Estimating the Impact of Limited English Language Proficiency on Mental Health Services for Spanish Speakers in the United States

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ABSTRACT

The Latinx population now comprises nearly 19% of the United States. Spanish speakers within this population are the largest non-English language group in the United States, at nearly 42 million and growing. An analysis of the most recent United States Census data reveals that over 16 million individuals within the Spanish-speaking population report limited English proficiency. This lack of English language proficiency presents a challenge to those seeking effective mental health services in the United States. The availability of language-concordant services is the most impactful dimension in reducing mental healthcare access disparities. An estimate of the impact of limited English language proficiency on mental health services was developed by combining United States Census data with the Substance Abuse and Mental Health Services Administration survey data. The combined data sets provide an estimate of 2.3 million Spanish-speaking individuals with limited English language proficiency and substance use or mental health disorders. The available research on the Spanish-speaking mental health care workforce seems to demonstrate a significant shortfall. More research is needed to determine the extent of the shortfall to effectively meet the needs of this underserved population.

Keywords*: Latinx, Spanish, mental health, language proficiency*

1. Introduction

The United States Latine/x population is now over 62 million and comprises nearly 19% of the population [1]. Over 42 million speak Spanish and comprise the second-largest language group in the United States [2]. As the largest non-English language group, Spanish speakers pose the greatest need for language-concordant mental health services. Providing language-concordant and culturally responsive services is critical to ensure meaningful access and improve treatment outcomes [3].

The current authors use the pan-ethnic terms Latine or Latinx as encompassing the terms Hispanic (derived from Spain plus the entire Spanish colonized empire), Latino/a (gendered, for those with ties to Latin America specifically), and Chicano/a (a racist slur reclaimed as a symbol of pride for Mexican Americans specifically) [4]. Latine/x includes widely varied acculturation, language, and immigration statuses, all of which impact an individual's ability and willingness to enter the United States mental health system and seek services [5,6]. Indigenous individuals from Latin America likely do not align with this term, and may or may not speak Spanish, however, are likely placed in the above monolithic categories in the databases referenced herein.

1.1 Latine/x Mental Health

While Latine/x in the United States as a group have shown to be remarkably resilient and a major contributor to the well-being of society [7,8,9], they also have a range of specific needs, not unlike other segments of the population. According to Villatoro et al. [10], the National Latino and Asian American Study shows that "approximately 60% of Latinos meet the diagnostic criteria for any lifetime mood, anxiety, or substance use disorder… comparable with patterns observed

among non-Latino Whites" (p. 354). Nonetheless, the authors found differences in the persistence of disorders, where "disadvantaged groups had higher risk" for further sustained persistence (p. 327).

The most vastly underserved Latine/x population comprises the adults, children, and families that arrive at the United States Southern border each year. The Border Patrol reports that between 155,000 and 241,000 migrants per month were encountered at the border in 2022 [11]. In addition, in 2020, over 26,000 unaccompanied minors arrived [12]. Greenberg estimates this is in addition to the 6,000 to 8,000 unaccompanied children arriving annually over the last decade. This has resulted in hundreds of thousands entering the United States with trauma histories originating from their home countries, migration journeys, separation and detention experiences, and ongoing stateside ethno-racial xenophobia and discrimination; this trauma often results in acute and then post-traumatic stress disorders (PTSD) [13-16]. Not all would seek or require services; however, those who desire help face multiple challenges in accessing practitioners who can serve them effectively due to linguistic and cultural barriers [17-20].

Recent immigrants report adverse childhood experiences, sexual assaults, chronic mental and medical illness, postpartum depression, domestic violence, and substance abuse [21,22]. They often report significant trauma histories from war, drug cartel violence, chronic poverty, discrimination, and immigration enforcement [23-29]. Research into adverse childhood experiences and racial trauma highlights that Latine/x immigrant populations are at increased risk for mental health and substance use difficulties, with more barriers to healthcare access than their non-Latine/x white American counterparts [21,30,31,32].

