shared sense of meaning. Criteria for assessing cultural competency often address clinician language proficiency, requiring that culturally competent clinicians speak the language of clients with whom they work. One recommendation for assessing clinician cultural competence is to "examine language skills—the degree to which clinicians speak the language of their clients, whether clinicians understand idiomatic expressions even when expressed in a common language, and how clinicians use language to elicit additional information from consumers and their families" (Vega & Lopez, 2001, p. 196).

In these and other ways, LEP, and language proficiency considerations in general, directly and indirectly informs psychological theory and research. Our aim is to complement such work by focusing on how LEP itself thwarts specialty mental health treatment access and undermines successful treatment participation and by focusing on policies already in place that acknowledge LEP as a barrier and offer instruments for remediation.

The Language Barrier: Empirical Findings

How great a barrier is LEP? Epidemiologic studies are the best source of evidence to answer this question. Their representative sampling improves external validity (Sue, 1999) and their large sample sizes enhance statistical power required for studying specialty-sector mental health service use, which remains a relatively rare event.

Research from the Los Angeles site of the National Institute of Mental Health Epidemiological Catchment Area Study found that among Mexican Americans experi-

encing mental disorders, those lowest in acculturation and most likely LEP were only half as likely to seek specialty care as were those born in the United States (Wells, Golding, Hough, Burnam, & Karno, 1988). Later, in the “Fresno study” of 4,000 Mexican Americans in Fresno County, California (Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999), findings again indicated that Mexican Americans born in Mexico, and therefore most likely LEP, were least likely to seek specialty care.

Reports from the Chinese American Psychiatric Epidemiology Survey, which sampled 1,747 Chinese immigrants and U.S. born residents of Los Angeles County, provide additional indirect evidence that LEP is indeed a barrier to mental health help seeking. Kung (2003) reported that persons who were more acculturated, and were therefore more likely proficient in English, were also more likely to use the services of a mental health treatment specialist. However, data from the study indicate that *perceiving* language to be a barrier to mental health help seeking is unrelated to mental health help seeking (Abe-Kim, Takeuchi, & Hwang, 2002).

Directly assessing LEP and its impact on mental health access, one research team found that Spanish-speaking Latino patients were significantly less likely than English-speaking Latinos and Whites to have had a mental health visit (Fiscella, Franks, Doescher, & Saver, 2002). In a Canadian sample, Li and Browne (2000) found that among Asians, poor English language ability was a major barrier to accessing mental health services.

Two recent California-based studies documented a strong association between LEP and poor mental health treatment. The first study (Snowden, Masland, & Guerrero, 2003) calculated quarterly language-specific Medicaid mental health “penetration rates”—proportions of Medicaid-eligible persons who received specialty mental health treatment each quarter—for speakers of five non-English languages from July 1998 to October 2001. For Spanish and Cantonese speakers, all quarterly mental health penetration rates were substantially below those for English speakers. Only penetration rates for Southeast Asian LEP groups (Vietnamese, Hmong, and Cambodian speakers) were higher than those for English speakers. Conceivably, the higher Southeast Asian rates reflect the extreme conditions under which these groups departed their native countries and which resulted in particularly high levels of mental health need and subsequent treatment.

The second study (Sentall & Shumway, 2004) used the 2001 California Health Interview Survey (CHIS) and its probability sample of 55,428 Californians to comprehensively evaluate LEP as a barrier to mental health treatment, comparing its impact to that of other well-known barriers. About 12% of CHIS interviews were conducted in a language other than English, and the interview posed questions relating to language proficiency. Among persons who acknowledged needing help for emotional or mental health problems, 50% of persons who spoke English “very well” received any care, whereas 29% who spoke English “well,” and only 9% who spoke English “not well or not at all,” received any care.

Additional findings from this study further indicate that English language proficiency, more than other correlates of ethnicity, was the primary barrier to accessing mental health services. In a regression equation predicting service use and controlling for ethnicity, insurance status, LEP, and demographic and other covariates, the odds ratio for speaking English “not well or not at all” was only .20 ($p < .001$). LEP was a notably more important barrier than were other recognized correlates including ethnicity (Asian/Pacific Islander odds ratio = .70, $p > .001$; Latino odds ratio = .68, $p > .001$; African American odds ratio = .62, $p > .001$) and lack of health insurance (odds ratio = .48, $p > .001$) (Sentall & Shumway, 2004).

