Free and Charitable Clinics: Helping to Fill the Mental Health Treatment Gap Among the Poor and Uninsured

Lindsay O'Brien, MPA, Leslie McGuire, MSW, and Geethika Fernando, MPH

May 2014

Summary

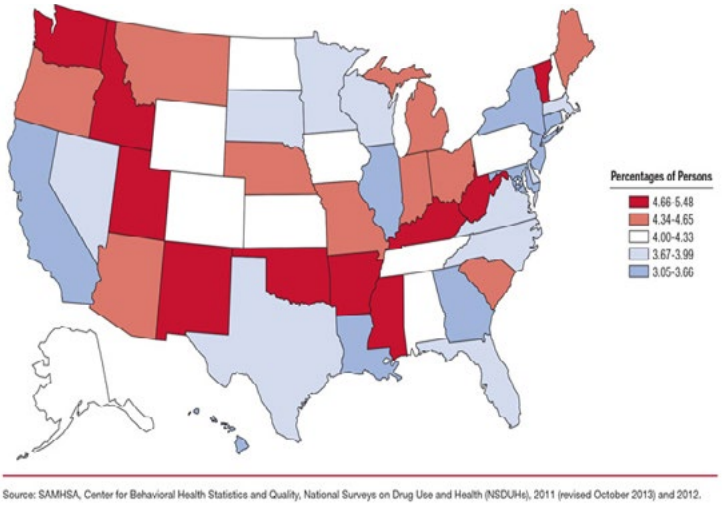
AmeriCares conducted a survey of its partnership network in March 2014 to better understand the extent of mental health practices of free and charitable clinics and the prevalence of mental illness among their low-income, uninsured and underinsured patients. Rates of mental illness are higher among patients at responding clinics than national averages. Responding clinics also provide mental health services at a higher rate than found during a nationwide census of free clinics published in 2010. The survey demonstrates that responding free and charitable clinics are burdened by high rates of mental illness and that the demand for free and heavily subsidized mental health services will remain strong even in the post-Affordable Care Act environment.

Background

Mental illness is a significant public health problem in the United States. Nationally, 42.5 million adults experienced a mental illness in the past year, corresponding to a rate of more than 18 percent of all American adults.[i] States with the highest rates of mental illness are located coast-to-coast and in all regions of the U.S. (Figure 1).[i] According to a 2005 report from the Substance Abuse and Mental Health Services Administration (SAMHSA), people without health insurance face significant difficulties in obtaining mental health treatment in the U.S.[ii] Without insurance, people with mental illness may have difficulty accessing treatment and needed medications and are thus at an increased risk of hospitalization, poor health outcomes and diminished quality of life.

Those with a serious mental illness are twice as likely to be poor and uninsured as compared to the general population.[iii] Serious mental illnesses include mental, behavioral and emotional disorders (excluding developmental and substance use disorders) that are diagnosable currently or within the past year and result in substantial impairment that interferes with daily functioning.[i] Morbidity and mortality are also higher in people who suffer from serious mental illness than in the general population. This patient population has higher rates of hypertension, diabetes, obesity, cardiovascular disease and HIV/AIDS. They also have a higher frequency of multiple medical conditions and have a premature death rate two times higher than the general population.[iv]

Figure 1: Any mental illness in the past year among adults



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2011 (revised October 2013) and 2012.

A movement is now underway in the U.S. to integrate mental health and primary care to better meet the needs of people suffering from mental illness, and address the excess morbidity and mortality they experience. The need for and evidence behind the effectiveness of integration is so strong that further integration between primary care and mental health has been identified as a key priority in the 2014 standards required for patient-centered medical home recognition by the National Committee on Quality Assurance (NCQA), a provider of accreditation to individual physicians, health plans and medical groups.[v] The federal government has also invested in integration through the Primary and Behavioral Health Care Integration (PBHCI) program, a $100 million, multi-year grant program funded by SAMHSA that recently awarded 100 grants to organizations working to integrate primary and behavioral health care services for people with serious mental illness.[vi] The 1-4 year grants up to $500,000 per recipient were awarded to community-based behavioral health care settings including hospitals, treatment facilities and mental health agencies.[vii]