Clinical and federal guidelines for the ethical treatment of mental health clients require agencies to ensure their clients understand the services they are receiving [33,34]. Valid informed consent throughout treatment means that clinical sessions, linkage to collateral services, advocacy, and all related documentation are accessible to the clients served under the ethic of autonomy [35]. The rising rates of politically and environmentally displaced migrants will continue exacerbating this need, a growing humanitarian mental health crisis that healthcare educators and providers must address [36]. For trauma processing to be effective, it must occur in one's preferred language [37]. For native Spanish-speaking clients, this means receiving mental health services in clinically fluent Spanish, which is becoming markedly harder to access in the states with the most growth in Spanish-speaking residents [32].

Chronic stress and trauma interrupt language processing, which is further complicated when one cannot communicate their service needs in their preferred language [37,38]. In addition, clinical miscommunication leads to attrition, premature termination, and increased danger for at-risk clients [32]. These clinical concerns, coupled with recent increases in immigration and educational barriers, are key reasons why more Spanish-language services are needed to improve access and effectiveness in mental healthcare.

Studies parsing out language acquisition and use suggest that attaining and maintaining bilingualism increases access to multiple support systems. Bilingualism seems to support lower rates of depression among Latine/x who have achieved English language fluency while maintaining Spanish fluency [39,40]. Spanish-English bilingualism increases as first and second-generation Latine/x become acculturated. By the third and fourth generations, it appears English has become the dominant language [41]. Achieving English language proficiency takes years. Until proficiency is achieved, there is a need for Spanish language services. Even after English proficiency is achieved, emotional processing for bilinguals is complex [42]; therapeutic benefits are more likely to be obtained when the practitioner can facilitate in both languages.

Limited English language proficiency by Spanish speakers in the United States presents a challenge to those seeking effective mental health services and to health care providers. This study sought to estimate how many Spanish speakers with mental health or substance use disorders in the United States are currently impacted by limited English proficiency. This was also done to get a better understanding of the current shortfall in Spanish language clinicians needed to meet current and future needs.

2. Methods

The authors attempted to answer these questions by examining the most recent United States Census data [1,2,43-48] to understand the language needs of Spanish speakers in the United States. We then combined the United States Census

population and language data sets with the Substance Abuse and Mental Health Services Administration survey results on Latine/x mental health [49].

The 2020 United States Census Bureau Decennial survey of the United States population provided the basic demographics regarding the Latine/x population [1]. That questionnaire was distributed in multiple languages, including both Spanish and English. One of the questions contained was: "Is this person of Hispanic, Latino, or Spanish origin?" [43]. Response choices were: "No, not of Hispanic, Latino, or Spanish origin; Yes, Mexican, Mexican Am., Chicano; Yes, Puerto Rican; Yes, Cuban; Yes, another Hispanic, Latino, or Spanish origin, for example, Salvadoran, Dominican, Colombian, Guatemalan, Spaniard, Ecuadorian, etc."

It is important to note that there was a significant change in 2020. The question regarding Hispanic, Latino, and Spanish origins was updated and differentiated from race. Therefore, commencing in 2020, an individual could categorize themself as a member of a race and Hispanic such as Black-Hispanic, White-Hispanic, American Indian-Hispanic, Alaska Native-Hispanic, and Asian and Pacific Islander-Hispanic.
The second data source is the United States Census Bureau American Community Survey (ACS) program [2,44]. The ACS survey sampled approximately 3.5 million mailing addresses to collect household-level data to produce annual social, economic, and housing demographics, as well as estimates of languages spoken and English language proficiency. That survey asked three language-related questions: (1) Does this person speak a language other than English at home? (2) What is this language? (3) How well does this person speak English?

The third data source is the Substance Abuse and Mental Health Services Administration (SAMHSA) results from the 2019 National Survey on Drug Use and Health: Hispanics [49]. This annual survey solicited responses regarding mental health, substance use, and treatment. The survey sampled 67,500 persons from the 50 states and the District of Columbia.

The authors first analyzed the most recent 2020 United States Census Decennial data to determine the percentage and number of individuals who may be categorized as Latine/x [1]. The United States Census Bureau estimates that the United States population is approaching 332 million, with nearly 19% identifying as Hispanic or Latine/x. Approximately 67% are United States-born; the remaining 33% are immigrants.

