

NOVEMBER 2018

LANGUAGE ACCESS MENTAL HEALTH OUTREACH PROJECT

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PREPARED AND PRESENTED BY

MENTAL HEALTH OUTREACH WORKING GROUP

Section I: Impetus of Project

In response to increased need for external mental health referrals that offer consistent language access to Limited English Proficiency (LEP) clients, both insured and uninsured, Nationalities Service Center (NSC), HIAS Pennsylvania, Bethany Christian Services, Mural Arts and the Department of Behavioral Health and Intellectual Disability Services (DBHIDS) formed a mental health outreach working group. The goal of the group was to conduct outreach calls to Community Behavioral Health (CBH) mental health providers to identify:

- 1. Network of clinical mental health providers***
- 2. Barriers and gaps in service access for LEP***
- 3. Recommendations for improved access for LEP***

In late 2017 through early 2018, the partners attempted **initial outreach to 89 CBH contracted providers** listed on the bilingual providers list provided on the CBH website (see link below). Of this 89, we successfully reached **27 of these providers**. Our initial outreach included key questions such as current language capacity, experience working with immigrant and refugee populations and trauma expertise. The remaining **62 providers** either answered no, did not know, or were not easily reachable by phone. We then identified **11 providers** (who said they offered in-person, phone, or bilingual interpretation) from the list of 27 as well as an **additional 10 providers** with whom the partners had previous success or other factors for targeted outreach--**totaling 21 providers**. Targeted outreach included first contact calls to identify key information needed for successful referrals. The Mental Health Outreach Working Group is committed to both serving and advocating for clients. We also recognize the strength of a well-connected network of service providers in Philadelphia. We seek stronger partnerships with key providers including DBHIDS, CBH and the community mental health catchment sites in order to support the needs of vulnerable immigrants and refugees in our region.

Complete List CBH Contracted Service Providers

https://dbhids.org/wp-content/uploads/2018/03/DBHIDS_CBH-Providers-Directory.pdf?pdf=ProviderDirectory

Section II: Background

DEMOGRAPHICS

Most recent census data from 2016 showed there were about 232,000 foreign-born Philadelphians making up 14.8% of the city's population (see Figure 1). This represents the highest percent of foreign-born Philadelphia residents in the city since 1940. Immigrants make up about 19% of the Philadelphia workforce and 14% of those living in poverty in Philadelphia are immigrants. It should be noted that the percentage of immigrants in the city is a proxy indicator for language proficiency, as only 48% of Philadelphia immigrants speak English “well” or “very well” (see Figure 2) and many who are living and working in Philadelphia who require language access are not counted in census data due to fear of deportation or loss of livelihood (PEW, 2018).

