Identifying and Addressing Mental Health Need at the Iowa City Free Medical Clinic

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Introduction:

The Iowa City Free Medical Clinic (ICFMC) is a foundational source of primary care for uninsured Johnson County residents. Serving over 1500 patients per year, 97% of which are uninsured (per 2018 statistics), services that the clinic provides include chronic disease management, STI screening, prenatal care, acute concerns, and limited specialty care. For a variety of reasons, notably including the scarcity of mental health providers both nationwide and within the county, the clinic has been unable to gain traction in providing longitudinal mental healthcare to its patients. The current patient load, funding, and available staff serve as additional barriers to adding mental health services to the clinic's repertoire.

As part of a Community Health Outreach elective project, I performed a mental health need assessment in 2022-2023. The goal of the survey was to assess the extent of need for mental healthcare in the ICFMC patient population, measure patient awareness of mental health resources presently available to them, and identify interventions the ICFMC may be able to enact in order to address current levels of need within the clinic. The key findings of the survey were as such:

1) There was a discrepancy between ICFMC patients who had not used mental health services in the past and those who didn't feel like they needed them, indicating a portion of the patient population had mental health needs that were not being met.
2) Amongst barriers to obtaining mental healthcare, cost and resource awareness were the two most cited **(Supplemental 1)**.
3) Nearly ½ of survey respondents did not feel confident they would be able to identify and connect with mental health resources within Johnson County if needed **(Supplemental 2)**.
4) Specialty-level care (i.e. speaking to Therapist/Psychiatrist) was not one of the most desired resources for patients. Hotlines, support groups, and speaking with their PCP (ICFMC provider) were ranked as the three highest resources in patient desire, respectively **(Supplemental 3)**.
5) 83% of survey respondents expressed a desire for more information about mental health services to be provided in the ICFMC **(Supplemental 4)**.
6) Amongst those who expressed desire for mental healthcare to be incorporated into the ICFMC's services, almost 60% cited relationships with ICFMC providers and staff as their primary reason for wanting these services in-house, indicating a high level of trust in the ICFMC as a foundational source of healthcare for the patients it serves.

The idea for this project was built upon the findings of this need assessment. Specifically, it aimed to address findings #2, #3, and #5 above. The goal was to improve mental health literacy in a population particularly vulnerable to mental illness. The clinic has established itself as a pillar of cost-free care for medical ailments within the community. The hope was that this project may serve as a step, albeit small, toward addressing mental health need in the ICFMC patient population going forward.

Literature Review:

It is well-documented that the uninsured and minority populations that the Free Medical Clinic serves are particularly vulnerable to mental health conditions and crises. Mistreatment and mistrust in minority populations, particularly in regard to psychiatric care, date back as far as the 1800s, when insanity rates were purposefully falsified to depict a relationship between northern latitude and mental illness in black Americans.[1] Uninsured patients are seven times more likely to report discrimination during mental health or substance abuse visits, citing racial/ethnic discrimination as the most common type experienced.[2] Secondarily, treatment ratings tend to be decreased in Latinos and higher treatment termination rates have been cited in the black populations. Poor health-related outcomes in these populations are likely multifactorial.[3]

In regard to insurance status, those with mental illness are less likely to have health insurance than those without a mental health diagnosis.[4] Prior studies have reported an increased prevalence of moderate or severe mental illness in the uninsured population in recent decades, citing worsening cost barriers during this period.[4] Other studies have found that underinsured or never-insured adults are more likely to report low subjective health ratings and nearly 40% more likely to report frequent mental distress.[5] Another study concluded that lack of insurance is associated with greater incidence and prevalence of substance use disorders as well as persistence of mood or anxiety disorder beyond the acute phase.[6] In addition to insurance status, poverty level and education are mechanisms of present disparities.[7]

Disparities in mental illness prevalence are compounded by differential access and pursual of treatment. Uninsured patients have the lowest access to specialty-level psychiatric care compared to their privately or publicly insured counterparts.[4] In an entire population assessed by Walker et al, 59% of patients had received treatment in the last 12 months.[8] Insured patients were 1.6-2.9 times more likely to have received treatment during this period and had a 20% reduction in perceived unmet mental health needs compared to uninsured patients. Cost was cited as a significant structural barrier for not receiving treatment. Interestingly, attitudinal barriers were less pervasive in uninsured patients. In total, 75% of uninsured adults with any diagnosed mental illness had not received treatment in the prior year. 56% of those with serious mental illness were untreated during this period.

As it pertains to this project, the concept of mental health literacy, defined as "understanding how to obtain and maintain positive mental health; understanding mental disorders and their treatments; decreasing stigma related to mental disorders; and, enhancing help-seeking efficacy" has gained popularity in recent decades.[9] Poor health literacy broadly has been correlated with increased chronic illness, increased mortality, and decreased use of health services. In recent years, many public health related interventions have targeted mental health literacy as a means of improving health outcomes in disadvantaged populations.