Next, the United States Census American Community Survey (ACS) was studied to address the issue of English language proficiency [2,44-48]. The ACS survey statistics estimate that nearly 22% (~68 million) of individuals in the United States aged five years and older speak a language other than English at home [44]. Spanish speakers make up over 41 million of that number. Spanish-speaking individuals currently comprise 16 million households across the country [44]. Two key statistics derived from the United States Census ACS data are (1) 66% of those categorized as Latine/x speak Spanish at home, and (2) at least 26% of those categorized as Latine/x speak English less than very well.

The United States Census Bureau ultimately dichotomized individuals as either speaking English very well or less than very well. Given the referenced surveys chose different language to describe categories, the current authors treat the ACS survey category of "less than fluent" in English as equivalent to the Federal language term "limited English proficient" [51]. The current authors went on to assume that the greatest need for Spanish language and culturally literate mental health services would likely come from the over 16 million Spanish speakers who self-identify as less than fluent in English.

Table 1 summarizes the most current information on language proficiency within the Latine/x population by age.

Table 1: Latine/x Spanish Speakers and English Proficiency in the United States

Age	United States Population in 2021	Latine/x Population	Latine/x as % of US Population	# Speaking Spanish at Home	# Limited English Proficiency
Under 5	18,661,245	4,851,979	26.00%	--	--
5 to 17	54,814,033	14,008,384	25.56%	8,118,810	1,727,839
18 to 64	202,526,453	38,622,762	19.07%	28,891S,508	12,103,379
65 and	55,892,014	5,045,939	9.03%	4,244,623	2,468,651
Total	331,893,745	62,529,064	18.84%	41,254,941	16,299,869

3. Results

The authors combined the United States Census Decennial and ACS data regarding Spanish speakers with the SAMHSA survey data to estimate the mental health service needs of Spanish speakers and those with limited English proficiency. The estimated interaction of English language fluency and mental health issues among the Latine/x population is summarized in Table 2. Based upon SAMHSA's National Survey on Drug Use and Health [49], it is estimated that 8.9 million Latine/x are living with substance use or mental health disorders. That number is further broken down into those with a mental disorder (7.4 million), a substance use disorder (2.9 million), and co-occurring substance use and mental health disorders (1.4 million). It is estimated that nearly 5.9 million Latine/x living with mental health or substance abuse issues speak Spanish at home and would benefit from Spanish language services. The greatest need for Spanish language services is likely among the 2.3 million Latine/x who are estimated to have mental health or substance abuse issues and limited English language proficiency. For many, Spanish language services are required for them to be able to fully participate in their own treatment and recovery.

Table 2: Intersection of SAMHSA's Data on Substance Use and Mental Health Disorders with United States Census Data on English Language Proficiency

	Latine/x with Mental Health Issues	# Speaking Spanish at Home (66%)	# Limited English Proficiency (26%)
Mental Health Disorder	7,400,000	4,884,000	1,924,000
Substance Use Disorder (SUD)	2,900,000	1,914,000	754,000
Co-Occurring Mental Health and Substance Use Disorder	1,400,000	924,000	364,000
No Co-Occurring Secondary Disorder	7,500,000	4,950,000	1,950,000
Substance Use or Mental Health Disorder	8,900,000	5,874,000	2,314,000

4. Discussion

The authors estimated the mental health service needs of Spanish-speaking individuals with limited English language proficiency. We found there is a need for Spanish-speaking clinicians to treat the 2.3 million Latine/x adults with limited English proficiency and either substance use or mental health disorders. Furthermore, there are an unknown thousands of children with mental and emotional issues that are yet to be counted [56].

There is evidence that the 2.3 million Spanish speakers with limited English proficiency would respond better if services were available in their preferred language [37]. Spanish-speaking clients will more likely reach out for help if they believe they can communicate effectively with their service provider. Actual treatment outcomes will improve if the same provider has both Spanish language proficiency and a cultural understanding of the unique circumstances that have brought the Latine/x client to seek support, and the skills to work from a collectivistic frame, honoring family dynamics [57].

Research has shown that relying on interpretation services alone to reduce disparities does not penetrate the language gap; insufficiently trained professionals often rely on more bilingual family members to deliver HIPAA-protected and other sensitive information, while professional interpreters are rarely specialized in the nuances of mental health assessment and intervention [58-61].

Based upon the SAMHSA survey, it is estimated that 8.9 million Latine/x have either a substance abuse or mental health disorder, with 1.4 million remaining untreated. Of those receiving treatment, it is not clear if the interventions were meaningful and effective. Treatment could mean something as simple as a single visit to a hospital room or one visit to a primary care physician.