Foreign-Born Share of Philadelphia's Population by ZIP Code, 2000 and 2012-16

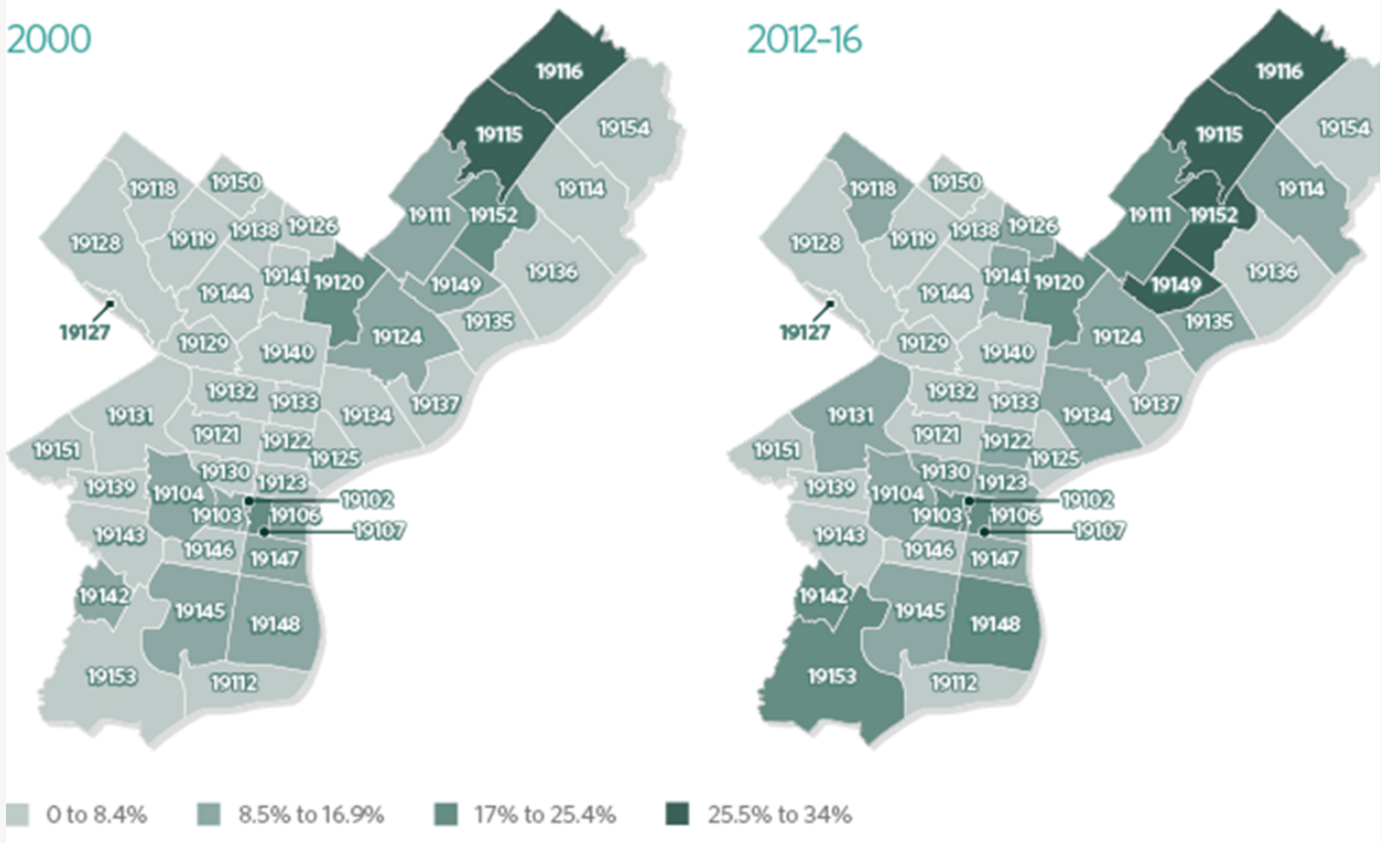


Figure 1: Pew Charitable Trusts, 2018

Figure 11
English-Language
Proficiency of Philadelphia
Immigrants, 2016

Among individuals ages 5
and older who speak a foreign
language at home

Source: U.S. Census Bureau, American
Community Survey, one-year estimates, 2016
© 2018 The Pew Charitable Trusts

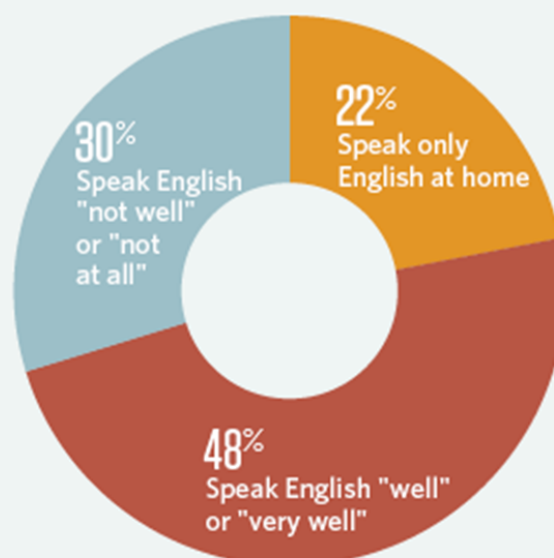


Figure 2: Pew Charitable Trusts, 2018; U.S. Census Bureau, 2016

REQUIREMENTS: TITLE VI CIVIL RIGHTS ACT

Since the passing of the Civil Rights Act in 1964, federal requirements uphold the legal right to access language services, as outlined in Title VI. The U.S. Supreme Court has interpreted this to include discrimination on the basis of national origin and primary language (Civil Rights Act, 1964). **This means that language is interpreted to be a proxy for nationality.** In 1980, the Department of Health and Human Services released an addendum, stating **“No person may be subjected to discrimination on the basis of national origin in health and human services programs because they have a primary language other than English.”** As a result of this strong federal legal precedent, new legal requirements have been adopted to ensure patients with limited English proficiency (LEP) have the right to access healthcare in their language as required by federal law (Chen et al., 2007).