Research has shown that more than 70 percent of all primary care visits are related to mental health issues.[viii] Demand for mental health services in all primary care settings – including the safety net sector – is clearly significant, and free and low-cost care is critically needed. The prevalence of depression has been shown to be higher among certain populations, including the uninsured and chronically ill. A publication in 2013 from Pfizer reported that rates of depression are two times higher in non-elderly, uninsured adults than their insured counterparts.[ix] Specifically looking at free clinics, a 2013 survey of patients at a free clinic site showed that both the physical and mental health functioning of patients was lower than in the general U.S. population.[x]

According to a report from the American Mental Health Counselors Association, uninsured individuals with mental illness consistently forgo needed preventive and routine care, resulting in clinical deterioration that can lead to crisis and overuse of both emergency and inpatient care.[xi] The primary reason for not receiving mental health services among nearly 5 million adults who reported an unmet need for mental health care in the past year was "could not afford the cost of care."[xii] The Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act (ACA) will improve but not solve this situation. The MHPAEA requires insurance groups that offer coverage for mental health or substance use disorders to provide the same level of benefits that they do for general medical treatment, thus prohibiting prior discriminatory practices that limit insurance coverage for behavioral health services. The ACA extends the reach of MHPAEA's requirements by requiring all small group and individual market plans created after March 23, 2010 to comply with federal parity requirements. Medicaid's Alternative Benefit Plans must also cover mental health and substance use treatment.[xiii] This benefit will not be available though to the poorest people suffering from mental illness who reside in the 24 states that are not expanding Medicaid, leaving more than 3 million of the poorest and most vulnerable mentally ill people without health insurance or access to mental health care.[xi]

In addition to challenges related to insurance coverage, there is also a severe lack of mental health care providers in the United States. According to an April 2014 Health Policy Brief issued by the Robert Wood Johnson Foundation, two-thirds of physicians report that they are unable to obtain outpatient mental health services for their patients. Mental health professionals also tend to be concentrated in high-population, high-income areas.[xiii] Further, across the U.S., state funding of community mental health programs was cut by $4.25 billion over the four years ending in 2012.[xiv] Together these issues leave millions of poor, uninsured people with mental illness with very limited choices and opportunities to obtain needed care.

Methodology

In recognition of Mental Health Month, which occurs every May, and the significant role that the health care safety net plays in mental health services, AmeriCares conducted a survey of its U.S. safety net partners in March 2014. This online survey was distributed to AmeriCares partners that identified themselves as free and charitable clinics, community health centers, or health departments. The purpose of the survey was to determine their capacity and identify their needs related to the identification, treatment and management of mental disorders. AmeriCares partnership network included 344 free and charitable clinics at the time of survey distribution. This analysis is based on responses from this free and charitable clinic subset. All together 135 free and charitable clinics from 36 states responded to the survey, representing a 39 percent response rate. They serve an average of 1,430 patients per clinic and deliver an average of 5,280 patient visits per clinic each year.[xv]

Free and Charitable Clinic Overview

Free and charitable clinics are a critical part of the health care safety net system in the U.S. By the National Association of Free and Charitable Clinics' definition, they are health care organizations that utilize a volunteer/staff model to provide a range of medical, dental, pharmacy, vision and/or mental health services to economically disadvantaged individuals for free or with nominal charges. Free and charitable clinics typically restrict eligibility for their services to individuals who are impoverished and uninsured or underinsured.[xvi]

Free and Charitable Clinic Sample

Responding free and charitable clinics operate under a range of budgets, with the largest share (43 percent) reporting an annual operating budget between $100,000 and $500,000. Five percent report an annual budget of less than $25,000, 13 percent report an annual operating budget between $25,000 and $100,000, and 26 percent report an annual budget of more than $500,000.
On average, responding clinics have three paid staff members. More than 60 percent have between one and nine paid staff members, 23 percent have between 10 and 29 paid staff members, 6 percent have 30 or more staff members and 9 percent have no paid staff. As expected, responding clinics rely heavily on volunteers to provide services. Responding clinics use an average of 69 volunteers, with more than 70 percent utilizing between 30 and 399 volunteers on a regular basis. Fifty-eight percent of responding clinics also rely on medical residents and trainees to supplement staff as volunteers.