Another area of need that was not captured by the SAMHSA 2019 survey is that of children's mental health. The SAMHSA mental health statistics are only for adults 18 years and older, while substance use statistics capture ages 12 and up. Of note, the Centers for Disease Control and Prevention have found that among all races and ethnicities of children up to 17 years of age, 9.4% had an ADHD diagnosis, 7.4% had diagnosed behavior problems, 7.1% had

diagnosed anxiety, and 3.2% of children were diagnosed with depression [56]. If the previous SAMHSA statistics were to include Latine/x children as part of the treatment gap numbers, the total number of Latine/x along with the number of untreated could grow significantly.

Anecdotally, mental health agencies appear to struggle to find Spanish-speaking clinicians. How many are needed? Currently, there are no definitive, authoritative statistics on the number of actual Spanish-speaking mental health professionals available in the United States. The few studies that exist regarding clinicians and available services indicate a significant gap [32,62,63]. The American Psychological Association performed a survey of 4,595 psychologists and found that only 231 (5%) respondents self-reported that they could provide treatment in Spanish (with no indication of how that was measured). Only 5% of the psychologists sampled were Latine/x [63,64]. Bailey and Hogan's 2019 study points out that disparities vary by region, with some states faring better than others [62]. For example, 48% of the New Mexico population identifies as Latine/x, with only 10% of therapists speaking Spanish. In Texas, 39% are Latine/x, and 10% of therapists speak Spanish. In Arizona, 31% are Latine/x, and 7% of therapists speak Spanish. Similarly, in Nevada, 28% are Latine/x, and 7% of therapists speak Spanish. Furthermore, Pro and colleagues recently found that between 2014 and 2019, the "proportion of facilities offering treatment in Spanish declined by 17.8%, a loss of 1,163 Spanish-speaking mental health facilities" (p.1) [32].

Part of the problem is that the top four states with Latine/x populations, Texas, California, Florida, and New York, are not currently meeting the mental health needs of their general population. Each is considered a Mental Health Provider Shortage Area (MHPSA) and would require a total of nearly 2,300 more psychiatrists to lose that designation [65]. This is in addition to an unknown number of psychiatric nurse specialists, clinical psychologists, social workers, mental health counselors and marriage and family therapists needed as well. It appears there is a need to fill the shortage of both mental health providers in general, as well as providers that can deliver services in Spanish.

4.1 Limitations

The United States Census data is probably under-reporting the number of Americans with Latine/x heritage. A Pew Research Center study reported that 11% of people with Latine/x heritage choose not to self-identify as such [52]. The 11 million or more recent immigrants are likely also underreported. In 2022 alone, the United States Border Patrol detained nearly 2.4 million people at the Southern border, with about 8700-9000 daily allowed to seek asylum [53]. An unknown number also came across the United States Southern border undetected. Thus, accurate estimates of recent immigrants into this country are unavailable [54].

Undocumented individuals may not have been counted in the Census, but they still add to the demand for services and increase agency caseloads. From the perspective of mental health providers ethically delivering services, documentation status is irrelevant to the right to access treatment, though unprotected status enhances barriers and ultimately risks [55].

For this analysis, we assumed that the English language proficiency of those Latine/x with mental health issues is the same as the English language proficiency in the overall Latine/x population. This is only an assumption, and it is likely that among recent immigrants, mental health trauma is greater and English language fluency far lower.

4.2 Future Directions

Two important questions are posed for further follow-up. First, is the Spanish language treatment gap getting smaller, or are we falling behind in our response to improve access and effectiveness? Second, what are training institutions doing to fill the need for linguistically and culturally trained mental health clinicians and staff? The United States is on track to becoming the second-largest Spanish-speaking country in the world by 2060 [50]. We need current training institutions to better understand this need and become inspired to incorporate language-concordant pedagogy in preparing the next generation of mental health staff and clinicians.

The authors also encourage clinicians fluent in the other 350+ languages spoken in the United States, including indigenous languages of Latin America, to take up the charge in developing commensurate language-concordant mental health services for their communities [66]. More work is needed in determining the language-based treatment gaps for those other language groups as well as the Spanish language community.

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