Title VI Civil Rights Act of 1964

Section 601 states: "No person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Courts have interpreted Title VI's prohibition of discrimination on the basis of national origin to include discrimination based on English proficiency.
(Civil Rights Act, 1964)

IMPLICATIONS

Beyond the potential legal and financial consequences of not providing proper language access for behavioral health services, organizations can receive benefits for successfully providing these services. Those organizations providing language access would continue to receive federal funding without risk of violating Title IV. As of 2016, both the Pennsylvania Department of Human Services and the Philadelphia Department of Behavioral Health and Intellectual Disability Services have published their own updated policies, procedures, and protocols on how to ensure language access is being provided in their respective departments (Department of Human Services, 2016; Sorn, 2016).

The need for cultural adaptation applies to services across the board, but is especially vital when it comes to healthcare, including mental health care. Mental health care is essential for individuals with diagnosed chronic mental illness as well as for anyone who experiences acute trauma or emotional distress from the death of a loved one, severe illness, major life transitions or exposure to violence or abuse among an infinite number of life challenges that impact all of us in Philadelphia, immigrant, refugee or not. Mental health is a part of physical health and wellness, and untreated or undiagnosed mental health issues, like any other injury, tend to get worse over time. As immigrants are 19% of the Philadelphia workforce (PEW, 2018), temporary or permanent disability due to mental illness can impact the economy of the city as well as their own socio-economic well being.

Language barriers in healthcare compromise:

- Quality of care
- Client safety
- Health equity
- Patient satisfaction
- Rate of return visits
- Positive health outcomes

Section III: Need Statement

All members of the working group, seek to ensure that each of our clients has equal access to needed mental health services. Currently NSC serves over 5,000 individuals from over 110 countries annually. The clients that we serve include refugees, asylum seekers, survivors of domestic violence and human trafficking and undocumented clients. Too often the clients that we serve, however, have a difficult time receiving needed mental health care. Key challenges include language access and insurance eligibility. Yet, these mental health services are desperately needed due to high levels of trauma and stress.

From June 2014 through April 2018, NSC has collected and analyzed data from the Refugee Health Screener-15 (RHS-15) results of 330 clients. The RHS-15 is a 15 question tool developed by Pathways to Wellness in 2011 to screen for pre-existing or developing mental disorders. The RHS-15 was made with the understanding that refugees have an increased burden of physical and emotional distress, and therefore may have an increased need for mental health services and trauma counseling (Pathways to Wellness, 2011).

The data collected by NSC reflecting the needs of NSC's own client population points to the need for mental health services. Of 330 clients screened, **62.1% (205 clients) had a positive screen result** (see Figure 3). A positive screen result means that they are recommended to receive further mental health services. In cases where they scored positive on the screen administered at NSC, the case manager would give the client the option of connecting to services to address their mental health concerns. These services include internal and external referrals. The screenings were administered in **32 languages** including English, either using translated materials, in-person interpretation or a phone interpreter (See Figure 4). Based on this data, we see that more than half of NSC's clients screened need access to mental health services, and that a majority of those screened do not use English as their primary language to communicate.