In the recently completed National Latino and Asian American Study (Alegria et al., 2004), respondents from eight Latino and Asian ethnic subgroups were interviewed in four non-English languages as well as in English. This study can furnish detailed and rigorous estimates of LEP as a barrier in a theoretical context of related cultural and other differences. While we await publication of LEP-related data from the study, we observe that present evidence indicates that LEP in its own right is a profound barrier to access.

Federal Law and Language Access: Title VI of the Civil Rights Act

Title VI of the Civil Rights Act of 1964 stipulates that no person should “on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or subject to discrimination under any program or activity receiving Federal financial assistance” (Civil Rights Act of 1964, § 601). Because LEP persons usually have non-U.S. “national origins,” and because providing them with health or mental health services that they cannot use “excludes” them or otherwise “denies” them “the benefits of” such care, then failure to address the language barrier has a disproportionate and unjustified effect—that is, a “disparate impact”—on people with non-U.S. national origins, and failure to address the language barrier becomes a violation of Title VI. By this logic, Title VI requires that all entities receiving funds from the federal DHHS—including state Medicaid agencies, managed care plans, and hospitals—take adequate steps to ensure that individuals receive, free of charge, the language assistance necessary to afford them equal access to services.

Over the years—with specific reference to “disparate impact” discrimination challenges—the scope of Title VI has been reduced, and enforcement barriers have been erected. Significantly, in *Alexander v. Sandoval* (2001), the U.S. Supreme Court denied the right of *private citizens* to sue potential violators under the “disparate impact” theory, requiring that their claims meet a more stringent overt exclusion standard termed “intentional discrimination.” Since *Alexander v. Sandoval*, only the U.S. Office of Civil Rights (OCR) within the DHHS can bring action under the “disparate impact” interpretation of Title VI. However, enforcement activity has proceeded apace: “[L]anguage

access cases are easily the OCR's most frequently encountered type of Title VI case" (Perez, 2003, p. 640).

In subsequent years, updates and supplements to Title VI have followed as the Office of Civil Rights regularly has fielded complaints and brokered implementation. In 2000, the Clinton administration issued Executive Order 13166, which affirmed the prohibition against discrimination based on LEP and affirmed the requirement of equal access to federally funded health care and services for those with LEP. The executive order also applied Title VI protections to all federal departments and agencies. In the December 2000 *Federal Register*, the DHHS's Office of Minority Health issued its Culturally and Linguistically Appropriate Services (CLAS) Standards—national standards for providing culturally and linguistically appropriate services for all recipients of federal funds (U.S. DHHS, Office of Minority Health, 2001). Four of the standards address the language barrier, echoing Title VI implementation requirements.

The Bush administration instructed all federal departments and agencies to continue implementation of LEP enforcement under Executive Order 13166. In response, the DHHS's Office of Civil Rights released guidelines in 2002 for provision of language-sensitive services that include assessment of language needs, development of written policies, training of staff, monitoring, provision of trained interpreters, translation of written materials, and notification of beneficiaries regarding their right to language assistance and the availability of such assistance free of charge (U.S. DHHS, Office of Civil Rights, 2005).

Behind these enforcement details lies a key point: that the spirit of these federal actions has been to accept, as a settled matter, that language access barriers violate Title VI and that failure to accommodate LEP people's language needs is a disparate impact violation of Title VI. The DHHS and other federal agencies have issued guidelines and sought greater uniformity and clarity as they monitor compliance and conduct enforcement, but they have accepted the underlying premise that failure to provide language assistance is a Title VI violation.

State Implementation of Title VI

Each state has adopted its own methods for meeting federal Title VI requirements (Alcalde & Morse, 2000). Many of the states' policies are similar in that they specify a number or proportion of speakers of a language that, when exceeded, triggers a variety of programmatic steps—often echoing Office of Civil Rights guidelines—that must be taken to accommodate the group's language-related needs and thereby provide linguistic access to public services, including mental health services (Alcalde & Morse, 2000). These "threshold language policies" vary in detail but contain threshold designations and trigger mechanisms as core elements.

