Collaborative for Community Wellness

Asociación Colaborativa para el Bienestar Comunitario

Assessing Mental Health Service Accessibility in Chicago: Findings from a Survey of City-Funded Private Non-Profit Providers

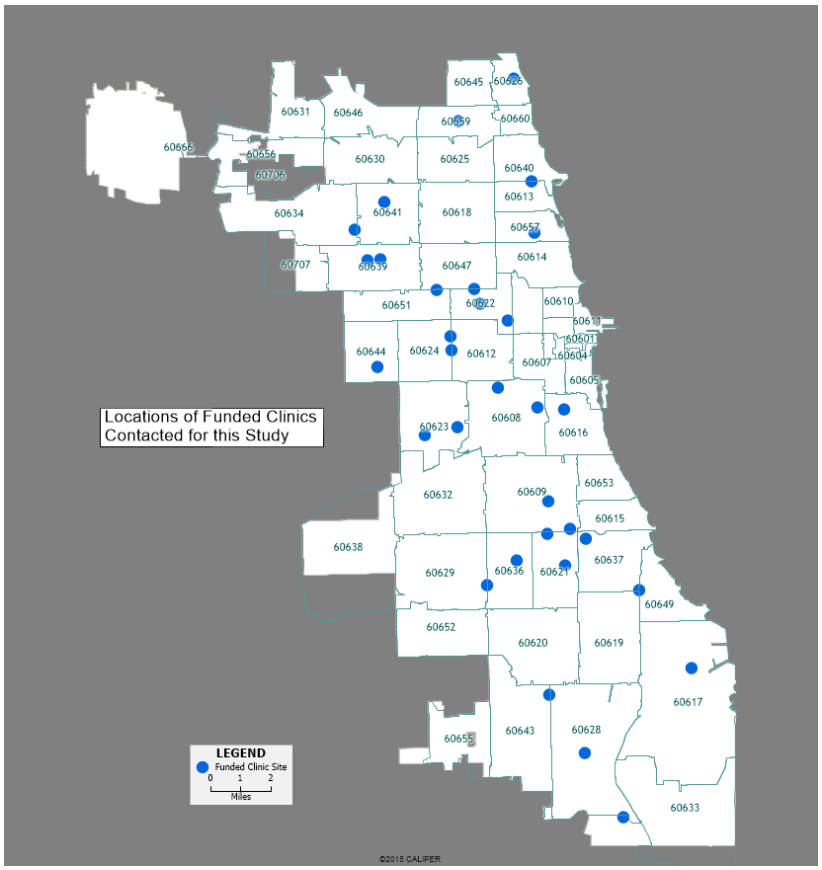
Introduction

In 2012, half of Chicago's public mental health centers were closed.[i] Past research has documented dire challenges with mental health service access among economically marginalized community residents in the context of these closures. Among the most prevalent access barriers are those associated with cost, lack of insurance coverage, lack of services in close geographic proximity, limited availability of culturally and linguistically appropriate services, and limited capacity of private non-profit providers to meet the demand for services.[ii] Despite these documented barriers, the City of Chicago and the Chicago Department of Public Health (CDPH) have consistently claimed that subcontracting funds to private non-profit providers is the solution for facilitating access to mental health care. In October 2020, Mayor Lori Lightfoot announced that the city was awarding a total of $8 million in grant funds to 32 private non-profit providers to support their delivery of mental health services.[iii] To understand the real-world accessibility of mental health services available through these private non-profit providers, the Collaborative for Community Wellness undertook a systematic assessment of the private non-profit providers who received grant funds through the city. The aim of this assessment was to gain a comprehensive understanding of the services that these organizations provided and to explore the extent to which they addressed commonly cited access barriers related to cost, insurance coverage, geography, and organizational infrastructure and capacity.

Study Methodology

Between February and March of 2021, we systematically contacted 32 organizations listed on the city of Chicago's website as being awarded grant funding. Then, in July of 2021, we received a list of funded organizations from the Chicago Community Mental Health Board that included the locations where services were to be provided at multi-site organizations. We identified five multi-site organizations where we had contacted locations that had not been funded, so we conducted a second round of calls to ensure we had contacted a funded location at each organization.