Refugee Health Screener-15 (RHS-15)

The Refugee Health Screener-15 (RHS-15) is a tool developed by Pathways to Wellness to sensitively detect the range of emotional distress common across refugee groups. The RHS-15 can be accessed at:

<http://unmfm.pbworks.com/w/file/fetch/110025628/Refugee%20Health%20Screener.pdf>

NSC Client RHS-15 Mental Health Needs Assessment Results

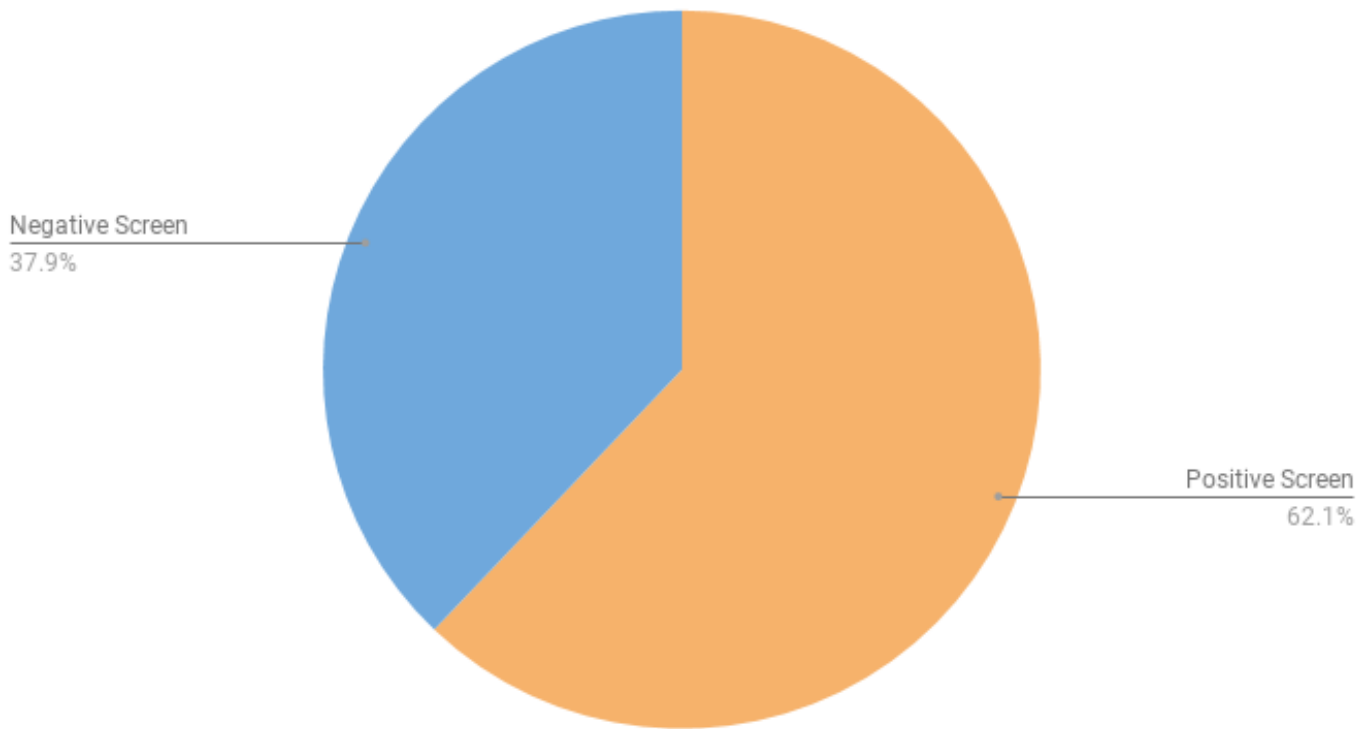


Figure 3: Nationalities Service Center, 2018