Systematic information on threshold language implementation is scarce, and little is known about the range of strategies enacted by states in response to varying conditions of implementation. One study attempted to document language services provided by states under Medicaid's

State Children's Health Insurance Program (SCHIP). It was conducted by the National Conference of State Legislatures, which informally surveyed, in late 1999 and early 2000, the 13 states with the highest percentage of immigrants: Arizona, California, Florida, Illinois, Maryland, Massachusetts, Michigan, New Jersey, New York, Pennsylvania, Texas, Virginia, and Washington. Reported responses to the needs of LEP persons included various threshold language requirements such as requiring contracted health plans to provide information in a specific language if at least 5% or 200 of their members speak that language (Arizona); requiring that a Medicaid-participating provider who is selected by at least 35 members of a single ethnic group provide linguistic services for that group (Oregon); or requiring that linguistic services be provided when there are at least 3,000 Medicaid beneficiaries who speak the language in a county, or 1,000 beneficiaries in a single zip code, or 1,500 beneficiaries in two contiguous zip codes (California). Most states printed SCHIP applications in both English and Spanish, although California printed applications in 10 languages and Virginia printed applications in English only (Alcalde & Morse, 2000).

Drawing on Medicaid behavioral managed care contracts, Stork, Scholle, Greeno, Copeland, and Kelleher (2001) conducted case studies in five states. The purpose of the studies was to learn about implementation of Medicaid policies addressing ethnic disparities in care and cultural access barriers. The investigators found widely varying contractual requirements and oversight mechanisms among the states. Notably, much of the contract language was vague, and in very few instances had data been identified that would permit monitoring and enforcement. Little was learned about implementation.

Some efforts have been made to address these concerns. Acknowledging the importance of contracting as a vehicle to implement services to LEP persons, the U.S. DHHS Health Resources and Services Administration (HRSA), the primary Federal agency for improving access to health care services for people who are uninsured, isolated, and medically vulnerable, participated in the development of contract language to serve as a model for public health care authorities. The language was made available to public health care purchasers at the time they entered into contracts with managed care providers (Agency for Healthcare Research and Quality, 2001).

In sum, the sparse literature indicates that there is wide variation among state Medicaid authorities' implementation of Title VI requirements. However, there is little oversight or monitoring of states' activities, and little knowledge has been acquired about the effectiveness of their approaches.

One State's Response: Limited English Proficiency in California

In discussing the unfulfilled potential of all Title VI provisions for eliminating disparities in health care, Smedley, Stith, and Nelson (2003) noted how little information is currently available to guide implementation. We therefore

provide an in-depth look at how LEP policy was implemented in the state with the largest LEP population: California.

The number of Californians aged five years and over who speak a language other than English increased from 8.6 million in 1990 to 12.1 million in 2000. The fastest growing non-English-speaking group is the Latino population (U.S. Census Bureau, 2000). Among Medi-Cal beneficiaries in 2001, approximately 54%—or 3,262,300 people—reported a primary language other than English. Statewide, nearly 32% of Medi-Cal beneficiaries reported Spanish as their primary language, but in some counties, over 50% of Medi-Cal beneficiaries reported Spanish as their primary language (California Department of Mental Health, 2002).

Like health and mental health authorities elsewhere, California officials have adopted the concept of “threshold language” in order to establish minimum requirements for assuring language access. Threshold language definitions have a 30-year history set by California state legislation (the Dymally-Alatorre Bilingual Services Act of 1973) and administrative decision-making declaring that state and local agencies serving a “substantial number of non-English-speaking people” must employ a “sufficient number of qualified bilingual staff in public contact positions” and translate documents explaining their services into the languages of their constituents (California State Auditor, Bureau of State Audits, 1999, p. 1). A “substantial number of non-English-speaking people” is defined as 5% or more of the people served. However, even at the state level, few agencies have met these requirements (California State Auditor, Bureau of State Audits, 1999).