We developed a survey to ask each provider whether they offered mental health services and if so, what type of services they provided. We additionally inquired about structural and organizational factors that could either facilitate or impede service access, including service cost, wait lists, transportation assistance, availability of culturally and linguistically appropriate services, and referral requirements. We also asked about the availability of emergency support for individuals who were experiencing mental health crises during and outside of business hours. Furthermore, to assess factors associated with service quality and duration, we asked providers for information on the length of sessions and whether there is a limit on the number of sessions an individual can receive. We made a minimum of two attempts to contact each organization.



Out of the 32 funded organizations, three locations indicated they did not provide mental health services for adults or that the location was closed, and we were unable to connect with four organizations despite multiple attempts. We were therefore able to contact 25 organizations that did provide mental health services and gathered information from the websites of the remaining four organizations. Not every respondent answered each question. Data are reported as the percentage of valid responses.

Results

Provision of Services: Several organizations (17%) did not offer services to undocumented individuals. An even greater percentage (25%) did not offer services to uninsured people. A referral for services was required at 28% of organizations and could potentially be required at another 28% of the surveyed organizations, depending on the type of insurance that the client had. At 21% of organizations (primarily Federally Qualified Health Centers), patients were required to have a primary care provider in order to receive mental health services. The majority of organizations (68%) offered both in-person and virtual services, while 24% offered only virtual services and 8% offered only in-person services.

Types of Services: Most organizations (89%) provided individual therapy. Just over half (56%) offered family therapy, just under half (44%) provided psychiatric services, 37% offered group therapy, 37% offered couples therapy, and 37% offered case management.

Language: Most agencies (65%) provided services in at least English and Spanish, presumably with on-site staff. Additional languages included American Sign Language, Amheric, Hindi, Mandarin, Cantonese, and Polish. Another 10% of providers indicated that services were available in multiple languages, but through the use of translation services. A quarter of the surveyed agencies (25%) only provided services in English; some of these had previously provided Spanish services but had suspended them.

Transportation: All providers reported being near a bus or train line. The majority (64%) of providers offered transportation assistance such as free parking, Uber or Lyft rides, or Ventra passes.

Waiting Times: How quickly a prospective client could initiate services varied considerably. While some organizations (29%) offered an appointment within 1 week, over one third (35%) indicated an appointment would take 1-3 weeks and another 29% offered appointments in 1-3 months. One site had closed their waitlist because the next available appointment was over a year away.

Appointment Days and Times: Of the valid responses, all indicated availability during weekday hours between 8 AM and 6 PM. One organization (4%) offered appointments in the early morning (before 8 AM), 31% offered evening appointments after 6 PM, and 15% offered Saturday appointments. However, 62% of organizations did not offer any appointment times outside the hours of 8 AM - 6 PM on Monday through Friday.

Limitation on Sessions: While 68% of organizations indicated they did not have a limit on the number of sessions, 32% were unsure whether there was a session limit.

Payment Methods and Cost: At agencies where clients could use insurance, 79% had a copay. Most providers (70%) offered a sliding scale, and less than half (48%) offered a free option for services. Only three providers (12%) offered a sliding scale rate of $10 or below. Many providers were unable to quote specific values for cash rates without insurance or sliding scale; for those that did, the rate for individual sessions ranged from $100 to $300.

Phone Experience The callers rated the friendliness and helpfulness of the person answering the phone on a 1 to 5, with 5 being the most friendly or helpful. Most interactions were rated as 4 or 5 for both friendliness (83%) and helpfulness (88%). Out of the answered calls, 48% of callers were put on hold.

Website Experience: The callers also reviewed the organizations' websites. They found that 36% of the surveyed organizations allowed appointments to be scheduled over the internet. When assessing how easy it was to navigate the websites on a scale of 1 to 5, with 1 being the most difficult to navigate and 5 being the easiest to navigate, the callers rated 68% of the

websites between a 4 and a 5. A total of 32% of the organizational websites were rated at a 3 or below.

Response Limitations: Despite several outreach attempts to each organization, we were unable to contact four organizations. Additionally, respondents were unable to answer all questions. It is noteworthy, for example, that when asked about the cost of mental health services without a sliding scale, several respondents were unable to quote an exact cost for services. For the appointment times, two responses were excluded because they were too vague (i.e. “varies” as the entirety of the response). Finally, responses were self-reported by front desk staff, intake coordinators, or program directors, and therefore could be subject to bias. For instance, while the waiting list may be quoted as one week, it may actually take longer to be seen.