Primary Languages of NSC Clients used for RHS-15 Screen

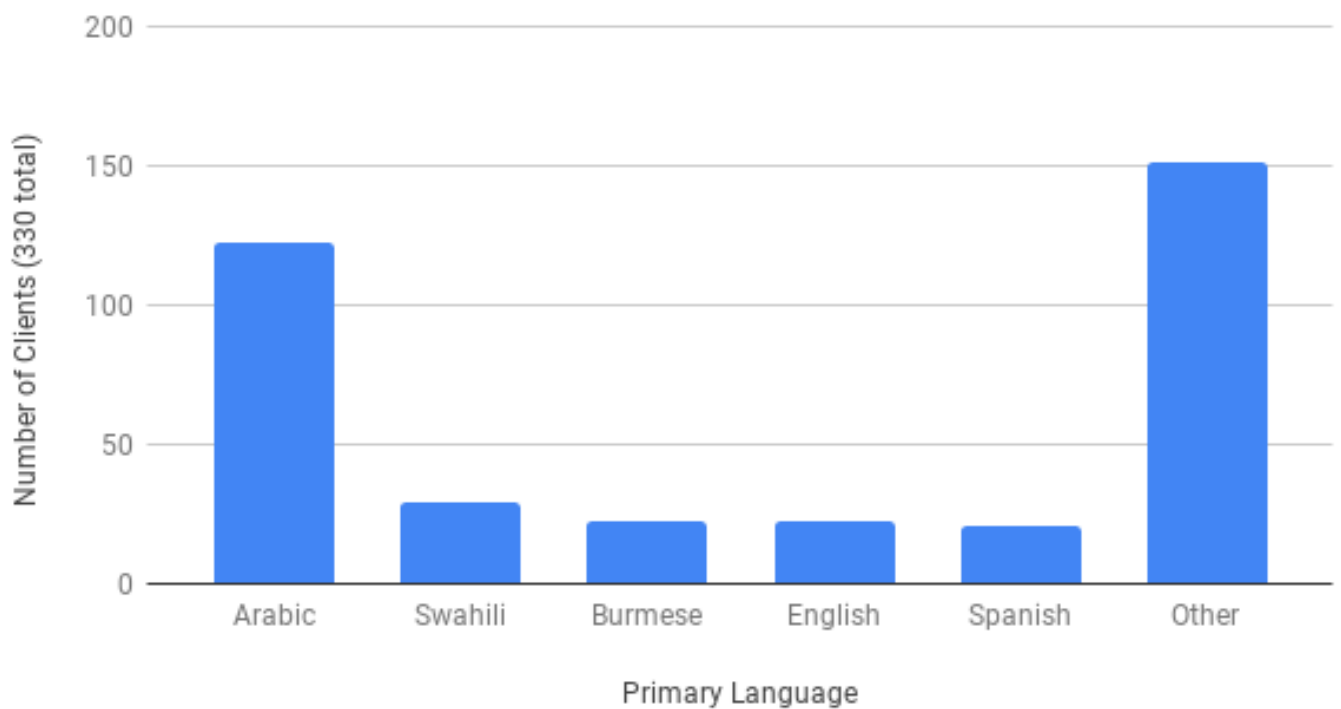


Figure 4: Nationalities Service Center, 2018

Section IV: Outreach Process 2017-2018

Initial Outreach 2017

Identified CBH-contracted providers with potential language capacity

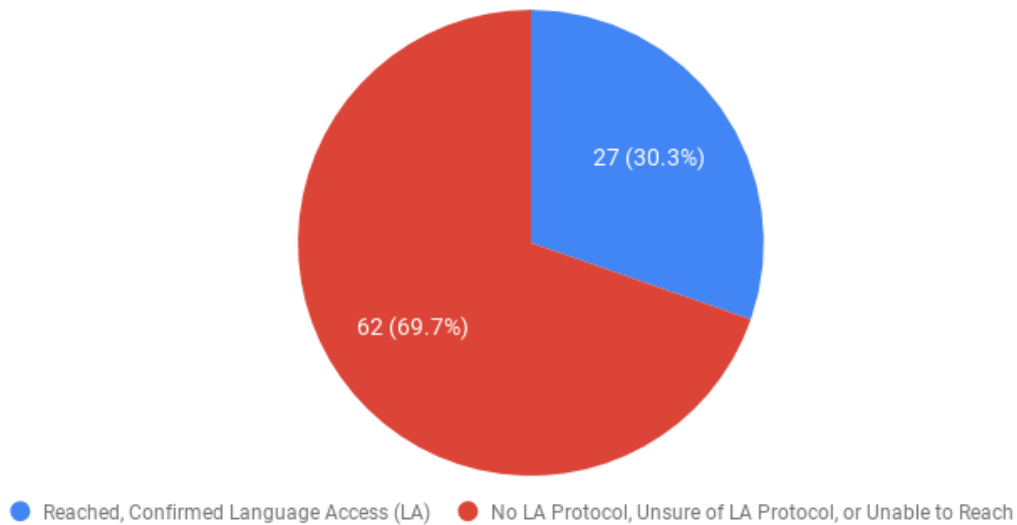
89 Providers



Initial Outreach Results: 89 Providers Total

27 providers (30.3%) successfully reached
62 providers (69.7%) answered no, did not know or were not easily reachable by phone