The California Department of Mental Health (DMH) with psychologist Stephen W. Mayberg serving as director went further than most state agencies in specifying and monitoring its language access policies as it transitioned into a managed care system for specialty mental health care. Beginning in November 1997 and ending in July 1998, nearly all Medi-Cal specialty mental health services were assigned to 57 county-administered managed mental health plans. Because of California’s burgeoning non-English-speaking immigrant population, a main focus of contracting provisions between the state and county managed care plans was ensuring equal access for persons with LEP.

To draft language access requirements between the state and county managed care plans, the state DMH convened the Cultural Competence Task Force, which comprised traditional providers, county administrators, families, and consumers. The task force, borrowing from the Department of Health Services, defined a threshold language as “the annual numeric identification on a county-wide basis, of 3,000 beneficiaries or 5% of the Medi-Cal population, whichever is lower, whose primary language is other than English, for whom information and services shall be provided in their primary language” (California Department of Mental Health, 1997, p. 3). Primary language was defined as “that language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the

beneficiary” (California Department of Mental Health, 1997, p. 3). The state DMH monitors how many non-English speakers are eligible for care and provides annual updates to counties.

As part of a vigorous response to Title VI requirements, the California DMH established thresholds and mandated a minimum level of response. For each threshold language identified in the county, the county mental health plan is required to provide the following: (a) the translation of written materials that assist beneficiaries in accessing medically necessary specialty mental health services, including personal correspondence; (b) a 24-hour, toll-free phone line with linguistic capability (required for threshold languages and languages not yet reaching threshold); (c) linguistically capable staff or interpreters at key points of contact; and (d) evidence that the mental health plan is informing ethnic consumers and communities about the availability of these language services (California Department of Mental Health, 2002). The DMH monitors each county’s compliance with these requirements annually.

Monitoring and enforcement remain key challenges. Implementing threshold language requirements is not always the highest priority for mental health plans and providers struggling to fulfill their mission as safety net providers for mentally ill persons and for whom threshold language requirements may seem an imposition. Nevertheless, because so many consumers do not speak English, and because federal and state laws mandate an affirmative response, threshold language policy must be enforced.

California’s experience illustrates one response to threshold language policy that seems appropriately vigorous in light of the large number of Californians with LEP. Ultimately, we cannot compare it with the experience of other states because we lack comparable levels and types of information. We do not know how responses were developed under widely varying statewide conditions, how they have been implemented, or their provisions and scope.

Implementation Barriers

No federal funds have been set aside for Title VI implementation; therefore it falls to state and local authorities to find the means to comply. Financial burdens imposed in this way are akin to federal “unfunded mandates,” a source of great concern to state and local governments and to private businesses. Through unfunded mandates, the federal government is perceived as shifting to others the financial burden of its commitments, thereby evading the financial consequences of its decisions. An increasing number of unfunded mandates spawned a political backlash, resulting in Congress’s passing of the Unfunded Mandates Reform Act of 1995 (UMRA) to restrict Congress’s passage of unfunded mandates. Excluded from UMRA’s purview, however, are acts of Congress related to federal grants programs, such as Medicaid, and to the constitutional rights of individuals (U.S. Government Accountability Office [GAO], 2004, 2005).

Because they fall under the umbrella of federal grant programs (Medicaid) and constitutional rights (the Civil Rights Act of 1964), language accommodations required

by Title VI are therefore excluded from UMRA's provisions and thereby escape unfunded mandate restrictions. Although state and local governments and private care providers may perceive Title VI compliance to be an unfunded mandate, it does not officially qualify as such (U.S. GAO, 2004, 2005).

Practically speaking, funding for language assistance services remains a barrier to implementation. One leverage point is the state–federal Medicaid program. Most mental health treatment, particularly that of minority and LEP persons, is financed by Medicaid (Clay, 2005; Thomas & Snowden, 2001), and language assistance services qualify for Medicaid reimbursement (California Endowment, 2003). The effect of this qualification is that if state Medicaid programs will finance language assistance services, then the federal government will provide Medicaid matching funds. For state and local officials, this reduces but does not eliminate language assistance costs. However, funding has been found in some states. According to a survey of states conducted by The Access Project and National Health Law Program (2003), eight states presently reimburse for language assistance services. Costs of language assistance services may be reimbursed either as an administrative expense of managed mental health care plans or through direct provider billing. These states' experience sets a precedent and serves as an example for other states to follow.