Methods:

The primary goal of this project was to increase mental health literacy and resource awareness in the clinic's patients by providing up-to-date, easy-to-interpret educational materials. To achieve this, educational materials were assembled and have been given to the ICFMC staff for distribution at any time during their appointment. Education materials created or gathered for the clinic are detailed below:

1) A self-made, succinct brochure containing resources within Johnson County that provide longitudinal and/or crisis mental healthcare available to low-income patients. This brochure focused on resources available locally with additional inclusion of nationwide resources as able.
2) A longer, more extensive "Where to Turn" brochure provided by CommUnity Crisis Services expanding on the shorter, student-made brochure by including housing, food, and other socioeconomic resources in addition to the healthcare resources present in the student brochure.

3) A pamphlet with information on self-referral to the Iowa City Free Mental Health Clinic for longitudinal mental healthcare. Spencer contacted ICFMHC leadership and ensured that the clinic is accepting new patients and can accommodate self-referrals within a reasonable timeframe.
4) Copies of the PHQ-8 and GAD-7 screens that may be distributed to patients for self-reflection (versus diagnostic) purposes.

Due to the proportion of clinic visits they constitute, the longitudinal nature of their relationship with the clinic, as well as the well-researched link between chronic disease and mental comorbidities, patients seen in the chronic care clinics were identified as the primary target population for these materials. Packets, however, have been made available to all clinic patients.

The aforementioned need assessment was available in English, Spanish, French, and Arabic due to the generosity of UIHC Translation Services. Due to their current project volume, UIHC Translation Services were unable to assist with the translation of project documents. I was, however, able to connect with the translators at the Free Mobile Clinic to get documents translated into English, Spanish, French, and Arabic prior to distribution.

As a volunteer of over five years at the ICFMC, Spencer has established a good working relationship with clinic staff and volunteers and feels confident that these materials will continue to be adequately distributed so long as supply is sustained.

The project was approved for $245 of funding provided by the Wright Mini-Grant fund, which was largely used for printing supplies.

Results/Findings:

Roughly 150 (50 English, 50 Spanish, 25 French, 25 Arabic) packets were assembled for distribution at the ICFMC. These packets consisted of physical copies of both a brochure summarizing Johnson County mental health resources as well as a self-referral form with information on the Iowa City Free Mental Health Clinic. Due to barriers in cost and ease of obtaining clinic approval, other forms initially intended to be included in the packets were placed into a Microsoft Teams folder for ICFMC staff to have access to if needed in the future (Please see *Barriers* section for more details). The brochure consisted of crisis resources, signs someone may be struggling with their mental health, resources for longitudinal mental health care, and helpful telephone numbers and website for further investigation. Packets were placed at the front desk of the ICFMC, with eventual plans to transition their placement into the waiting room with the rest of the various educational materials the clinic currently offers.

Analysis:

An acknowledged shortcoming of this project was the difficulty assessing meaningful outcomes from the distribution of educational packets. The initial plan during the proposal phase was to include a survey within the packets that respondents could fill out electronically in order to provide feedback regarding the helpfulness of the materials. Unfortunately, there were delays getting approval from ICFMC leadership for inclusion of these surveys within the packets. Because of this, we are unable to assess whether or not the packets made a significant difference in mental health literacy at the clinic. The surveys are available, translated in all four languages, if the clinic wishes to pursue this in the future.

However, given the aforementioned findings of the mental health need assessment, I feel that the goal of improving the quality of mental health education within the clinic's walls was accomplished. Whether this has made a tangible impact on mental health literacy in the clinic's patients, however, remains

unclear. Future directions can focus on not only expanding the variety of materials available to patients, but also a repeat need assessment to measure mental health literacy in the clinic's patients over time.

Barriers/Challenges:

There were multiple challenges, both anticipated and unanticipated, which were encountered over the course of this project. Perhaps most notably, the longtime administrative direct of the ICFMC retired following completion of the need assessment, as the capstone project phase was just beginning. As I had previously discussed and approved the idea of the capstone project with her, there were some struggles maintaining continuity as the newly hired director was understandably orienting to the other, more time-sensitive duties of her job. This was only further complicated by an increased rate in staffing turnover in the clinic in the months following. Some of the longtime staff that I had relied upon to assist me during the need assessment left their prior roles. These two factors led, understandably, to delays getting project approval. I was able to get the brochure and ICFMHC self-referral forms approved in time, however, for their inclusion in the packets this past fall/winter.

Another barrier to this project was getting documents translated. As mentioned before, I had relied heavily on UIHC Translation Services to translate surveys for the need assessment, which they graciously did for free. Due to staffing issues of their own, their workload did not allow them to take on this project without payment. Initial estimates for document translation were far beyond this project's budget.

Fortunately, Dr. Runde was able to connect me with the translation team at the Mobile Health Clinic, who translated the documents free of charge. This barrier, however, delayed getting the documents to ICFMC staff for their eventual approval.

Sustainability/Future Recommendations:

Although I was unable to include all the desired materials into the initial packets, I have worked with the clinic coordinator to put together a file in Microsoft Teams that includes all materials, including the brochure, ICFMHC information sheet, GAD-7 and PHQ-9 questionnaires, as well as other community resource materials. All ICFMC employees have access to this Teams file. The hope is that this file can serve as a source for staff to not only restock materials but also add/update materials going forward.