Implications and Recommendations

Nine years after the City of Chicago closed half of its public mental health centers and subcontracted with private non-profit service providers to facilitate mental health access and service delivery, no evidence exists that this goal has in any way been achieved. Despite a wide array of services documented among the surveyed providers, significant barriers to availability and accessibility continue to exist. Moreover, the barriers are most pronounced among the most vulnerable and at-risk populations in the city.

For the most part, community providers appear to be making good faith efforts to provide appropriate and accessible services, including a large percentage which offer some form of transportation assistance. However, significant limitations were documented which have adverse effects on accessibility and availability.

While most providers provide a sliding fee scale, free services are not universally available, and sliding scale fees remain unaffordable for many of the most vulnerable, specifically the undocumented and uninsured. Recognizing that cost and lack of insurance coverage have been cited as the most prevalent service access barriers in past research, it is concerning that options for accessing free services continue to be markedly limited. Similarly, while hours of operation vary widely, there is a notable lack of evening and weekend appointments—the times most working people and families are available.

While individual counseling services are generally available, more specialized services such as couples and family therapy are less frequent. Case management can provide a centralized and an updated referral database to people in need, and it was only provided by 37% of those surveyed. And while services in English and Spanish were commonly available, services in other languages, notably those represented in newer immigrant and refugee groups, were not.

It is also significant to note the number of those surveyed who did not respond or simply did not know the specific services their agencies provided, including their hours of availability and the cost of services.

Despite an overwhelming demand for services and a documented willingness of potential clients to seek help, a first-time potential consumer of mental health services inevitably approaches the process with some combination of hesitance, confusion, uncertainty, or fear.[iv] Under these circumstances, anything less than a fully engaging approach that eliminates all barriers at the point of initial contact will inevitably work as a deterrent. The combined factors documented in this survey are significant barriers to initiating services. Lack of access to services and treatment can lead to crisis situations. It cannot be over emphasized that in a 911 response to a mental health crisis, the person in crisis is 16 times more likely to be shot by police than in a non-mental health crisis situation.[v]

In summary, we recommend that the City of Chicago and CDPH take ownership in providing the necessary services to ensure that appropriate, accessible, and affordable mental health services are available to all Chicagoans and address barriers present in the private non-profit system. The City has continued to abdicate this responsibility of providing a public safety net by not reestablishing public mental health centers that have been closed by the City. Instead, this administration has repeatedly invested public resources in police oriented reactive crisis responses, such as CIT-police training and co-responder police programs.

In addition, the City should take leadership in immediately directing at least $10M in ARPA funds towards financing:

- Comprehensive mental health and case management services by expanding the capacity of the five existing CDPH mental health centers. The city should invest in additional clinical therapists and psychiatric nurse practitioners at each location, as well as support staff that assist community members in connecting to CDPH clinic services. Support staff should include outreach specialists who disseminate information about available services; peer support staff who support with mental health crisis calls; and staff who educate program participants about insurance options and assist with the insurance application process. With this expanded staff capacity, CDPH mental health centers should extend their hours of operation to enable complete evening and weekend availability to support individuals experiencing mental health crises as the city works on developing a crisis response system.
- The reestablishment of at least seven new CDPH mental health centers. This may include opening the closed sites, leasing or purchasing property to open new sites, and embedding clinicians within accessible, community-based settings.
- Accountability mechanisms to ensure that the CDPH mental health centers are operating as intended. There currently is a Community Mental Health Board that provides oversight to the five CDPH mental health centers. This structure should be expanded to include a Board at each clinic location, composed of community members who are current or former CDPH mental health service participants. Outreach specialists can play an instrumental role in engaging with community members to invite their participation in the Board. Recognizing that this formal accountability mechanism is not built into models of service delivery among non-profit providers, Community Mental Health Boards offer a critical quality assurance measure that is often missing within the private sector.

- The expansion of language capabilities to serve larger immigrant/refugee populations in Chicago (Polish, Mandarin, Arabic, Urdu, etc.), either through training of bilingual paraprofessionals, or development of more specialized translation banks.

This is a time of historic opportunity as well as massive need. We urge the City of Chicago to establish a model of responsive and accessible public mental health services.

About the Collaborative for Community Wellness

The Collaborative for Community Wellness is a collaborative that brings together mental health professionals, community-based organizations, and community residents to address the lack of mental health access and to redefine mental health to match the needs of the community.

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https://www.collaborativeforcommunitywellness.org/

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