Language Access Protocol Unclear to English-Speaking Caller upon Initial Outreach (89 total)



Targeted Outreach Selection 2018

11 providers of the 27 reached indicated available interpretation services (in-person, phone or bi-lingual staff)
Additional **10 providers** selected due to previous referrals success or other factors

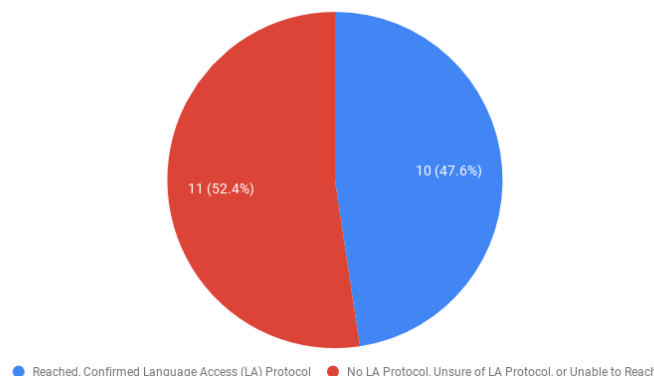
21 providers selected for targeted outreach



Targeted Outreach Results: 21 Providers Total

47.6% answered "yes" to interpretation
52.4% answered no, unsure, or were not easily reachable by phone

Targeted Outreach Responses of Front Desk Staff on Language Access Protocol (21 total)



Section V: Outreach Results

Initial Outreach Results:

Partners identified providers with potential language capacity from the CBH provider list totally **89 initial outreach providers**. Of these 89 providers, **27 providers (30.3%)** were successfully reached and **62 providers (69.7%)** either answered no, were unsure or were not easily reachable by phone.

Targeted Outreach Results:

As follow-up outreach, partners narrowed the list of 27 providers reached to **11 providers** that indicated that they offered interpretation (in-person, phone or bi-lingual staff). An additional **10 providers** were added due to previous referral success or other factors totally **21 targeted outreach providers**. The data reflects information collected from 21 CBH-funded mental health service facilities throughout Philadelphia. Partners contacted these facilities by phone to determine whether or not they provide interpretation services. Since these facilities are funded by CBH, they should be held to federal standards, as outlined by Title VI.

The front desk staff are generally the first contact someone has when seeking out mental health services, so our goal was to determine their responses as to whether or not their facility provides interpretation or language access services.

Of the 21 targeted outreach providers, **10 providers (47.6%)** said that they do provide interpretation services, and **11 providers (52.4 %)** said no, were unsure or were not easily reachable by phone.

CONCLUSIONS

We recognize the complexity of multi-lingual client coordination as well as the cost attached to providing consistent language access. As agencies that serve refugee and immigrant populations, we too have struggled with how to address this issue in the most cost effective way and have had to strategically manage this necessary cost in our budgets. We know that language barriers compromise health equity, quality of care and client safety so it is critical that we work to bridge this gap. Title VI of the Civil Rights Act was developed in order to ensure that individuals are not discriminated against due to nation of origin, which includes LEP. It is for this reason that we use Title VI as the basis for this report. Providing linguistically appropriate services improves equity, quality of care and service efficacy.

The results of our outreach efforts indicate that there are CBH-funded providers that are not consistently offering language interpretation to LEP patients for mental health services. Other providers may offer interpretation as a matter of policy, but in reality these services are difficult to access due to various factors including coordination, insurance requirements, or limited service. In other cases, frontline staff are not adequately informed of Title VI and provider language access policies and protocols.

Taking these gaps in service delivery into consideration, we are putting forth four recommendations that can be considered for short-term as well as long-term planning: 1. Provide telephonic interpretation as a back-up to in-person interpretation to ensure immediate language access 2. Increased policy development 3. Increased training and 4. Consideration of alternative more cost-effective modes of language interpretation (See section VI).