The vast majority (85 percent) operate one health delivery site.

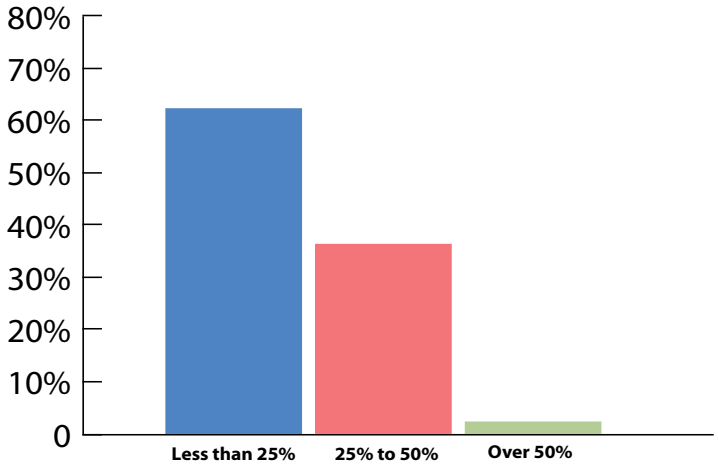
Despite modest budgets and a small number of paid staff, responding clinics have sizable patient volumes. Forty-four percent of responding clinics treat between 1,000 and 4,999 unique patients annually, while slightly less (37 percent) see only 200 to 999 patients per year. Only 8 percent of clinics treat 5,000 or more unique patients per year. The vast majority of responding clinics' patients fall into the 35- to 54-age category (76 percent), with more than 15 percent reporting that the "near elderly" group of 55- to 64-year-olds account for their highest percentage of patients. Seventy-one percent of clinics reported that all of their patients are uninsured.

Results

Patient Visits Related to Mental Health

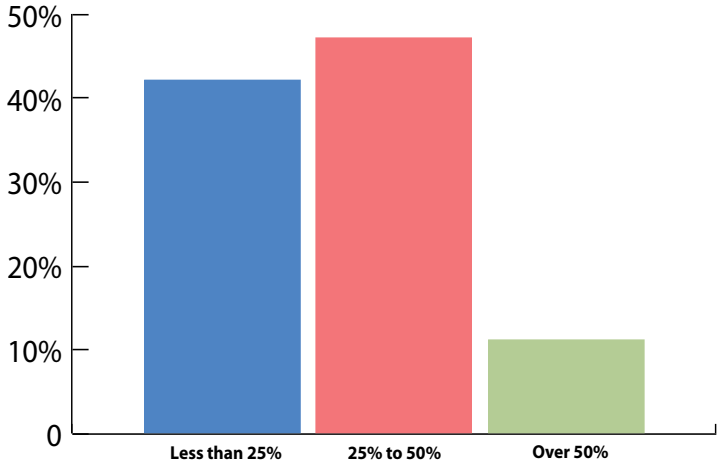
Among clinics that report tracking the nature of the medical visit, 36 percent report that between 25 and 50 percent of their patient visits are related to mental health. Sixty-two percent report that less than 25 percent of all patient visits are related to mental health and 2 percent report that over 50 percent of visits are related to mental health (Figure 2). Of note: A sizeable portion of responding clinics—16 percent—do not track whether patient visits are related to mental health.

Figure 2:
% of Patient Visits Related to Mental Health at Free and Charitable Clinics (n=113)



Eighty percent of responding clinics track the number of patients that have a diagnosed mental illness, with the largest share of those clinics tracking mental illness (47 percent) reporting that 25 to 50 percent of their patients have a diagnosed mental illness (Figure 3).