This current project aimed to address a few specific findings of the need assessment, namely the desire for educational materials and the uncertainty ICFMC patients had in their ability to identify and connect with mental health resources if needed. There are other findings of the need assessment that have not been addressed. Although we were able to provide self-referral information to the ICFMHC in these packets, many patients expressed a desire to discuss their mental health with their primary care provider. It would take a lot of time, funding, and other resources to implement mental health care into the ICFMC's already extensive list of services. I do believe that this goal, however lofty, should continue to be part of the clinic's future aspirations. Hopefully we were able to make a small step toward this goal via this project.

Personal Reflection:

For the personal reflection section, I'd like to start by discussing my experience not only with this project but with the Iowa City Free Medical Clinic more broadly. I started volunteering with the ICFMC as a sophomore in undergraduate. Over the past six years I've experienced the clinic through many changes, most notably having to navigate a global pandemic. The clinic has changed the way I view not only the healthcare system, but the world in general. As someone going into emergency medicine, it has made me more empathetic to the patients presenting to the ER with what most may consider "primary care complaints." I recognized the barriers that these patients experience finding consistent, quality primary care access early on in my time at the ICFMC. With time, and with the help of my projects through CHO and the SDT, I've been able to become more familiar with the work it takes on the reciprocal end of that relationship: which is the work done by the ICFMC to provide these services.

Many obstacles were encountered even over the course of this small project. These obstacles gave me a better appreciation of the administrative concerns that go into every change made within the clinic. For example, my original plan for my project was to include PHQ-9 screening into the clinic's workflow for primary care visits. If patients, however, were to fill out the assessment and endorsed suicidal ideation while in the clinic, then the clinic was obligated to have a means of providing crisis support to these patients, something that they were not confident they could provide if this were to occur. I had not considered this prior to proposing the idea to clinic staff, but it helped shape how I view the administrative difficulties that these organizations face.

I came into medical school highly motivated to integrate service into both my studies and into my future practice. I have been fortunate enough to have role models and mentors in my life that strike this balance amazingly well and will continue to serve as guides going forward. My work with the service distinction track, from CHO to my rural family medicine rotation to my capstone project, has only grown this passion and given me avenues to which I can serve as I become a physician. It has also heavily influenced my specialty choice. I am of the firm belief that in all specialties there is an avenue to care for the medically underserved. However, part of what drew me to emergency medicine is the ability to be a true safety net for these patients. My project has grown my interest in emergency psychiatric care, which I intend to carry forward into my future practice as both a learner and practitioner. Working in rural communities as part of the SDT curriculum additionally sparked a desire to integrate rural healthcare into my future practice, which is something that did not necessarily exist prior to medical school, even as a native Iowan.

As I reflect on my capstone project and the SDT more broadly, I think it has greatly shaped the physician that I strive to be as I enter the next step in medical training. It has grown preexisting passions while also sparking new ones. It has given me a better appreciation of the barriers that will continue to exist as I try to improve the health of the communities I serve. Lastly, the SDT has given me a structured way to prioritize service and push me outside of my comfort zone during medical school, and for that I am extremely grateful.

References:

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Appendices:

"If you have not used mental health services in the past, please circle all reasons why you have not."		
Response	**n**	**Percentage**
I do not feel like I need them	40	74.1%
I do not feel like they would help	2	3.7%
Cost	7	13.0%
I do not know where to find them	5	9.3%
Language	3	5.6%
Wait Lists	1	1.9%
Transportation	1	1.9%
I'm afraid of what others would think	3	5.6%
Other	1	1.9%
No Response	21	38.9%

Supplemental 1. Reasons cited for previous lack of mental health resource use.

Objective #2: Measure patient awareness of resources presently available in Johnson County.

"If I needed mental health services, I know where I could find help in the Iowa City area."		
Response	**n**	**Percentage**
Strongly Agree	7	9.3%
Agree	22	29.3%
Neutral	15	20.0%
Disagree	17	22.7%
Strongly Disagree	5	6.7%
No Response	10	13.3%

Supplemental 2. Need assessment results for question assessing present awareness of local mental health resources.

Objective #3: Identify interventions that the ICFMC can enact to connect patients with desired resources.

"What types of mental health services do you think you would use in the community?"		
Response	**n**	**Percentage**
Support Groups	24	32.0%
Hotlines	32	42.7%
Talk Therapy	13	17.3%
Speaking to ICFMC Doctor	20	26.7%
Information Sheets	5	6.7%
I would not use any resources	5	6.7%
Other	5	6.7%
No Response	9	12.0%

Supplemental 3. Desired resources by ICFMC patients.

"I think that information about mental health services in the area would be helpful to offer in the clinic."		
Response	**n**	**Percentage**
Yes	62	82.7%
No	6	8.0%
No response	7	9.3%

Supplemental 4. Assessment of desire for more mental health information to be offered in clinic.