At the practitioner–client level, employing bilingual clinicians and pairing clients and clinicians proficient in non-English language is the remedy of choice for improving communication (e.g. Betancourt, Green, Carillo, & Ananeh-Firempong, 2003). In a widely cited study of the large and ethnically diverse Los Angeles County mental health system, Sue, Fujino, Hu, Takeuchi, and Zane (1991) showed that when clinicians who spoke the consumer's primary language were paired with LEP consumers, consumers remained in treatment longer and were more likely to improve. Other naturalistic studies of large samples have produced comparable findings (Akutsu, Snowden, & Organista, 1996; Snowden, 1998; Snowden & Hu, 1997; Takeuchi, Sue, & Yeh, 1995; U.S. DHHS, 2001; Yeh, Takeuchi, & Sue, 1994). Programs like those promoted by the APA Minority Fellowship Program—including the Substance Abuse and Mental Health Services Administration (SAMHSA)-funded Mental Health and Substance Abuse Services Fellowship (MHSAS)—may increase the supply of mental health practitioners from minority backgrounds and thus contribute to increasing the supply of mental health practitioners proficient in non-English languages.

Use of interpreters is a common response to a lack of bilingual mental health practitioners and is likely to continue, especially for infrequently spoken languages (The Access Project and National Health Law Program, 2003). Interpreters can be ad hoc interpreters (asked to interpret by default on the spot); on-staff and salaried interpreters (trained professionals regularly available to interpret in the most commonly encountered languages); trained telephone interpreters available through AT&T Language Line or

another service; independent professional interpreters who work freelance or through an interpreter agency; or community volunteers working through community language banks (Carter-Pokras et al., 2004). Very few states have adopted standards to assess interpreter language competence. However, by implementing testing and certification procedures for medical interpreters, Washington State has been especially active (The Access Project and National Health Law Program, 2003).

Evidence from general medical care indicates that interpreters can be effective in improving patient understanding, satisfaction, and even improvement but that ad hoc interpreters are the least effective (Flores, 2005). Moreover, Office of Civil Rights guidelines discourage the use of minor children as translators (U.S. DHHS, Office of Civil Rights, 2005). How to appropriately and effectively use interpreters under subtle and complex conditions of mental health treatment remains to be determined.

Advocating for Language Assistance for LEP Persons

Title VI presents ripe opportunities to advocate for the language assistance needs of LEP persons. Failure to provide such assistance is a clear-cut violation of Title VI. Such failure exposes mental health providers to the threat of quality of care lawsuits. Furthermore, there are published guidelines, endorsed by federal authorities, documenting reasonable and specific steps that others have taken to provide language assistance. Finally, tools are available to craft funding mechanisms to support language assistance services.

Changing political winds and restrictions on Civil Rights Act enforcement have left standing the principle that failure to provide language assistance is a civil rights violation. It is an adverse impact violation because it disproportionately affects people from non-U.S. national origins. Although use of the adverse impact standard has been restricted, failure to provide language assistance remains a violation. Nothing in subsequent legal rulings or administrative interpretations alters this conclusion.

The federal government has held that failure to provide appropriate and effective language assistance to LEP persons compromises quality of care (California Endowment, 2003). Successful lawsuits have been brought against health care providers who failed to provide appropriate language assistance (Carbone, Gorrie, & Oliver, 2003). One case hinged on a single word—*intoxicado*—which, when misunderstood, set off a chain of events culminating in grave medical injury and a \$71 million settlement (Harsham, 1984). If implementing language assistance programs can be expensive in the short run, then not implementing them may be more expensive in the long run. No prudent administrator or mental health care provider wishes to be at the forefront of a new wave of consumer litigation targeting poor quality of mental health care provided for lack of language assistance services.