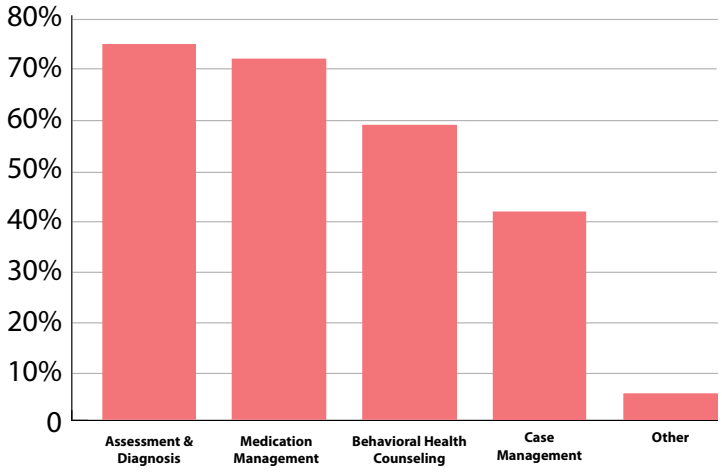
Figure 3:
% of Patients with a Diagnosed Mental Illness at Free and Charitable Clinics (n= 107)



Provision of Mental Health Services

Sixty-four percent of responding free and charitable clinics currently provide mental health services, with another 4 percent reporting that they plan to begin providing mental health services in the next 12 months. Of the services offered by the 86 clinics providing mental health services, 74 percent provide assessment and diagnosis, 71 percent provide medication management, 58 percent provide mental health counseling and 41 percent provide case management (Figure 4).

Figure 4:
Types of Mental Health Services Offered at Free and Charitable Clinics (n=86)

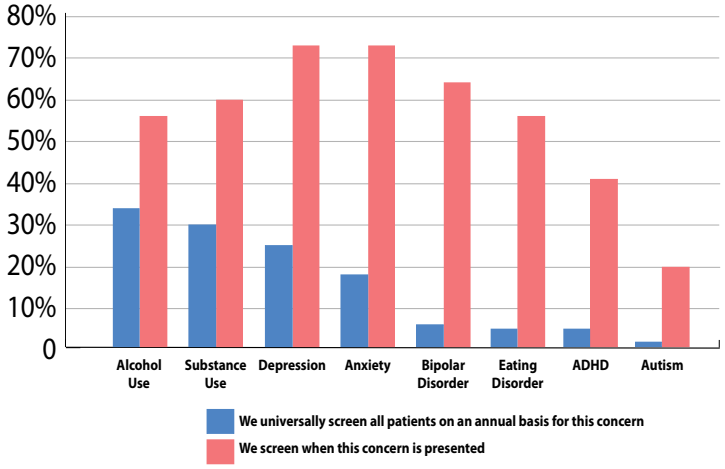


Mental Health Screening

Fifty-four percent of responding clinics that provide mental health services report that they screen patients for at least one mental health concern. Few conduct universal screening to proactively identify patients with undetected mental illness. Alcohol and substance use are

the conditions that are most often universally screened for, followed by depression and anxiety. In the absence of universal screening, many report the capacity to screen patients when a concern is presented by the patient or identified by a provider. Depression, anxiety and bipolar disorder are most likely to be screened for when a concern is presented (Figure 5).

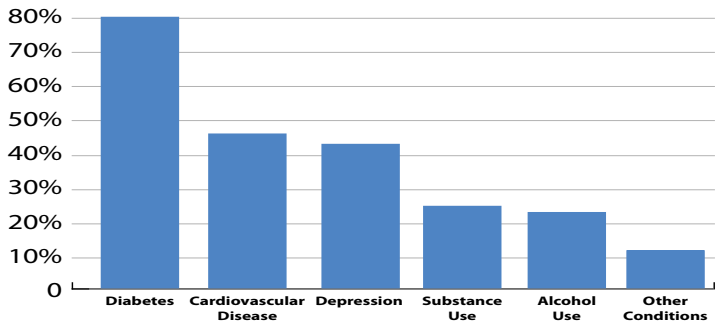
Figure 5:
% Screenings at Free and Charitable Clinics Providing Mental Health Services (n=75)



Mental Health Staff

More than 80 percent of free and charitable clinics providing mental health services report having psychiatric nurses, psychologists, master's-level social workers, and/or bachelor's- and master's-level mental health counselors on staff in a paid or volunteer capacity. At 27 percent, master's-level social workers account for the highest share of clinics' mental health staff. Further, more than 75 percent of primary care providers at responding clinics provide mental health care.
In terms of training, 58 percent of clinics that provide mental health services report that they also provide training to clinical staff on practice and treatment guidelines focused on depression, substance use and alcohol use (Figure 6).