The Mental Health Outreach Working Group thanks you for your time and consideration, and we welcome more opportunities to discuss future plans for improved language access.

Immediate Recommendation 1: Provide telephonic interpretation as back-up to in-person to ensure immediate language access

Other Recommendations for Improved Language Access

1. Increased policy development
2. Increased training
3. Consideration of alternative modes of language interpretation

Section VI: Recommendations

RECOMMENDATION 1:

PROVIDE TELEPHONIC INTERPRETATION AS BACK-UP TO IN-PERSON TO ENSURE IMMEDIATE LANGUAGE ACCESS

RECOMMENDATION 2:

INCREASED POLICY DEVELOPMENT DEMONSTRATES LEADERSHIP COMMITMENT AND ENSURES LONG-TERM SUCCESS

Assessment of current efforts and resources:

Oral (interpretation) and written (translation) services

Types of interpretation available (in-person, phone, bilingual staff)

Types of interpretation used (professional or ad hoc)

Available languages

Assessment of implementation of current efforts:

How language services are accessed

How patients are informed of available services (website, outreach, appointment staff, frontline staff)

Establish language access data collection method

Conduct short term needs assessment:

Assessment of staff understanding

Provide repeated training for front line staff, providers, leadership

Understand demographic and language needs of service area

Conduct long-term needs assessment:

Plan for scaling language access

Consider shift to more reliable language services

Analyze data collection and disseminate to other providers

Ensure language access at all levels of patient care (website, phone, website, intake, scheduling, appointments, follow up)

RECOMMENDATION 3:

INCREASED TRAINING WILL ENSURE THAT POLICY IS FOLLOWED AT EVERY LEVEL OR CLIENT INTERACTION

Leadership training: Title VI, interpretation options, client demographic

Frontline staff training: Title VI, available interpretation, effectively communicating language services to patients, use of telephonic interpretation as back-up

Agency wide trainings: cultural humility training, effectively using interpreters

RECOMMENDATION 4: ALTERNATIVE METHODS OF INTERPRETATION ADDRESS SPECIFIC AGENCY AND CLIENT NEEDS AND CAN BE COST-EFFECTIVE

Method	Advantages	Considerations
Contract On-Site Interpreters (Per diem or scheduled when needed)	Can be cost effective Captures nuances of interaction Can be scheduled in advance	Requires formal training Additional coordination of dispatching, payment, etc. Interpreter and client may be from same community Role of interpreter can be confusing- protocols are critical
Staff On-Site Interpreters (Part or full time, most common languages)	Familiarity with provider and population More consistent availability	Requires hiring part time/full time staff member Only offers limited languages Limited availability with multiple providers
Shared On-Site Interpreters (Shared with local affiliates)	More cost effective Affiliates can share responsibilities	Possible scheduling conflicts Challenging coordination Consistent oversight
Telephonic Interpretation (Commercial service)	Access to most languages Agency not responsible for management of interpreters Spontaneity	No quality control Costly Requires phone lines Reception issues Confidentiality issues Discomfort of patient
Bilingual Staff (Employed staff that serve in other role)	Familiarity with providers and population On-site availability Cultural insight	Interferes with other responsibilities Training needed Boundaries with patients serving in multiple roles
Audiovisual Interpretation (Similar to telephonic but has video screen)	Cost effective-pay/minute Instantaneous Multiple languages Face-to-face	No quality control Audiovisual equipment needed Internet access needed
Family Member	This model is highly discouraged as it violates client privacy and creates a conflict for both the client and the family member.	Violates privacy Client may not share all information Family member may not share all info. Unknown family power dynamics Untrained
Adapted from: Baruch, E. & Freeland Walker, S. (2013). <i>Health equity and language access</i> . Denver, CO: The Colorado Trust.		

Source: National Center on Interpreting in Health Care (2002). Models for the provision of language access in health care settings; National Center on Immigration Integration. (2011). *Communicating more for less: Using translation and interpretation technology to serve limited English proficient individuals*.

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