Published federal guidelines help to define the problem in local terms and outline boundaries of acceptable

action. Advocates need not grope to explain terms of the problem to administrators and providers nor grope to propose how the federal government will greet attempts at compliance. Well-established and officially endorsed principles are readily available; what is considered in and out of compliance is accessible.

Funding mechanisms can be crafted from existing funding programs. By far the largest payer for all mental health treatment and for treatment of ethnic minorities, among whom LEP persons are overrepresented, is the Medicaid program. Medicaid will pay for language assistance services. The rules and procedures are complex, and whether reimbursement levels are adequate has not yet been determined. Nevertheless, resources can be made available for language assistance services. Advocacy can focus on concrete actions such as getting state Medicaid programs to cover language assistance services and adopting a provider billing code to facilitate practitioner billing (California Endowment, 2003).

Learning More About Title VI Policy Implementation

Much remains to be learned about Title VI that would facilitate its use in overcoming the language barrier and reaching out to LEP populations. At present, three areas stand out as high priorities for research to advance our understanding of threshold language requirements and point toward a more effective future response. They are (a) descriptive studies to determine the nature and scope of threshold language policy response; (b) epidemiologic studies and simulations from epidemiologic data to guide in setting thresholds; and (c) effectiveness studies of strategies to overcome the language barrier and provide appropriate care to LEP consumers.

Presently, we know very little about who responds to threshold language policy requirements and how. Studies like the one conducted informally by the National Conference of State Legislatures (Alcalde & Morse, 2000) describing components of threshold language response should be rigorously conducted and repeated at regular intervals to track changing responsiveness over time.

Research is also needed that would enable us to better understand how to set a proportion of persons with LEP at the threshold level. Rules of thumb currently in use are only guesses about when the number or proportion of speakers of any non-English language justifies a comprehensive and continuing response rather than an ad hoc response. By analyzing data on the link between LEP and mental health need, we could translate proportions of non-English speakers into numbers of potential consumers—the true indicator of concern. Simulations can help us determine whether there are true thresholds: where small increases in percentages of non-English speakers are associated with greater or lesser increases in treatment need and whether there are subgroups of non-English-speaking consumers who might be targeted to make for a more efficient response. An empirical foundation can assist in making necessary trade-offs between lower threshold levels of re-

sponse to reach more potential non-English-speaking consumers and higher threshold levels of response to conserve scarce resources and make them available for other needed areas of mental health programming.

It is also important to better determine the effectiveness and cost-effectiveness of outreach strategies for informing LEP communities about the availability of mental health care and for providing them with services in non-English languages. Translated media play an important role, but little is known about the effectiveness of alternate approaches to translation, with respect both to mode of delivery and content of text.

Use of interpreters is difficult and complex because of the need to ensure proficiency in the non-English language as it applies to mental health problems and treatment and because interpreters become active agents of influence in treatment relationships. Studies are needed to determine the best possible use of interpreter services in clinical practice and other forms of mental health treatment. Informative studies will take into account differences in the interpreter's relationship with the organization and whether the clinician specifies how his or her services are employed in the course of service provision (cf. Flores, 2005).

Other innovative approaches remain to be proposed, documented, and evaluated. For purposes of providing general health care services, community health workers are now widely employed in outreach efforts to many ethnic minority communities, serving as brokers between health care service systems and local communities. Whether such workers are labeled lay health advisers, *consejera*, or *promotora*, studies indicate that they can be successful in improving access and preventive use of health services (Kreiger, Collier, Song, & Martin, 1999). Perhaps new ways might be discovered for these established linkages and capacities to help fulfill threshold language requirements.

Conclusion

Title VI of the Civil Rights Act of 1964 offers a here-and-now mandate to address the language barrier. It acknowledges the potentially negative effect of language barriers on citizens' equal access to public services and requires that remedial action be taken to overcome them. It reaches large numbers of administrators and providers and obligates them to act.

Many questions about the design, implementation, and effectiveness of Title VI-initiated strategies must be asked and answered if researchers are to lay a foundation on which practitioners, administrators, and advocates can build in seeking to promote remedial, effective measures for overcoming the language barrier to treatment access. Ultimately, the Title VI research base must grow if it is to motivate an effective response to this widespread issue.

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