Figure 6:
% Clinical Staff Training Conducted at Free and Charitable Clinics Providing Mental Health Services (n=85)



Mental Health Referrals

Fifty-nine percent of clinics that provide mental health services have formal partnerships or agreements with local mental health organizations. When asked to report on mental health referrals, the largest share of respondents (46 percent) reported that effective referrals are difficult to arrange but can be made for patients who seriously need them. Free and charitable clinics report collaboration and communication between their providers and external mental health specialists to be a challenge. Only 23 percent of clinics reported that effective mental health counseling is readily available and coordinated with care through active and effective communication with mental health specialists. In addition, providers in responding free and charitable clinics generally do not follow up to ensure successful transition to care when making referrals to external mental health specialists. Half of the responding clinics that provide mental health services reported that follow-up is largely left up to patients that receive referrals to a mental health specialist. Though 43 percent report that follow up to specialists is scheduled by the front desk in accordance with clinic guidelines, only 7 percent assure follow-up through regular contact with patients to check on adherence to the treatment plan, progress and/or medication side effects.

Discussion

Free and charitable clinics from AmeriCares partner network that responded to the survey provide a significant amount of mental health services. However, it is speculated that the provision of services may be even higher since clinics may not be tracking the provision of mental health services during primary care visits and some clinics may not have the capacity to report on the nature of patient visits. Given the low implementation of universal screening reported, it is also likely that rates of mental illness are higher than reported by responding clinics. In terms of screening, the U.S. Preventive Services Task Force (USPSTF) recommends screening for depression only when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment and follow up.[xvii] The low rates of universal screening identified in this sample are not surprising then since only a minority of clinics report availability of mental health referrals and a very small minority report the assurance of follow up.

The rate at which this AmeriCares sample of free clinics provide mental health services is more than double the rate of mental health services reported in a nationwide census of 1,007 free clinics published in 2010.[xv] That study of a national free clinic sample showed that 30 percent of 727 responding medical clinics across the country provided mental health services and 9 percent provided substance use disorder services. It is important

to note, however, that clinics in both this AmeriCares survey and the 2010 study may be limiting their responses based on their reporting capabilities.

There is limited data available on the quality of mental health care provided by free and charitable clinics and little data exists within the literature. There are, however, a number of widely accepted standards that address the quality of mental health care provided in primary care locations (e.g., NCQA standards for patient-centered medical homes) as well as standard models that point to key indicators around the integration of mental and primary health care (e.g., the SAMHSA/HRSA Framework for Levels of Integrated Care). Our survey analysis suggests that the free and charitable clinics in AmeriCares partner network are already undertaking a number of these standards of practice.[xviii] Further, based on the SAMHSA/HRSA Framework for Levels of Integrated Healthcare, most responding free and charitable clinics that provide mental health services could be categorized as Level 1 or 2, indicating that they are providing just basic levels of coordinated care for patients suffering from mental illness. About one-quarter of responding clinics could fall into Level 3 or higher categories due to the co-located services they provide or the collaboration they achieve between mental health, primary care and other healthcare providers.[xix] This alignment with several components of behavioral health and primary care integration measures and models suggests that a good portion of this sample of clinics are on the continuum of integration care models and are meeting some of the identified standards of care.

Finally, the sample of clinics from this survey indicates that demand for mental health services is high, but that arranging referrals to mental health specialists outside of the clinic for patients is difficult. Anecdotally, clinics across the country noted on the survey: "behavioral health referrals are difficult to find in our area for free," "we utilize a public mental health facility with a two month waiting list" and "we have no help in our community." This substantiates the need for further development of and referral to behavioral health services within the free and charitable clinic sector to meet patient demand.

"Behavioral health referrals are difficult to find in our area for free."

- Free Clinic Partner

Limitations

Limitations of this survey include that responses are limited to AmeriCares network of free and charitable clinics, all responses were self-reported and self-selection among those clinics that currently provide mental health services may have occurred. In addition, standardized medical definitions were not provided in the survey.

Implications

Results from this survey indicate that free and charitable clinics play a key role in caring for low-income patients with mental illness. There is a scarcity of mental health providers in the U.S. in general and this is particularly true for those that provide free or low-cost services to the poor and uninsured. In addition to increasing quality of life and productivity for people with mental illness, mental health programs have been shown to reduce health care and emergency department costs, decrease criminal and juvenile justice spending, and cut down on educational expenditures.[xi] To help their patients realize these benefits, free and charitable clinics will continue to require resources and mental health referrals.

About AmeriCares

AmeriCares is a nonprofit global health and disaster relief organization that delivers medicines, medical supplies and aid to people in need across the United States and around the world. Since it was established in 1982, AmeriCares has distributed more than $11 billion in humanitarian aid to 164 countries. AmeriCares U.S. Medical Assistance Program is the largest provider of donated medicine, vaccines and medical supplies to the U.S. health care safety net. The program partners with 635 free clinics, community health centers and health departments serving 5 million uninsured and underinsured people at 1,485 health delivery sites. The U.S. Medical Assistance Program is generously funded by the GE Foundation.

References

i. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (February 28, 2014). *The NSDUH Report: State Estimates of Adult Mental Illness from the 2011 and 2012 National Surveys on Drug Use and Health*. Rockville, MD.

ii. SAMHSA, Office of Applied Studies National Survey on Drug Use and Health, 2005. Retrieved from: http://www.samhsa.gov/data/nsduh/2k5nsduh/2k5results.htm

iii. Mechanic, D. (2001). Closing Gaps in Mental Health Care. Health Services Research, 36:6.

iv. Deborah Scarf, Nicole Eberhard, Nicole Hack Barth, Marcela Horvitz-Lennon, Robin Beckman, Bing Han, Susie Lovejoy, Harold Incus and M. Audrey Burnham. *Evaluation of the SAMHSA Primary and Behavioral Health Care Integration Grant Program: Final Report*, December 2013.

v. "Proposed Changes and New Standards for NCQA PCMH 2014," *Patient-Centered Primary Care Collaborative*, April 2014.

vi. Laura Galbreath, "Building Primary Care Capacity in Behavioral Health Settings," *SAMSHA Website*, May 2014.

vii. Substance Abuse and Mental Health Services Administration, *Center for Mental Health Services Program Profiles: Primary and Behavioral Health Integration*, 2012.

viii. Robinson, P., and Reiter, J. (2007). *Behavioral Consultation and Primary Care: A Guide to Integrating Services*. New York: Springer.

ix. Margaret McDonald and Robin Hertz, "A Profile of Uninsured Persons in the United States," *Pfizer Facts*, October 2008.

x. Kamimura A1, Christensen N, Tabler J, Ashby J, Olson LM, "Patients utilizing a free clinic: physical and mental health, health literacy, and social support," *J Community Health*, 2013 Aug;38(4):716-23. doi: 10.1007/s10900-013-9669-x.

xi. Joel E. Miller, "Dashed Hopes; Broken Promises; More Despair: How the Lack of State Participation in the Medicaid Expansion will Punish Americans with Mental Illness," *American Mental Health Counselors Association*, February 2014.

xii. Center for Behavioral Health Statistics and Quality. (2012). Results from the 2011 *National Survey on Drug Use and Health: Mental health detailed tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

xiii. Sarah Goodell, "Health Policy Brief: Mental Health Parity," *Health Affairs*, April 3, 2014.

xiv. Michael Ollove, "Nearly 4 Million Seriously Mentally Ill Still without Insurance," *Stateline*, April 9, 2014.

xv. Darnell J. S. (2010). Free clinics in the United States: A nationwide survey. *Archives of Internal Medicine*, 170(11), 946-953.

xvi. National Association of Free and Charitable Clinics. Retrieved from: http://www.nafcclinics.org/

xvii. *Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse, Topic Page*. U.S. Preventive Services Task Force. Retrieved from: http://www.uspreventiveservicestaskforce.org/uspstf/uspsdrin.htm

xviii. "Atlas of Integrated Behavioral Health Care Quality Measures," *U.S. Department of Health & Human Services Website,* May 2014.

xix. Heath B, Wise Romero P, and Reynolds K. *A Review and Proposed Standard Framework for Levels of Integrated Healthcare*. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions, March 2013